NATIONAL AIDS COMMISSION

Global AIDS Response Progress Reporting

Indonesia Country Progress Report 2014

Reporting Period 2012-2013

Indonesian National AIDS Commission 2014

Executive Summary

Indonesia's HIV epidemic is still concentrated among specific key populations (direct and indirect female sex workers, people who inject drugs, men who have sex with men, transgendered people, and high risk men[1]) except in Papua, which is experiencing a low-level generalized epidemic. The estimated prevalence among the national adult population is 0.4%. While a decline in HIV prevalence has been indicated in some key affected populations, particularly people who inject drugs in some cities, the epidemic is still in the expansion phase, unlike some other countries in the region. The majority of new infections are occurring amongst men who have sex with men and clients of sex workers. There is a need to intensify efforts to stop the spread of the epidemic through better quality and coverage of interventions, particularly to reduce sexual transmission of HIV.

The overall goals of the NASAP 2010-2014 are to prevent and reduce the risk of HIV transmission; to improve the quality of life of people living with HIV (PLHIV); and to reduce the social and economic impact of HIV and AIDS among individuals, families and communities, enabling PLHIV to participate fully as valuable, productive members of society. The key strategies to achieve these goals are increasing ART coverage; increasing harm reduction activities; increasing condom use among key populations; increasing the effectiveness of outreach services; and improving data quality and analytical capacity. Indonesia's multisectoral response, led by the National AIDS Commission (NAC), prioritises key affected populations and geographical areas with the highest burden of disease. The key targets for 2014 are: to reach 80% of key populations with effective programmes, with 60% of them engaging in safe behaviour; and for 70% of funding for the targeted response coming from domestic sources.

Since the launch of the NASAP 2010-2014, coverage of HIV services has expanded to all provinces as well as priority districts and cities, delivered by government and non-government agencies. There has been a considerable expansion in the number of HIV counselling and testing (HCT), STI testing and treatment and harm reduction sites; ART delivery has been scaled up and is being increasingly decentralised to the primary health care (PHC) level in high burden areas; integrated TB/HIV testing and treatment is more widely available and there has been a huge expansion in the coverage and implementation of PMTCT, particularly through its integration into maternal and child health (MCH) services, resulting in more than 100,718 pregnant women aged 15 and above receiving an HIV test and their results in the past 12 months, compared to 42,276 in the previous year.

Despite this progress, consistent condom use among key populations remains low overall,[2] and the epidemic is expanding, particularly among MSM, high-risk men and