National AIDS Commission 2007-2010 HIV and AIDS Response Strategies

Foreword

The systematic HIV and AIDS response in Indonesia commenced in 1994. However, the geographic extent of the epidemic and the number of HIV and AIDS cases has continuously increased since then. There are many factors that have influenced the spread of the epidemic in this country. In the early stages, considerable obstacles faced the HIV and AIDS response, not least public misperceptions as to the true nature of HIV and AIDS. This gave rise to stigmatizations, which in turn led to discrimination against people living with HIV. The misconception that HIV and AIDS only affected people with unhealthy or reprehensible lifestyles also led to people living with HIV concealing their identities, thus making them more difficult to reach. In addition, economic difficulties forced many more people to engage in high risk behavior – many of them young women, one of the most vulnerable population categories in Indonesia today. Furthermore, little headway was made in the effort to reduce the incidence of drug abuse, particularly among injecting drug users, the members of a subpopulation where HIV is spreading very rapidly.

Inherent weaknesses in the response and prevention efforts further undermined the progress achieved. Programs all too often were fragmented and involved too many parties without having regard to the need for proper coordination and integration. Lack of resources was also a major constraint. The central government provided very little in the way of funding compared to the seriousness of the epidemic, while most local governments continued to believe that their areas would somehow remain immune from the epidemic, and were therefore loath to commit funding to the HIV and AIDS response. A lack of leadership and resources resulted in the AIDS Commissions in the regions failing to function as originally anticipated. In fact, the HIV and AIDS response in many regions continued to be totally dependent on overseas technical and financial assistance.

In the light of these weaknesses, it was decided to review and update the National Strategies having regard to the challenges that will likely emerge during the timeframe of the Millennium Development Goals and that set by the United Nations General Assembly Special Session on HIV and AIDS, namely, the period up to 2020. The task of preventing and responding to HIV and AIDS will be an onerous but noble one for all of the stakeholders as identified by Presidential Regulation Number 75 of 2006.

These 2007-2010 HIV and AIDS Response Strategies are intended to serve as guidelines for a joint response to HIV and AIDS involving the government sector (at the center and in the regions), the non-governmental sector, civil society and our international partners.

In conclusion, we would like to express our gratitude to the Drafting Team and to all those who contributed to the preparation of these 2007-2010 HIV and AIDS Response Strategies. This document forms an integral and inseparable part of Coordinating Minister for Public Welfare/Chair of the

National AIDS Commission Regulation No. 07 / PER / MENKO/ KESRA / III / 2007 on the 2007-2010 HIV and AIDS Response Strategies

National AIDS Commission

Secretary

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Chapter I. Introduction

The HIV epidemic has developed into a global crisis. Throughout the world, more than 20 million people have already died, while 40 million more are infected as a result of the epidemic. HIV and AIDS currently constitute the greatest threat to socioeconomic progress, stability and security in developing countries, and have resulted in rapidly increasing poverty. Most worrying is the fact the some 2,000 children under the age of 15 contract HIV every day, mostly as a result of mother-to-child transmission, while 1,400 children under the age of 15 die of AIDS every day, and another 6,000 people of productive age between 15 and 24 are infected with HIV every day. It is this age group that accounts for the majority of people living with HIV.

In order to effectively respond to the epidemic in Indonesia, HIV AND AIDS Response Strategies were prepared for the periods 1994-2003 and 2003-2007.

It is widely recognized that in the years to come the challenges faced will be even greater and more complex than ever before. Accordingly, it has been deemed necessary to prepare a new set of strategies that will enable us to more effectively respond to the HIV crisis. These 2007-2010 HIV and AIDS Response Strategies have been designed having regard to the successes achieved to date, and spell out the new paradigm for the response to HIV and AIDS in Indonesia. While originally our efforts tended to be piecemeal and uncoordinated, they will in future be carried out in an integrated, synchronized and comprehensive manner by all stakeholders.

The accelerated provision of treatment, medication and support for people living with HIV will be accompanied by intensified prevention efforts among both high- and low-risk subpopulations, and among the population in general.

The ongoing consolidation and strengthening of the National AIDS Commission at all levels and AIDS Working Groups in all sectors will be continued so that proper leadership, implementation, coordination, monitoring and evaluation may be effected in respect of these 2007-2010 HIV and AIDS Response Strategies at the national, local and institutional levels.

1.1. HIV and AIDS situation in Indonesia, 1987-2006

The number of HIV and AIDS cases in Indonesia increased slowly between 1987 and 2000. That changed however in 2000, and since then the number of cases has been increasing rapidly. During the development these Strategies, it was found that the history of HIV and AIDS in Indonesia to date has involved the following two distinct periods:

1.1.1. Situation between 1987 and 2002

The first ten years of this period was marked by a slow increase in the number of HIV and AIDS cases. Based on serosurveys conducted in the Sentinel regions, it was found at the end of 1997 that there was a cumulative total of 153 people living with AIDS, while another 486 people were HIV-positive. Seventy percent of cases arose from unprotected sex. Since the end of 2002, a sharp increase has been recorded in the total number of AIDS cases, and in a number of regions the prevalence among high-risk populations has reached 5 percent. Since that time, Indonesia has been categorized as a country with a concentrated epidemic. In 2002, a total of 1016 AIDS cases and 2552 HIV cases were reported. These are much lower figures than the Department of Health's estimate that there were 90,000 and 120,000 HIV and AIDS cases in the country in 2002. The rapid spread of HIV has been primarily caused by the use of contaminated injecting equipment by injecting drug users, while the spread of HIV through unprotected sex continues apace.

1.1.2. Situation between 2003 and 2006

By the end of 2003, the number of AIDS cases had increased by 355, bringing the overall figure to 1,371, while the number of persons tested positive for HIV had increased by 168 to give a total of 2,720. Also by the end of 2003, 25 of Indonesia's provinces had reported AIDS cases, while transmission among the injecting drug user subpopulation had increased by 26 percent. The number of AIDS cases continued to increase through 2004, so that by the end of 2004 a total of 2,682 people had developed AIDS. By the end of 2005, this figure had almost doubled to 5,321, and by the end of September 2006 it had reached 6,871.

All of the above figures are based on reports from 32 of Indonesia's 33 provinces. The 2006 estimate for the number of people infected with HIV stands at between 169,000 and 216,000. Data from sentinel surveillance conducted by the Department of Health shows that the increase in HIV-positive prevalence was highest among the sex-worker high risk subpopulation at 23 percent, injecting drug users at 48 percent and prisoners at 68 percent. The increases in HIV prevalence were mostly found in major cities, while the increase in HIV prevalence among sex workers was found in both large and small cities, and even in rural areas, particularly in the provinces of Papua and Irian Jaya Barat. In these two provinces, the epidemic has started to spread into the general population, as may be seen from the fact that housewives are contracting HIV in both urban and rural areas.

The AIDS distribution pattern in 2006 revealed high percentages of people with AIDS among young people and children. Young people between the ages of 20 and 29 accounted for 55 percent of all cases. If we combine these with those in the age group of up to 49, then the two groups account for 89 percent of all cases. Meanwhile, the figure for under-fives with AIDS amounted to 1 percent. It is estimated that in 2006, a total of 4,360 children contracted HIV from their HIV-positive mothers, and that have of these children have already died.

1.1.3. Future Trends

1.1.3.1. Epidemiological and Behavioral Trends

Epidemiologists in Indonesia predict that if the response to HIV and AIDS is not significantly ramped up, then by the year 2010 the number of AIDS cases will have increased to 400,000, with 100,000 people having died, while by 2015 the number of cases will have increased to 1,000,000, with some 350,000 people having died. The greatest risk of HIV AND AIDS will continue to be among members of subpopulations with high risk of exposure to HIV, and to the partners of members of these subpopulations. It is estimated that by 2015, a cumulative total of more than 38,500 children will be HIV-positive as a result of mother-to-child transmission.

The above trends are the result of increases in the sizes of subpopulations with high risk of exposure to HIV, particularly the injecting drug user subpopulation, and as a result of stigmatization and discrimination against people living with HIV. Other causative factors include resistance to first-line antiretroviral drugs, inadequate antiretroviral surveillance, and insufficient availability of second-line antiretroviral drugs.

1.1.3.2. Response Trends

Presidential Regulation Number 75 of 2006 mandated the ramping up of the HIV and AIDS response throughout the Republic of Indonesia. This response must be designed so as to minimize to the maximum extent possible the number of new cases of HIV and AIDS and resulting deaths.

One of the strategic initiatives that will be pursued is the strengthening and consolidating of the National AIDS Commission at all levels. It is hoped that additional budgetary funding will be provided by the state in line with the increasing complexity of the problems being faced. Each sector will need to increase its human resources and expand its coverage. Civil society, including non-governmental organizations (NGOs) will also be encouraged to expand their roles right down to the village level as partners of the government in the response to HIV and AIDS. Meanwhile, it is hoped that our international partners will continue to provide technical and funding assistance.

1.2. Social and Economic Impacts

1.2.1. Impact on Demography and Ensuing Consequences

One of the most significant long-term effects of the worsening HIV and AIDS epidemic is its impact on demographic indicators. This impact has been particularly pronounced in Africa. The disproportionate number of young people with HIV and AIDS results in reduced life expectancy. As more people will have shorter life spans, their contributions to the national economy and social development will diminish. This is a serious problem as the loss of educated and trained young people will be difficult to make up.

1.2.2. Impact on Health Services

A high prevalence of HIV and AIDS in any population group means that more people will fall sick and require health services. The slow worsening of a person's health following HIV infection means that the individual will likely be in need of long-term medical services and care. The cost of this medical care to people living with HIV will increase as time goes on. One of the economic costs that will have to be borne arises from the time spent by members of the family in caring for the people living with HIV, where such time could otherwise be devoted to productive economic activities. The amount of time and resources that have to be devoted to caring for people living with HIV will slowly but surely have an impact on other programs and the resources available for other healthcare aspects.

A study sponsored by AusAID (2005) on the impact of HIV and AIDS on socioeconomic conditions in a number of Southeast Asian and Pacific countries predicted that by 2010, if the HIV and AIDS response is not significantly ramped up, six percent of hospital beds will have to be allocated to AIDS patients, while in Papua the equivalent figure will be fourteen percent. By 2025, the report predicted, these figures will have increased to 11 percent and 29 percent respectively. An increase in the number of people living with HIV means an increase in antiretroviral needs, which in turn will have an impact in the form of higher government spending on procurement and distribution.

The destruction of the body's ability to fight off infection and disease exacerbates the problems caused by tuberculosis. A variety of studies have shown that the incidence of TB significantly increases among people living with HIV. TB is currently one of the principal health challenges facing Indonesia, with more than 300,000 new cases being reported every year. Thus, the responses to both HIV and tuberculosis must be simultaneous and coordinated.

1.2.3. Impact on the National Economy

As HIV disproportionately affects young people and those of productive age (94 percent of cases affect people between the ages of 19 and 49), the HIV and AIDS epidemic has a major impact on the availability and productivity of labor, and will result in greater poverty and economic disparities resulting from its impact on individuals and the overall economy. From the point of view of the individual, infection will mean time off work, a reduction in the overall number of days worked, fewer chances to secure better paid employment, and a shorter productive lifespan. These consequences for the individual must be taken together with the consequences for the individual's family and community. The effects on business include loss of profit and productivity as a result of a diminution in people's zeal for work, higher levels of sick leave or compassionate leave to look after sick family members, more rapid staff turnover, the loss of experienced employees, a decline in productivity resulting from the hiring of new, inexperienced employees, and increased costs associated with training new employees. HIV and AIDS also play a role in eroding the motivation of workers (fear of discrimination, loss of colleagues, etc.), and earnings per employee as a result of increased

demand for medical services from company clinics, the taking of early retirement, early pension lump-sum payouts as a result of a higher mortality rate among employees, and increased insurance costs. Consequently, the instituting of HIV prevention programs in the workplace, involving both labor and employer associations is very important.

Economic growth will be seriously undermined if the HIV epidemic results in greater poverty, thereby increasing social disparities and the level of social envy.

Poverty is a major factor encouraging people to engage in high risk behavior. However, high income levels (generally to be found at the skilled and professional levels) also open the door to high risk behavior: Living far from home and engaging in unprotected sex with multiple partners or sex workers, taking prohibited drugs, consuming alcohol, etc.

1.2.4. Impact on Society

The discrimination and stigma that has historically been directed at people living with HIV will have a pronounced impact on society. People living with HIV may be deprived of care and warmth in their communities. Others may lose their jobs and sources of livelihood, which in the end will give rise to social tensions. Many couples have divorced after one of the partners tested HIV-positive. The increasing number of children infected with, or affected by HIV and AIDS will give rise to social problems on its own. Consequently, efforts to encourage openness and the ending of all forms of stigmatization and discrimination in the community will be essential.

1.3. Response to HIV and AIDS

1.3.1. Response from 1985-2001

The National Response to the HIV and AIDS epidemic in Indonesia commenced in 1985, and has been intensifying since then in line with the increasing scale and complexity of the problems being faced by both the government and community in general. The principal responses during the early period were the establishment of the Department of Health's AIDS Response Working Group, the introduction of compulsory reporting of AIDS cases, the designation of laboratories authorized to conduct HIV tests, and the designing and dissemination of information, education and communication (IEC) materials. HIV surveillance was also introduced among designated subpopulations, while the capacity of health and other professionals in responding to the HIV and AIDS epidemic were improved. In addition, a large number of NGOs concerned with HIV and AIDS issues were established.

With the issuing of Presidential Decree Number 36 of 1994, the government established the National AIDS Commission at the center, which was followed by the establishment of branches of the National AIDS Commission in a number of provinces. The formulation and adoption of the 1994 National HIV and AIDS Response Strategies (STRANAS 1994) was a highly significant response during this period. The National AIDS

Commission also started to coordinate the disparate responses of the government and NGOs, while overseas assistance in the form of both bilateral and multilateral aid began to have a beneficial effect on the robustness of the HIV and AIDS response. As time went by, the amount of assistance continued to increase in terms of both variety and quality.

In 2002, the Indonesian government held two Cabinet meetings specifically to discuss the HIV and AIDS issue (one in March and one in November). These resulted in the following important decisions:

Government departments/organizations had to make strong commitments and responses to preventing the spread of HIV;

The organizing of a National HIV and AIDS Prevention Movement, which will continue until 2010;

The identifying of HIV and AIDS Prevention as a National Development Priority, and its including in the National Development Strategic Plan of each government department/organization;

The allocation of annual funding to the National Stop HIV and AIDS Movement;

Designating and strengthening the National AIDS Commission as the organization responsible for coordinating the HIV and AIDS response.

1.3.2. Responses in 2003-2006

The year 2003 say the launching of the 2003-2007 National HIV and AIDS Response Strategies, which set out to address the increasingly difficult and complex challenges presented by the HIV and AIDS epidemic. From 2003 to date, the Department of National Education has been running its Life Skills Program in Indonesia's schools. In 2004, the HIV and AIDS Response in the Workplace Program was launched by the Department of Manpower and Transmigration based upon ILO recommendations. In order to ramp up the harm-reduction effort among injecting drug users, a Memorandum of Understanding on an integrated response to HIV, AIDS and injecting drug use was signed in 2003 by the Coordinating Minister for Public Welfare (in his capacity as the chair of the National AIDS Commission) and the National Police Chief (in his capacity as the chair of the National Drugs Agency (BNN)). This was followed in 2007 by the issuance of a Coordinating Minister for Public Welfare Regulation on harm reduction among injecting drug users. In order to meet the need for antiretroviral drugs, the domestic production of these drugs was initiated by state-owned pharmaceutical firm PT Kimia Farma. Meanwhile, accelerated responses were introduced in the six Indonesian provinces suffering from the highest HIV and AIDS prevalence levels. This took place after the Sentani Commitment was signed in January 2004. These accelerated responses have since been expanded to another 8 provinces. The HIV and AIDS response in correctional facilities commenced in 2005, and continues to be intensified. The year 2005 say the launch of a response acceleration program in 100 regencies/municipalities located in 22 provinces, together with the introduction of a National HIV and AIDS Monitoring, Evaluation and Reporting System. The Department of

Health originally designated 25 hospitals for the provision of CST services, including the provision of antiretroviral treatment. This figure has since been increased to 75. In July 2006, the National AIDS Commission was restructured by virtue of the issuance of Presidential Regulation Number 75 of 2006, which led to the involvement of more sectors, including the Armed Forces, National Police, National Drugs Agency, and civil society. The year 2006 ended with the submission of a report on the estimated membership of high-risk subpopulations that will serve as a basis for future planning. The end of the year also saw the issuance of Coordinating Minister for Public Welfare/National AIDS Commission Regulations on harm reduction among injecting drug users, which represented a follow-up to the Memorandum of Understanding that had been signed by the National AIDS Commission and the National Drugs Agency in 2003. In addition, a restructuring of the National AIDS Commission secretariat was carried out.

1.4. Significant Issues

1.4.1. Increase in number of injecting drug users

The number of people using prohibited drugs in Indonesia continues to increase, especially among teenagers and young people. Although the majority of the country's estimated 1.32 million drug users do not use heroin or inject, a small percentage of them do. According to a 2006 Department of Health estimate, there are between 191,000 and 248,000 injecting drug users in Indonesia. Separately, the National Drugs Agency estimated the number in 2006 to be as high as 572,000. The incidence of injecting drug use continues to be concentrated in the big cities of Java and other provinces outside of Java. This is highly worrying given that the rate of transmission of HIV among the injecting drug user subpopulation is high, and continues to rapidly increase. The problem is exacerbated by a lack of concern about HIV and AIDS, as revealed by a 2002 behavioral survey, which found that two-thirds of injecting drug users who said they were not at risk of infection also said that they had used contaminated injecting equipment in the week prior to the survey.

1.4.2. Injecting drug use among prisoners

Of the total 101,036 prisoners in Indonesia's correctional facilities, 23,409 of them were convicted of drug offenses. Of these, 70 percent are drug users (17,088) and 40 percent are injecting drug users. Although Indonesia has 13 correctional facilities designed for the housing of drug offenders, between 50 percent and 60 percent of these prisoners continue to be housed in ordinary facilities.

A correctional facility is a very high risk place for the spread of HIV due to the increased incidence of high risk behavior. This situation is exacerbated by overcrowding and the minimal health facilities available to prisoners. In addition, prison officials and guards appear to know very little about HIV and AIDS.

The number of prisoners testing positive for HIV in Indonesia continues to increase. Figures from the Department of Health show that in 2000, 17.5 percent of all prisoners were HIV-positive. This figure had increased to 22 percent in 2002. Another study found that 24.5 percent of prisoners in Jakarta correctional facilities were HIV-positive, while in Bali the figure was 10.2 percent. In the same prison in Bali, 56 percent of injecting drug users were HIV-positive. The rapid increase in the number of HIV-positive prisoners in Indonesia's correctional facilities appears to be the result of increasing numbers of injecting drug users being sent to jail. The number of injecting drug users in Indonesian correctional facilities increased from 7,211 in 2002 to 11,973 in 2003, and further increased to 17,000 in 2004. While many prisoners may have been infected outside prison, there is no doubt the many others have been infected inside prison as a result of engaging in high risk behavior.

HIV-positive prisoners who have served their sentences will return to society, and, if they do not receive counseling, will very likely transmit HIV to their partners and other people.

1.4.3. Unsafe sex

One of the significant characteristics of both industrial areas and tourism destinations marked by high levels of population mobility is the high incidence of unsafe sexual behavior. The number of sex workers (male, female and transgender) is increasing from year to year. Direct prostitution is carried on in red-light areas, brothels and similar establishments, and public places, while indirect prostitution is carried on in places of entertainment, such as karaoke centers, bars, beauty salons, massage parlors, etc. Sex workers constitute a subpopulation with a higher risk of exposure to HIV, together with gay people, transgendered people, and men who have sex with men. According to Department of Health estimates, the number of female sex workers in Indonesia in 2006 stood at between 177,200 and 265,000, the number of transgendered sex workers at between 21,000 and 35,000, and the number of men who have sex with men at between 384,000 and 1,148,000. Meanwhile, the client numbers for female sex workers were much bigger at between 2,435,000 and 3,813,000, compared with between 62,000 and 104,000 for transgendered sex workers. The number of male sex workers has been increasing in the country's big cities. It is feared that faster economic growth in the cities and stagnant growth in rural areas will lead to further increases in the number of female sex workers. If efforts are not consistently made to promote safe sex among these women and their clients, then HIV will continue to be spread by this means, with the virus then being brought back by infected women to their home villages.

Gay people, men who have sex with men and transgendered people continue to be marginalized in Indonesia. Although these subpopulations play a significant role in the spread of HIV, little in the way of prevention efforts have been specifically targeted at homosexual and transgendered people. The marginalization they experience forces many homosexual men to lead superficially heterosexual lives that accord with the values prevailing in the

community, while at the same time concealing their homosexuality. Accordingly, it is not easy to reach this vulnerable group using messages that touch a cord with them. The marginalization of the homosexual community also results in a lack of trust and an unwillingness to engage in open communication, a lack of dissemination of appropriate information, and high levels of unsafe sex. This situation will ultimately have an impact on society at large as a result of members of this community having sexual relations with both women and other men.

1.4.4. Population Mobility

The physical development taking place in urban areas and the lack of job opportunities in rural areas results in significant rural-urban migration in Indonesia. The industrial and construction sectors are dominated by male workers, while the domestic-help market is dominated by female workers. The domination of different sectors by one or other of the sexes results in large numbers of single people, which in turn increases the likelihood of people engaging in high risk behavior. Improvements to transportation infrastructure also play a role in increasing population mobility.

International migration has the potential to accelerate the spread of HIV and AIDS. The number of Indonesian workers being sent overseas is increasing from year to year, with the majority of these workers being young and having very little knowledge about HIV and AIDS.

1.4.5. Children infected or affected by HIV and AIDS

The increasing number of people living with HIV will have an impact on the number of children who contract HIV from their HIV-positive mothers. Children are also threatened by deviant sexual behavior on the part of adults, particularly in the country's large cities. The high mortality rate among people with AIDS will result in increasing numbers of children left orphaned by AIDS. These children will be burdened not only with health problems, but also psychosocial and economic problems.

1.5. Challenges

Over the course of at least the next four years, the HIV and AIDS response in Indonesia will continue to face a number of significant challenges that will require attention. These challenges may be enumerated as follows:

1.5.1. Social Behavior and Norms

The nature of Indonesian society has an influence on the progress of the epidemic. Many circles continue to express dissatisfaction with the promoting of condom use for safe sex. Poor communications between couples regarding their sexual needs, together with the dependency in Indonesia of women upon men both emotionally and for their socioeconomic needs, have reduced the capacity of women to require safe sex. These factors are compounded by the high level of sexual violence in some communities, and the fact that sexual activity among young people often starts at a much younger age than is believed by their parents, teachers and other adults.

The fact that discussing sexual issues is often considered taboo makes it more difficult to transmit messages about sexual health to teenagers, and prevents the inclusion of sex education in the school curriculum. Negative opinions about same-sex relations result in both individuals and groups being unwilling to accept the existence of real and present risks. Many men who have sex with men also engage in sexual relations with women, thereby increasing the risk of transmission to women and their children. Although condoms are easier to obtain nowadays, limited social acceptance is still hampering their more widespread use. Excessive and widespread consumption of alcohol and other addictive substances among young people often results in their losing control of themselves, and in sexual violence and various forms of high risk behavior. In order to increase the chances of success, the prevention campaign will need to recognize and respond to these factors in a realistic and strategic manner.

1.5.2. Coordinating the Multiparty Response

Experience in many countries shows that an effective response to HIV must involve all government sectors in encouraging greater community participation. The support of the government at the policy-making level and the existence of an unequivocal political commitment are essential to the success of the response over the long term. Although many public figures speak publicly about the importance of properly responding to this epidemic, real, unequivocal and sustained political will and commitment will be required so as to effectively combat the HIV epidemic. Since the rolling out of local autonomy, such political will and commitment have also been essential at the local level, where physical development needs to be matched by social development, including as regards the effort to combat the spread of HIV.

1.5.3. Policy and Program Development

The policy and program development areas still suffer from weaknesses as a result of various constraints, including a lack of accurate data on the extent of the epidemic, causes and consequences, and future trends. More operational and behavioral research needs to be undertaken so as to provide a solid foundation for policy-making. The limited funding available for the HIV and AIDS Response Program (particularly from domestic sources as opposed to donor assistance) clearly shows the low level of priority attached to the HIV and AIDS response, despite the gains that have been made in recent years. Strategic planning is frequently marked by inconsistency, particularly as regards effective and efficient intervention, and the funding thereof. Accordingly, statistics need to be collected on a regular basis in each province and regency/municipality so as to provide policy makers with accurate information that will allow them to design effective programs and responses.

1.5.4. Meeting the needs of teenagers and young people

The “teenager and young people” group has an essential role to play in the HIV and AIDS response. The fact that 57.8 percent of AIDS cases in 2006 involved people of between the ages of 15 and 29 clearly shows that young

people are particular vulnerable to HIV. This is in line with the fact that the majority of drug users are teenagers and young people. Almost 30 percent of Indonesia's population is aged between 10 and 24. It is these young people who need to be specifically targeted by well-conceived education and outreach campaigns so that they can avoid becoming members of subpopulations with high risk of exposure to HIV. Premature sexual contact entails the risk of HIV infection.

Many surveys have revealed that the majority of respondents had their first sexual experiences at between the ages of 13 and 15. These sort of findings surprise many adults, including teachers and parents, who frequently act to obstruct the furnishing of information on sexual and reproductive health to young people. Most life skills and reproductive health programs in Indonesia are focused on older age groups (high school students, for example. However, the evidence clearly shows that such information needs to be provided to young people at a much earlier age. The statistics reveal that some 60 percent of girls in rural areas do not continue their education after graduating from elementary school. Accordingly, they will be unable to benefit from life skills programs (which, among other things, provide information on reproductive health and HIV) if these are only provided at the junior high and high school levels. Consequently, such information now needs to be furnished at the elementary school level.

1.5.5. Particular Risks faced by Girls

Young girls in certain communities are highly vulnerable to infection. This reflects the social conditions prevailing in these communities. Pressure from peers to engage in premature sexual relations, and the concealed problems of sexual coercion, rape, incest and domestic violence all have a serious effect on the lives of young girls.

Children, particularly girls, are also highly vulnerable to sexual exploitation and violence. These problems are frequently associated with poverty and dysfunctional family relations. Children who are sexual abused often end up losing their self-respect, and control over their lives. This in turn heightens the risk of their falling victim to drugs, engaging in premature sexual relations, and leading promiscuous lifestyles, all of which increase the chances of infection with HIV. The overall incidence of violence against women in general, and girls in particular, appears to be on the rise. This worrying trend will need to be addressed in concrete terms by policy makers so as to protect girls from HIV.

1.5.6. Need for expanded care, treatment and support

Improving the availability and quality of medication and treatment services for the increasing number of people living with HIV must be made a priority. As of the end of 2006, the health facilities available to people in need of treatment, medication and support had been expanded in line with the increasing number of infections. A total of 75 hospitals are now equipped to provide treatment and antiretroviral medication, and with the necessary facilities for making diagnosis and monitoring medication.

A start has been made on involving the Puskesmas (community health centers) as part of the effort to bring medical services closer to those who need them. Improving the training of health workers will need to be coordinated so that they are capable of providing prevention and treatment services, administering antiretroviral treatment, treating opportunistic infections, providing psychosocial support, and improving the nutrition of people living with HIV. The healthcare capacity-building program not only covers the provision of adequate supplies of medicines, but also improving the quality, as well as the confidentiality, of healthcare information. The possibility of resistance to front-line antiretroviral drugs must be anticipated through the conducting of antiretroviral surveillance and the provision of second-line antiretroviral drugs.

1.5.7. Stigma and discrimination

Stigmatization and discrimination in respect of people living with HIV are still a reality and a challenge that must be overcome in Indonesia as otherwise they have the potential to obstruct the HIV and AIDS response. The elimination of discrimination directed at people living with HIV in healthcare facilities, the workplace, public places such as hotels, in the family and in the community at large must be made a priority and an integral part of the HIV and AIDS response. Accordingly, support and active participation in this endeavor on the part of the government, private sector and community are of the essence. The role played by peer support groups also needs to be strengthened, and they need to be mobilized as effective partners in reducing stigmatization and discrimination, while at the same time providing support for those most in need of it.

1.5.8. Decentralization and Local Autonomy

The decentralization process and the rolling out of local autonomy are intended to improve overall conditions in society, including in the healthcare sector. Local autonomy provides the opportunity to local governments to plan and implement programs that the region actually needs (rather than one-size-fits-all programs being imposed from the center as was the case previously). This also applies to the HIV and AIDS response, where programs can now be tailor-made to suit local needs. Inspired by the Sentani Commitment, a number of provinces, and regencies/municipalities have devoted quite considerable attention to the HIV and AIDS epidemics in their respective regions. However, the majority of local governments to date have failed to take on board the seriousness of the situation, or to make the HIV and AIDS response one of their priorities, despite the worrying statistical trends. Advocacy directed at local governments needs to be moved up a gear so as to ensure that the National AIDS Commission's branches in the regions are strengthened and provided with greater funding and other forms of assistance.

Chapter II. National HIV and AIDS Response Strategies

2.1. Objectives of HIV and AIDS Response

2.1.1. General Objectives of HIV and AIDS Response

To prevent and reduce the spread of HIV, improve the quality of life of people living with HIV, and reduce the social and economic impacts resulting from HIV and AIDS on the individual, family and society.

2.1.2. Specific Objectives of the HIV and AIDS Response

2.1.2.1. To provide and disseminate information on HIV and AIDS, and to foster a conducive climate for HIV and AIDS prevention efforts, with the focus being placed on high-risk behavior and environments, while at the same time having regard to other subpopulations in society.

2.1.2.2. To provide and improve the quality of treatment, medical, and support services to people living with HIV, and to integrate these services with the HIV and AIDS prevention effort;

2.1.2.3. To increase the roles played by teenagers, women, families, the public at large, including people living with HIV, in the HIV and AIDS response;

2.1.2.4. To develop and improve partnerships between the government and civil society, including NGOs, the private sector, the business community, professional organizations, and international partners at the center and in the regions so as to heighten the national response to HIV and AIDS;

2.1.2.5. To improve policy coordination in the HIV and AIDS response and prevention effort at the national and local levels.

2.2. Policy Basis for HIV and AIDS Response

The transmission and spread of HIV is closely connected with high risk behavior. Consequently, the prevention effort must have regard to those factors that influence such behaviors. As the majority of HIV and AIDS cases affect those subpopulations with high risk of exposure to HIV, most of which subpopulations are marginalized in society, the HIV and AIDS prevention and response program will need to have regard to religious and cultural values, rather than focusing solely on the medical aspects. An effective and expanding HIV and AIDS prevention program is essential, together with comprehensive medication, treatment and support programs for both people living with HIV and people affected by HIV and AIDS so that the quality of their lives may be improved.

Based on the approach, the following HIV and AIDS responses have been formulated:

2.2.1. The HIV and AIDS response and prevention effort must have regard to religious and cultural values in society, and should be focused on maintaining and strengthening the resilience and wellbeing of the family.

2.2.2. The HIV and AIDS response and prevention effort shall be undertaken by civil society and the government based on the principle of partnership. Civil society, which includes NGOs, peer support groups, people living with HIV and people affected by HIV and AIDS, shall have the primary responsibility in this regard, while the government shall provide directions and guidelines, and created a conducive environment for the HIV and AIDS response and prevention effort;

2.2.3. The HIV and AIDS response prevention effort needs to be predicated upon the understanding that HIV and AIDS is both a social and national problem that has been responded to by the "National HIV and AIDS Prevention Movement".

2.2.4. While the HIV and AIDS response and prevention effort will prioritize high risk subpopulations, it will also have regard to other vulnerable populations, including those rendered vulnerable to HIV and AIDS by the nature of their work, and marginalized populations.

2.2.5. The HIV and AIDS response and prevention effort must respect the dignity of human beings, as well as gender equity and gender equality.

2.2.6. The HIV and AIDS response and prevention effort among school children, teenagers and young people will in general be carried out by way of information, education and communication (IEC) so as to encourage young people to lead healthy lives. Education efforts shall include both intra- and extracurricular activities.

2.2.7. One effective method of HIV prevention is the 100 percent use of condoms during high risk sex, solely for the purpose of breaking the chain through which HIV is transmitted.

2.2.8. HIV transmission among injecting drug users will be tackled through comprehensive harm reduction programs designed to help injecting drug users overcome their addiction.

2.2.9. The HIV and AIDS response and prevention effort will be carried out in an integrated manner through improving health behavior, disease prevention, medication and treatment based upon scientific facts and data, and the provision of support to people living with HIV.

2.2.10. Every AIDS test must be preceded by the furnishing of accurate information so as to secure the informed consent of the person concerned. Proper counseling must be provided both prior and subsequent to the conducting of the test, with the results of the test being informed to the person concerned, but kept confidential from all third parties.

2.2.11. Legislation and regulations need to support and be harmonized with the HIV and AIDS response and prevention effort at all levels.

2.2.12. Service providers must be prohibited from discriminating against both people living with HIV and people affected by HIV and AIDS.

2.3. Strategies

In order to achieve the above objectives, the following strategies have been adopted:

2.3.1. Promoting and expanding tried and tested prevention methods, and assessing new methods.

The scaling-up and expansion of prevention efforts focused on effective methods of prevention, such as condom use during high risk sex, harm reduction among injecting drug users, and upgrading the effort to prevent the spread of sexually transmitted diseases. This strategy also involves the scaling-up and expansion of voluntary counseling and testing services, and the prevention of mother-to-child transmission. This is in line with the prevention principles recommended by UNAIDS.

2.3.2. Empowering individuals, families and communities to prevent the spread of HIV in their environments.

Various activities will be directed at individuals, families and communities for the purpose of involving them at various levels of the prevention effort in their own environments. Individuals, families and communities will be encouraged to protect themselves against HIV through the dissemination of information using various media. Broad participation will encourage positive social changes in the direction of greater gender equality and concern for safe and healthy sexual lifestyles. These empowerment efforts are also intended to encourage individuals, families and communities to accept people living with HIV and people affected by HIV and AIDS in their environments, and provide them with the support they require.

2.3.3. Strengthening the basic healthcare and referral systems so as to anticipate an increase in the number of people living with HIV requiring access to treatment and medication.

Heightening the response to HIV and AIDS will require the expansion of services so as prepare for an anticipated increase in the number of people living with HIV requiring treatment and medication. A comprehensive service expansion and improvement program will involve the gradual equipping and upgrading of more community health centers. The strengthening of these first-line healthcare facilities will also mean strengthening their subsystems as part of the overall National Health System.

2.3.4. Strengthening the capacity of those involved in the HIV and AIDS response at both the center and in the provinces through continuing education and training.

A wide variety of people are involved in the HIV and AIDS response and prevention effort at the center and in the provinces, including policy makers, planners, field executives, and monitoring and evaluation personnel. Their

number will need to increase in line with the expanded scope of their work. They must be fully prepared and equipped so as to be able to properly discharge their responsibilities, something that can be achieved through the provision of quality and continuing education and training. No distinction will be made between those working for government organizations and those from civil society. The provision of training will also require the formulation of training standards.

2.3.5. Increasing research and survey efforts so as to obtain accurate data on the progress of the HIV and AIDS response and prevention effort.

Accurate data and facts are essential for the planning of programs so as to ensure that they are properly focused. Appropriate indicators can be drawn up for evaluating their success. In this regard, more research and studies will need to be conducted. Data is also required for improving and developing programs. Identifying the reasons why a particular program failed to achieve its targets will require study and analysis. Monitoring also needs to be intensified.

2.3.6. Improving national HIV and AIDS monitoring capacity

In modern management science, monitoring and evaluation are of the utmost importance. It is only through continuing monitoring and regular evaluation that programs can be fine-tuned so as to ensure that they achieve their targets. Monitoring and evaluation processes require sensitive and accurate indicators that have been jointly agreed on.

2.3.7. Mobilizing resources and harmonizing their use at all levels.

The up-scaling and expansion of the HIV and AIDS response will require greater funding from various sources, including both domestic and overseas sources. The available resources will be mobilized for the purpose of achieving clear objectives. In addition, resource use will be harmonized and synchronized so as to ensure efficiency. The collection of funds for one program and not for another program will be avoided.

2.4. Continuity

The 2007-2010 HIV and AIDS Response Strategies are based upon the previous National Strategies and the successes achieved to date. Activities already underway will continue to be expanded, improved and fine tuned.

Chapter III. HIV and AIDS Response Priorities

In line with the preceding chapters, the priorities for the HIV and AIDS response in Indonesia over the next four years will continue as before, but will be further fine-tuned and developed.

Provided that the programs developed for each priority area are implemented in a committed, serious, accountable, integrated, harmonized and sustained manner, then the targets set as part of the HIV and AIDS response will be capable of being achieved within the agreed timeframe, despite the current lack of resources allocated to the response. These targets may be enumerated as follows;

Preventing the spread of HIV and ensuring access to prevention, treatment, medication and support services;

Contributing to the needs of people living with HIV so as to relieve their burden and improve their quality of life;

Capacity-building for those involved in the HIV and AIDS response

Coordinating and maintaining the response.

Bearing in mind the vast geographical extent of Indonesia and the limited resources available, the process of determining priority locations and regions for program implementation needs to have regard to HIV and AIDS epidemiological data, and the leverage that will be obtained as the result of instituting a program in a particular area.

The priority areas for HIV and AIDS response during the 2007-2010 period are as follows:

Preventing the transmission of sexually transmitted infections, HIV and AIDS;

Providing care, treatment and support to people living with HIV;

HIV, AIDS, and sexually transmitted infection surveillance;

Conducting of operational and other forms of research;

Encouraging conducive environments;

Engaging in multiparty coordination and harmonization;

Ensuring a sustained response

3.1. Prevention

The spread of HIV is influenced by high risk behavior among certain subpopulations. The prevention effort will be primarily focused on these subpopulations, with the approaches and materials employed being

designed to bring about behavioral change. Activities will include information, education and communication, the promotion of healthy lifestyles, life skills education, and training on the proper use of prophylactics, and will be appropriately packaged for each target group.

The different target groups are as follows:

Infected people

Infected people are people who are already infected with HIV. Our work among this group will be focused on slowing down the progress of HIV, maintaining the productivity of individuals, and improving their quality of life.

High risk people

High risk people are those who tend to engage in high risk behavior. These people are categorized into a number of high risk subpopulations, including male, female, and transgendered sex workers, and their clients, injecting drug users and their partners, and men who have sex with men (gay men). Prisoners are also categorized as a high risk subpopulation. The prevention effort among these subpopulations is focused on encouraging safe behavior.

Vulnerable people

Vulnerable people are those who are at high risk of exposure to HIV on account of their work, environment, or family circumstances, as well as prisoners and those whose health renders them particularly vulnerable.

Included within this subpopulation are 1) persons with high levels of mobility (civilian and military), healthcare staff, and refugees/IDPs; 2) women, teenagers, street children, expecting mothers, and those who have received blood transfusions. The prevention effort among those described in point 1) above will be focused on encouraging them to refrain from doing anything that could put them at risk from HIV, while among those people in point 2), the effort will be focused on empowering them, and if necessary, protecting them (helping them avoid becoming members of high risk subpopulations).

General Population

The general population is made up of all people who do not come within the three groups described above. It includes those involved in education, and religious and community leaders. The education sector (formal and informal) has a crucial role to play in channeling messages to the general population. Prevention efforts in this regard will be directed at heightening awareness, concern and involvement as regards the HIV and AIDS response in people's own environments.

3.1.1. Objective

The objective of the prevention programs is to bring about a situation where every person has the capacity to protect themselves and other people so as to avoid contracting HIV, or transmitting it to other people.

3.1.2. Programs

In order to achieve the above objective, the various activities involved have been grouped into the following programs.

3.1.2.1. Program to increase voluntary testing and counseling

Voluntary testing and counseling services will be increased both in terms of quality and quantity. This effort also includes the involvement of peer support groups so as to ensure greater effectiveness.

3.1.2.2. Program to Increase Condom-Use during High Risk Sex

Condom use during unsafe sex will continue to be encouraged so as prevent infection with HIV and sexually transmitted infections. The use of female condoms in particular situations will be facilitated. The scope of this program also encompasses behavior change intervention

3.1.2.3. Injecting drug user harm reduction program

The injecting drug use harm reduction program is intended to prevent the spread of HIV and will be implemented in a comprehensive and coordinated manner by all stakeholders. The program is also intended to reduce the need for drugs on the part of injecting drug users, and will be focused on the provinces of Java and the capital cities of the country's other provinces. This program also encompasses behavior change intervention.

3.1.2.4. Program to Prevent Mother-to-Child Transmission of HIV

The effort to prevent HIV transmission from HIV-positive mothers to their babies will be carried out in a comprehensive manner, and will involve efforts to prevent HIV transmission to women of productive age, the avoidance of unwanted pregnancies among HIV-positive women, and the prevention of HIV transmission from HIV-positive expecting mothers to their babies and family members, particularly in those regions where the epidemic is concentrated or has entered the general population.

3.1.2.5. Program for the Prevention of Sexually transmitted infections

The chance of a person who has a sexually transmitted infection contracting HIV is between 2 and 9 times higher than a person who does not have a sexually transmitted infection. The sexually transmitted infection prevention program will involve the scaling up of surveillance, consultation, treatment and prevention activities in all areas.

3.1.2.6. Safe Blood Transfusion Program

Efforts will be made to ensure that safe blood and blood products are available in all blood transfusion units, whether run by the Indonesian Red Cross or government or private sector hospitals. This program will be focused on those areas that have a high prevalence of HIV.

3.1.2.7. Universal Precautions Program

Universal precautions must be correctly implemented by all involved, whether officials or members of the public, including health workers, social workers, police officers, mortuary attendants, prison officers, etc. The knowledge of officials needs to be improved in this regard, and the necessary requisites supplied in sufficient quantities.

3.1.2.8. Public Communication Program

Effective and sustained public communication will be of great assistance in reducing vulnerability among high risk subpopulations. This effort will involve information, education and communication, outreach work, face-to-face consultations, marriage guidance counseling, and gender-equality promotion using a variety of communications channels and media. The materials and methods employed will need to have regard to cultural and language diversity, and the principal means of HIV transmission in Indonesia.

3.1.2.9. Life Skills Education Program

The life skills education program, which includes information on how HIV can be avoided, is targeted at children from elementary school up to high school, including those attending both state and private schools. The program is also aimed at teenagers' groups and children who have dropped out of school.

3.1.2.10. Child Support, Care and Protection Program

The Child Support, Care and Protection Program is aimed at providing health, social and educational services to children for the purpose of ensuring that their rights are fulfilled. Special attention will be given to children infected with AIDS, or affected by HIV and AIDS.

3.2. Treatment, medication and support for people living with HIV

The increase in the number of people living with HIV will require a corresponding increase in the quantity and quality of treatment and medical services. Efforts will also be made to increase the support available to people living with HIV. These endeavors will involve clinical, community and family-based approaches. The concept of universal access, namely, access to care and medication for all who need them, forms the basis for the programs in this area, which also cover infected infants and children. The management of drugs and reagents will be improved so as to support the establishment of universal access.

3.2.1. Objectives

To reduce the suffering caused by HIV and AIDS, to prevent the further spread of HIV, and to improve the quality of life of people living with HIV.

3.2.2. Programs

In order to achieve the above objectives, the various activities involved have been grouped into the following programs:

3.2.2.1. Healthcare Expansion Program

The quantity and quality of voluntary testing and counseling services, services to prevent the mother to child transmission of HIV, and care and support services for people living with HIV will be increased. Nutrition improvement services will also be expanded. These services will take the form of information, education and communication on nutrition, and the provision of nutrition incentive packages for people living with HIV. Nutrition is of the utmost important as good nutrition increases the effectiveness of medication, as well as resistance to infection, and improves the psychological state of people living with HIV.

3.2.2.2. Program to improve the availability and distribution of drugs and reagents

In order to meet the needs of people living with HIV and in line with the expansion in the number of treatment and medication facilities, the availability of antiretroviral drugs, drugs to fight opportunistic infections, and reagents will need to be improved in terms of both quality and quantity. These also need to be made available at affordable prices.

In addition, drug and reagent procurement, distribution and management need to be improved so as to guarantee availability at all times.

3.2.2.3. Education and training program

The envisaged increase in the quantity and quality of medical and support services for people living with HIV will require more trained, skilled, and ethical human resources. The necessary technical training shall be provided to those working in the HIV prevention field in line with their responsibilities.

3.2.2.4. Program to increase access to high risk subpopulations

Concerted efforts will be made to reach at least 80 percent of high risk subpopulations so that those who require treatment, medication, care and support will be able to obtain it.

3.2.2.5. Support program for people living with HIV

Concrete and tangible support is required by people living with HIV. Such support is aimed empowering them and allowing them to live full lives in line with the GIPA principle (Greater Involvement of People with HIV and AIDS). People living with HIV will be encouraged to actively participate in the HIV and AIDS prevention efforts. In order to prepare them for this work, they will be provided with support and accurate and comprehensive information, as will as skills, knowledge, medication, care, education and employment.

3.3. AIDS surveillance, and AIDS and sexually transmitted infections

Information about HIV and AIDS distribution and trends is ascertained from the data and statistics produced by surveillance. This consists of disease surveillance and behavior surveillance, both of which provide us with information on the success of the HIV and AIDS response, and are essential to the process of formulating policies and plans. The surveillance effort will continue to be improved as regards both methodology and implementation so as to ensure that the results produced are consistently accurate and reliable.

Besides HIV and AIDS, and behavior surveillance, the sexually transmitted infection surveillance will also be improved, with the results being published so that they as to make them available to all who need them.

3.3.1. Objectives

To obtain valid data on the HIV and AIDS distribution and trends, and the factors influencing these

3.3.2. Programs

In order to achieve the above objectives, the various activities involved have been grouped into the following programs.

3.3.2.1. Program to increase HIV surveillance

This conducting of HIV surveillance among subpopulations with different levels of vulnerability to HIV will be expanded in terms of both coverage area and quality. In areas where a generalized epidemic already exists, HIV surveillance will also be conducted in respect of the general population.

3.3.2.2. Program to expand behavior surveillance

Behavior surveillance will be expanded in terms of both coverage area and quality. Sensitive variables will be selected that are capable of identifying the level of success of behavior change intervention programs.

3.3.2.3. Program to expand surveillance of sexually transmitted infections

STD surveillance will be expanded in terms of both coverage area and quality so as to identify the level of success of behavior change intervention and condom promotion programs.

3.3.2.4. Program for the surveillance of HIV among expecting mothers.

The HIV surveillance conducted in respect of expecting mothers refers to passive surveillance that is conducted in areas where the epidemic is concentrated or has spread into the general population. It is carried out in voluntary testing and counseling, PMTCT and mother and child clinics.

3.3.2.5. Program to increase the number and quality of HIV laboratories

HIV laboratories are need for surveillance, diagnosis and monitoring treatment purposes. This program envisages an increase in the number and quality of HIV laboratories.

3.3.2.6. Program to improve quality of reporting

Reporting is an essential aspect of surveillance. The surveillance reports that are produced must be timely, accurate and readily comprehensible to those who need them.

3.4. Operational Research

The HIV and AIDS prevention effort needs to be continuously developed. Many aspects connected with the epidemic are still not fully understood, For example, why the spread of the epidemic is faster in some regions than in others? In order to find the answers to these puzzles, the conducting of operational research is of the utmost importance. In this regard, concerted efforts will be made to ensure that the level of operational research in Indonesia will be increased over the coming four years.

So that high quality operational research can be conducted, researchers will be trained at all levels. In addition, collaboration between HIV and AIDS research institutes at home and overseas will be encouraged. An inventory of research findings to date will also be taken in accordance with the generally applicable procedures. All findings will be widely publicized so that they may be accessed by those who need them.

3.4.1. Objectives

In order to achieve the above objectives, the various activities involved have been grouped into the following programs:

3.4.1.1. Operational research Program

The various prevention efforts underway require study so as to make them more effective and efficient. Surveys will also provide pointers to the conducting of more in-depth studies.

3.4.1.2. Antiretroviral drug resistance research program

The increasing use of antiretroviral, not always accompanied by proper supervision, has to potential to give rise to resistance. Studies on this will be required so as to plan the next line of antiretroviral drugs.

3.4.1.3. Traditional medications research program

Indonesia has a great diversity of flora and fauna that can be availed of for the production of medicines. Many claims have been made down the years regarding the efficacy of natural products against HIV and AIDS. Research will be conducted into these claims with a view to finding scientific proof to back them up, while at the same time seeking other possible treatments.

3.4.1.4. Program for the study of the social, economic and cultural impacts of HIV and AIDS

This program will be carried in order to collect material for advocacy purposes, and the designing of support programs for people living with HIV.

3.4.1.5. Epidemiological and Behavioral Research

Epidemiological and behavioral research studies will be conducted for the purpose of learning more about the behavior of the epidemic and the factors influencing it. The results of these studies will take the form of the most basic facts needed for the formulating of prevention policies.

3.5. Conducive Environment

A conducive environment for the prevention of HIV and AIDS is needed so that the efforts being made can meet with success. This is because HIV and AIDS are complex problems that display a number of unique characteristics.

The UNGASS Declaration in 2001 requires states to issue, support and uphold laws and other regulations to eradicate all forms of discrimination and ensure that the human rights and liberties of people living with HIV and vulnerable subpopulations are respected in full.

3.5.1. Objectives

To improve the quality of the laws and regulations issued both at the center and in the regions for the purpose of creating a conducive environment for the HIV and AIDS prevention effort.

3.5.2. Programs

In order to achieve the above objectives, the various activities involved have been grouped into the following programs:

3.5.2.1. Legislation Review Program

This will involve the review of all legislation and ancillary regulations related to the HIV and AIDS prevention effort both at the center and in the regions. This will include the conducting a study on whether a specific National AIDS Prevention Act is required.

3.5.2.2. Advocacy Program

This program envisages the ramping up of advocacy in the HIV and AIDS prevention areas among members of the executive, legislature and judiciary at both the center in the regions so as to inform them of the problems being faced on the ground and which need to be addressed by way of legislation or ancillary regulations.

3.5.2.3. Program for capacity-building at local level

This program involves capacity-building among members of the executive, legislature and judiciary in the regions so as ensure the issuing of local ordinances that help provide a conducive environment for the HIV and AIDS prevention effort in the regions.

3.5.2.4. Program for capacity-building among civil society.

The capacity of civil society groups, including NGOs and peer support groups, will be improved so as create a conducive environment for the HIV and AIDS prevention effort in the regions.

3.6. Multiparty coordination and harmonization

HIV and AIDS are no longer solely health problems, but have rather involved into highly complex social problems. Prevention efforts require a variety of approaches, and the involvement of a variety of sectors. The principal role will be shouldered by the community based on directions and guidance from the governmental sector. The government will assume the leading role in the HIV and AIDS response at both the central and local levels. Meanwhile, international partners will provide assistance and support for this response.

Due to the many stakeholders involved in the HIV and AIDS prevention effort, it is essential that proper coordination be effected from the planning stage right up to the implementation stage.

By harmonization we mean that all HIV and AIDS prevention efforts must be coordinated and synchronized so as to ensure that the overall response progresses in an integrated and focused manner. Harmonization needs to be effected at all levels.

3.6.1. Objectives

To coordinate and synchronize the various HIV and AIDS prevention programs and efforts carried out by the government, civil society and international partners so that common goals may be successfully achieved.

3.6.2. Programs

In order to achieve the above objectives, the various activities involved have been grouped into the following programs:

3.6.2.1. Institutional capacity-building program

As the organization charged with coordinating and harmonizing the various HIV and AIDS prevention programs, the National AIDS Commission at all levels will continue to improve its capacity. Such capacity building will also be encouraged in other sectors so as to improve program implementation. This will involve improving the capacity of human resources, providing the necessary work facilities, and lobbying policy makers to allocate sufficient for operational activities.

3.6.2.2. Program to improve information and communications networks

The existence of an extensive and effective information network facilitates the effecting of coordination and harmonization as regards the HIV and AIDS prevention effort. This network will be expanded to all levels, and IT facilities will be improved.

3.6.2.3. International Cooperation Improvement Program

Existing international cooperation will be further upgraded at both the regional and global levels, while even closer relations will be forged with our international partners within the country.

3.7. Sustainability

Given current trends in the HIV and AIDS epidemic and the factors that influence it, it is clear that the HIV and AIDS prevention effort Indonesia will have to continue for the foreseeable future.

Accordingly, the sustainability of the HIV and AIDS response must be ensured. This will to great extent be determined by the existence or otherwise of strong political will and commitment, the availability of funding, maintenance of infrastructure and facilities, the mobilization of financial and human resources, and adequate financing over the long term, as well as the full participation of the community, including people living with HIV.

3.7.1. Objectives

To ensure the sustainability of the HIV and AIDS prevention effort at all administrative levels based upon a high level of commitment and leadership, supported by adequate information and resources.

3.7.2. Programs

In order to achieve the above objectives, the various activities involved have been grouped into the following programs:

3.7.2.1. Advocacy shall be conducted on a continuing basis to policy makers at both the national and local levels.

The advocacy efforts will be focused on members of the executive, legislature and judiciary, and on the leaders of political parties and civil society organizations.

3.7.2.2. Upgrading human resources

The quality of human resources will be upgraded through the provision of education and training at both the center and the regions. Education and training opportunities overseas may also be availed of.

3.7.2.3. Improving infrastructure and facilities

Infrastructure and facilities in HIV and AIDS service units will be improved both in terms of quality and quantity. In addition, efforts will be made to ensure that they are properly maintained. Quality control will also be conducted in respect of infrastructure and facilities

3.7.2.4. Formulate appropriate policies and mechanisms for the mobilizing of both human and financial resources

In order to ensure the sustainability of HIV and AIDS prevention program, appropriate policies and mechanisms will need to be formulated for the mobilizing of both human and financial resources. The levels of funding received from various sources at the present time need to be increased. In addition, efforts need to be made to find new sources of funding in the government sector, private sector (including transnational corporations), and the community. For such purposes, advocacy efforts directed at potential sources of funding will be continued. As the efforts to improve the nation's capacity to fund the HIV and AIDS prevention program itself continue, technical assistance from overseas will continue to be required.

Chapter IV. Participants in the HIV and AIDS Response

The HIV and AIDS response and prevention effort will be carried out jointly by the people and government, with the assistance of international partners. The government effort will be carried out by its departments, ministries, non-departmental organizations, local administrations and local-government agencies, and the National Police and Armed Forces, while the community will play its part through NGOs, the private sector, civil society and the public at large. The National AIDS Commission at all levels will function as coordinator.

Each of the stakeholders have their own roles, and will work together with the other stakeholders in a spirit of partnership. The basic responsibilities of each stakeholder are as follows:

4.1. Central Government

The central government's departments, ministries, non-departmental organizations, and the National Police and Armed Forces will each establish HIV and AIDS Prevention Working Groups, and draw up HIV and AIDS prevention plans that are in line with the 2007-2010 HIV and AIDS Response Strategies. The National AIDS Commission at the center should lead and coordinate the activities undertaken by the different organs of the central government.

4.2. Provincial Governments

Provincial government agencies, the provincial offices of the central government, and the National Police's and Armed Forces' command structures in the provinces will all be responsible for playing a role in the HIV and AIDS response and prevention effort under the coordination of the provincial governor. Each provincial government will establish a Provincial AIDS Commission, and provide the resources to it needs to play an effective role in the national HIV and AIDS response at the provincial level.

4.3. Regency/Municipal Governments

Regency/municipal government agencies, the regency/municipal offices of the central government, and the National Police's and Armed Forces' command structures at the regency/municipal level will all be responsible for playing a role in the HIV and AIDS response and prevention effort under the coordination of the regent/mayor. Each regency/municipal government will establish a Regency/Municipal AIDS Commission, and provide the resources to it needs to play an effective role in the national HIV and AIDS response at the regency/municipal level.

4.4. District and Sub-district Governments

In those areas that are vulnerable to the spread of HIV and AIDS, Prevention Task Forces may be established at the district or subdistrict levels, with these task forces being headed by the district or sub-district head, as the case may be. Their principal duties will be to mobilize the public to play a greater role in the HIV and AIDS response and prevention efforts planned by the Regency/Municipal AIDS Commission.

4.5. House of Representatives, Regional Representatives Assembly, and local legislative assemblies

Based on the highest levels of sensitivity and concern, the House of Representatives, Regional Representatives Assembly, and provincial and regency/municipal legislative assemblies shall be responsible for collecting information on the HIV and AIDS within the areas they represent, and for doing everything in their power to assist the response and prevention effort. In addition, communications forums may be established in collaboration with the National AIDS Commission or local AIDS commissions.

4.6. National AIDS Commission

The National AIDS Commission, as the organization charged with coordinating the HIV and AIDS response in Indonesia, has been vested with very onerous responsibilities. As a result, its powers and authority will need to be clearly spelled out if it is to be able to successfully discharge its duties.

The principal responsibilities and functions of the National AIDS Commission, as set out in Presidential Regulation Number 75 of 2006, are as follows:

To issue national policies, strategic plans, and guidelines for the prevention and combating of AIDS;

To determine the strategic measures that need to be take as part of the HIV and AIDS prevention effort;

To coordinate the implementation of AIDS outreach, prevention, service, monitoring and control activities;

To disseminate information on AIDS to the media for the purpose of encouraging the dissemination of accurate information to the public and the avoiding of sensationalism to could give rise to public unease;

To engage in regional and international cooperation in the context of the AIDS prevention effort;

To coordinate data and information management in connection with AIDS;

To control, monitor and evaluate the implementation of the AIDS prevention and control effort;

To provide directions and guidelines to the AIDS Commission at the provincial and regency/municipal levels as part of the AIDS prevention and control effort.

4.7. Provincial and Regency/Municipal AIDS Commissions

Provincial and Regency/Municipal AIDS Commissions will be established and be chaired by the governor or regent/mayor, as the case may be. The Provincial/Regency/Municipal AIDS Commissions shall assist the National AIDS Commission in the performance of its duties.

The principal duty of an AIDS Commission at the provincial/regency/municipal level is as follows:

4.7.1. Formulating the policies, strategies and measures that are considered necessary in the context of the HIV and AIDS response and prevention effort in the region in line with the policies, strategies and guidelines issued by the National AIDS Commission.

The implementation of this principal duty shall involve the following functions:

4.7.1.1. Leading managing and coordinating HIV and AIDS prevention and control activities within the region;

4.7.1.2. Collecting, mobilizing and utilizing resources originating from the center, region, community or overseas assistance in an effective and efficient manner;

4.7.1.3. Providing advice and guidance to stakeholders in the context of the HIV and AIDS prevention effort within the region;

4.7.1.4. Conducting monitoring and evaluation in respect of the implementation of the HIV and AIDS response and prevention effort, and submitting regular reports to the National AIDS Commission in line with the established hierarchy.

4.8. Civil society

Civil society is an important partner in the HIV response.

4.8.1. NGOs

NGOs and other civil society organizations, such as peer support groups, have an important contribution to make as regards accessing high risk subpopulations and providing counseling as part of the care and treatment processes for people living with HIV. In particular, they have a important

role to play as regards the provision of outreach, counseling, support and mentoring services. In order to expand the scope of their services, capacity-building will be required. For the future, it is expected that the role played by NGOs will increase, and become more evenly spread across the entire country. AIDS Commissions at all levels are responsible for creating a conducive environment that will allow these NGOs to thrive and perform their roles to the full in conditions of safety and security.

4.8.2. Private sector

People's work, workplaces or working environments may leave them more vulnerable to HIV. The International Labor Organization (ILO) has acknowledged that HIV and AIDS is a major problem in the workplace. The principles adopted by the ILO in connection with HIV and the workplace need to be put into effect in Indonesia through a tripartite agreement on the combating of HIV in the workplace, and their subsequent wholehearted implementation.

4.8.3. Professionals, Professional Organizations and Institutes of Higher Education

The HIV and AIDS response will require the full involvement of professionals in both their individual capacities and through their professional organizations. In addition, the country's institutes of higher education need to be firmly brought on board. Both professional organizations and third level institutes will have important roles to play in policy formulation and the conducting of studies and operational research.

4.8.4. Community Institutions

Community institutions, such as PKK, Karang Taruna, Pramuka, religious organizations, artistic bodies, etc., generally tend to be very solid. Accordingly, every effort will be made to ensure their involvement in the HIV and AIDS response and prevention effort. These organizations have a particularly important role to play as regards receiving messages and information, and then passing these on to the public.

4.8.5. Family and the public at large

The HIV and AIDS response and prevention effort will require the support of the public at large. The family, as the smallest unit of society, has an important role to play as the first line of defense against the spread of HIV. Continuous efforts need to be made to strengthen families. In addition, the family is capable of providing a conducive environment for people living with HIV, where they will be surrounded by love and removed from the sort of discriminative attitudes that are still so common in Indonesia society.

The public at large also has an important role to play in the HIV response by providing the conditions necessary for a conducive environment. In order to properly discharge their responsibilities as part of the HIV and AIDS response and prevention effort, people have the right to receive and access accurate information.

4.8.6. People living with HIV

The role of people living with HIV in the future will become more important than ever. In line with the principle of "Greater Involvement of People with AIDS (GIPA), people living with HIV have the right to participate at all levels of the response and prevention effort, from the policy-making stage to the evaluation and monitoring stages. In order to play their roles effectively, people with HIV will need to improve their knowledge and capabilities.

In tandem with their rights, people living with HIV also have the obligation to not spread HIV to their partners and other people.

Chapter V. International Cooperation

International cooperation with our bilateral and multilateral partners is one of the most significant components in the HIV and AIDS response and prevention effort, the benefits of which are already being felt. Assistance has to date been provided for the institutional capacity-building program at the center and in the regions, the program for the care, treatment and support of people living with HIV, the harm reduction among injecting drug users program, the program for the prevention of mother to child HIV transmission, and the program for preventing HIV and AIDS in the workplace.

It is hoped that this international cooperation will be elevated to a higher plain following the adoption of the 2007-2010 HIV and AIDS Response Strategies and the 2007-2010 National Action Plan. In line with Presidential Regulation Number 75 of 2006, the mobilization and utilization of international funding and technical assistance will be coordinated by the National AIDS Commission, while monitoring and evaluation will be carried out nationally using standard monitoring instruments.

The assistance of international partners is required to support the priority HIV and AIDS responses during the 2007-2010 period, particularly as regards institutional capacity-building; the care and treatment of people living with HIV; the expansion of prevention efforts among high risk subpopulations, developing the life skills program through both formal and informal channels; the provision of antiretroviral drug to adults and children; preventing mother to child transmission; providing protection, care and support to children infected or affected by HIV and AIDS; dealing with crossborder problems caused by HIV and AIDS; and the conducting of research.

The National AIDS Commission will facilitate the harmonization and coordination of the efforts being undertaken with those of our international partners, the government sector and other stakeholders (the public at large, private sector, NGOs, academia, etc.). This is intended to ensure that the required assistance is made available and accessible to those most in need of it.

In order to ensure the better harmonization and coordination of international assistance, the National AIDS Commission will require a special information system. So that this will be capable of being established, the National AIDS Commission, in its capacity as coordinator , will require the support and active participation of its international partners.

Chapter VI. Implementation of 2007-2010 HIV and AIDS Response Strategies

The 2007-2010 HIV and AIDS Response Strategies will be implemented in tandem with the National Development Plan. At the provincial, regency and municipal levels, the implementation of the National Strategies will be adjusted in line the respective region's development plan.

The implementation of the 2007-2010 HIV and AIDS Response Strategies must be consistent with the policies objectives that it is desired to achieve, and be tailored so as to respond to both the local and national situation. This National Strategies document is a living document that may be altered or varied as needs dictate.

The role of the National AIDS Commission as regards the implementation of the National Strategies is in line with the "Three Ones" principles recommended by UNAIDS, namely: (1) every country needs to have one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work

of all partners, (2) one National AIDS Coordinating Authority, with a broad based multi-sector mandate, and (3) one agreed country level Monitoring and Evaluation System.

These 2007-2010 HIV and AIDS Response Strategies have been further elaborated in the National Action Plan for the same period. The other sectors and stakeholders at both the sector and in the regions will formulate their own HIV and AIDS Prevention Societies in their respective fields or areas using the 2007-2010 HIV and AIDS Response Strategies and the 2007-2010 National Action Plan as a reference.

Chapter VII. Monitoring, Evaluation and Reporting

Monitoring and evaluation are conducting in order to (i) ensure that HIV and AIDS prevention programs achieve high levels of accountability and efficiency; (ii) inform us whether program intensification or expansion is required; (iii) to allow corrective action to be taken; and (iv) to provide information that is beneficial for the implementation of the program and can serve as input for the design of future programs. The results of monitoring and evaluation are reported in line with the hierarchy set out in Presidential Decree Number 75 of 2006.

The National HIV and AIDS Monitoring, Evaluation and Reporting Guidelines that were published in 2006 will be used as the basis for monitoring and evaluation in respect of the implementation of the 2007-2010 HIV and AIDS Response Strategies by AIDS Commissions at all levels. These guidelines have been purposely kept as simple and practical as possible so as to allow monitoring, evaluation and reporting to be properly carried out.

The dissemination of these guidelines, and the provision of training on how they should be used, will continue so that monitoring, evaluation and reporting may be optimized at all levels.

Chapter VIII. Funding

In tandem with increasing numbers of people living with HIV, the HIV and AIDS response program is becoming more varied and expansive. Obviously, this continued expansion will require greater funding.

In line with Presidential Decree Number 75 of 2006, the funding for the implementation of these 2007-2010 HIV and AIDS Response Strategies is provided out of the national budget, and from other sources. By "other sources" is meant the private sector, community and international donors.

It is expected that the role played by the public and private sector in funding the HIV and AIDS response will be expanded in tandem with increasing efforts to mobilize funds from these sources under the coordination of the National AIDS Commission and the AIDS commissions in the provinces. International aid in the form of grants and technical assistance is primarily used to upscale programs, and must not be considered as a substitute for government funding.

The National AIDS Commission is committed to financial management based on the principles of transparency, accountability, efficiency, efficacy and harmonization. For this reason, the mobilization and utilization of funds is coordinated by the National AIDS Commission.

Chapter IX.Conclusion

These 2007-2010 HIV and AIDS Response Strategies represent the response of the Indonesian government and people to the worsening HIV and AIDS epidemic. Based upon these concise strategies, we will be able to develop and roll out comprehensive, integrated and synchronized responses and prevention programs over the coming years.

We are fully aware that it will be far from easy to implement so many large-scale programs due both to the complexity of the problems faced and the speed with which the situation is developing. Nevertheless, we believe that with strong commitment, leadership, sincerity and determination, together with the experience of the Indonesian nation in overcoming seemingly insurmountable challenges, these HIV and AIDS prevention strategies will ultimately be successful in curbing the spread of HIV in Indonesia.

Chapter X. Executive Summary

As a national response to the HIV and AIDS epidemic in Indonesia, the government adopted its first set of National HIV and AIDS Response Strategies in 1994. In 2003, in line with the worsening HIV and AIDS situation, the move away from a centralized to a decentralized system of governance, and new international commitments, a review process was launched leading to the formulation and adoption of the 2003 to 2007 National HIV and AIDS Response Strategies. The implementation of these strategies, however, has not been as successful as originally anticipated.

Epidemiological data shows that the number of HIV and AIDS cases has been increasing rapidly, particularly among injecting drug users in Indonesia's large cities. In addition, the epidemic has entered the general population in Papua, primarily as a result of unsafe sex. The year 2006 saw the National AIDS Commission being placed on a firmer foundation with the issuing of Presidential Regulation Number 75 of 2006, which superseded Presidential Decree Number 36 of 1994. Meanwhile, there is now a new "universal access" policy in place at the global level, which means guaranteed access to care and medication for those who need them. All of these changes encouraged the National AIDS Commission to review the 2003-2007 National HIV and AIDS Response Strategies and formulate new strategies for the 2007-2010 period.

The epidemiological data shows that there has been a significant increase in HIV and AIDS cases over the last 3 years. The number of AIDS cases increased from the 1,371 reported by 25 provinces at the end of 2003 to 6,871 cases reported by 32 provinces by the end of September 2006. Epidemiological experts predict that that if the response to HIV AND AIDS is not significantly ramped up, then by the year 2010 the number of AIDS cases will have increased to 400,000, with 100,000 people having died, while by 2015 the number of cases will have increased to 1,000,000, with some 350,000 people having died. Meanwhile, the number of cases of mother to child transmission stands at 38,500.

The worsening HIV and AIDS epidemic is giving rise to various adverse effects, including negative social and economic impacts, as well as putting additional pressure on the healthcare system and the social structure.

The strategic national response to HIV and AIDS during the 2003-2006 period was marked by increasing sectoral activities, the launch of a "HIV and AIDS in the Workplace" program by the Department of Manpower and Transmigration, the signing of a Memorandum of Understanding between the National Drugs Agency (BNN) and the National AIDS Commission to serve as an umbrella for the HIV and AIDS prevention effort among injecting drug users, and the commencement of the domestic production of antiretroviral drugs by PT Kimia Farma. In addition, the Sentani Commitment was signed by the central and provincial governments for the purpose of accelerating the HIV and AIDS response at both the central and provincial levels, the Department of Justice and Human Rights launched its

HIV and AIDS prevention program in correctional facilities, and the Department of Health designating 25 HIV and AIDS referral hospitals where people could access treatment and antiretroviral drugs.

Among the significant issues that require attention are the following:

Increasing numbers of injecting drug users;

High levels of population mobility;

Increasing numbers of injecting drug users in the prison population;

Increasing incidence of unsafe sex.

Besides these issues, the national HIV and AIDS prevention effort over the next four years will face a variety of challenges, including:

Challenges associated with norms and behavior;

Coordinating a multiparty response;

Formulating program-development policies;

Responding to the needs of teenagers and young people;

Responding to the specific risks faced by girls;

The need to expand treatment, medication and support for people living with HIV;

Eliminating stigmatization and discrimination against people living with HIV;

Government decentralization.

These 2007-2010 HIV and AIDS Response Strategies continue to employ the policy bases set out in the previous National Strategies as these constitute normative references for the Indonesian nation and people. However, a process of fine-tuning has been undertaken in respect of some of them.

Accordingly, the strategies that will be applied over the next four years for the purpose of achieving our HIV and AIDS response targets are as follows:

Promoting and expanding tried and tested prevention methods, and assessing new methods.

Empowering individuals, families and communities to prevent the spread of HIV in their environments.

Strengthening the basic healthcare and referral systems so as to anticipate an increase in the number of people with HIV who require treatment and medication.

Strengthening the capacity of those involved in the HIV and AIDS response at both the center and in the provinces through continuing education and training.

Increasing research and survey efforts so as to obtain accurate data on the progress of the HIV and AIDS response and prevention program.

Improving national HIV and AIDS monitoring capacity

Mobilizing resources and harmonizing their use at all levels.

Based on the above strategies, various HIV and AIDS prevention and response programs will be rolled out in the following priority areas:

HIV and AIDS, and sexually transmitted infection prevention;

Care, treatment and support for people living with HIV;

HIV and AIDS, and sexually transmitted infection surveillance;

Operational and other forms of research

Encouraging the creation of conducive environments;

Engaging in multiparty coordination and harmonization;

Ensuring a sustained response

The stakeholders, whether from the government, civil society or international partner sectors, will select the programs they wish to focus on from this list in line with their responsibilities, areas of interest, expertise, and available resources. In order to ensure that no overlapping ensues, the duties, roles and responsibilities of all of the partners will be spelled out clearly.

International collaboration with bilateral and multilateral partners will be further scaled up so as to help accelerate the achievement of program targets. All of the assistance received, whether financial or technical, will be utilized efficiently and efficaciously under the coordination of the National AIDS Commission.

These 2007-2010 HIV and AIDS Response Strategies will be implemented in line with the National Development Plan, and will be adjusted as necessary to accord with local development plans. Above all, this is a living document that may be altered or varied as needs dictate.

Implementation will be monitored and evaluated on a hierarchical basis by all of the stakeholders under the coordination of the AIDS commission at each level in the hierarchy using the National Monitoring and Evaluation System that has already been put in place.

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Kulit Dalam

National AIDS Commission

Attachment:

Comfpw1/Chairman of the National AIDS Commission Resolution No. 07 / KEP / MENKO / KESRA / III / 2007

On

The 2007-2010 HIV and AIDS Response Strategies

Kulit STRANAS 2007-2010, Sementara

National AIDS Commission

2007-2010 HIV and AIDS Response Strategies

National AIDS Commission, 2007

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Coordinating Minister for Public Welfare	Department of Health	Department of Home Affairs	Department of Religious Affairs	Department of Social Welfare	Department of Communications and Information
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Coordinating development of HIV and AIDS response policies	Care and treatment programs	Decentralization and funding allocations at center, province, regency and municipality levels	Inserting HIV and AIDS prevention messages in curricula of religious schools	Social support and rehabilitation for PLHIV and families	Media policies in HIV and AIDS field
Advocacy Coordinating planning, implementation and evaluation	HIV and AIDS control programs	Supporting participation in eliminating stigmatization and discrimination	HIV and AIDS prevention through information disseminated by religious leaders	Programs for high risk and vulnerable subpopulations	Disseminating HIV and AIDS information through government and private media at both local and international levels.
Coordinating discussion of	HIV, AIDS and STD surveillance	Coordinating response of correctional	Program to combat HIV and AIDS through	Counseling programs	

central issues	programs	facilities to HIV and AIDS	greater focus on faith		
Coordinating inter-departmental cooperation as regards HIV and AIDS policies	Coordinating harm reduction programs for injecting drug users			Social support and rehabilitation for populations in conflict and disaster-affected areas	
	Disseminating information of healthy lifestyles				
Department of Justice and Human Rights	Department of Culture and Tourism	Department of National Education	Department of Manpower & Transmigration	Department of Communications	Department of Youth Affairs & Sport
Development of Law and Legislation	Tourism Industry	Preventative Education	Manpower & transmigration policies	Transportation Policies	Youth Empowerment
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NGO draft law on PLHIV		HIV and AIDS prevention program for educators	Coordinating HIV and AIDS programs for migrants		
Department of Women's Empowerment	National Development Planning Board (Bappenas)	Department of Research & Technology	Cabinet Secretariat	Indonesian Armed Forces	Indonesian National Police

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	Integrating HIV and AIDS response programs into poverty alleviation policies	Support for HIV and AIDS research	Facilitating holding of special Cabinet meetings devoted to HIV and AIDS	HIV and AIDS response and prevention programs in Army, Navy and Air Force	HIV and AIDS response and prevention programs in Police
					Helping create a conducive climate for the national HIV and AIDS response

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Developing appropriate technology for use as part of the HIV and AIDS response	Empowering families	Coordinating response to spread of HIV and AIDS among injecting drug users	Program to improve the capabilities of doctors in dealing with HIV and AIDS cases	Program to improve the concern and capabilities of community health specialists as regards HIV and AIDS	Policies for the supply of safe blood and blood products
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Conducive environment					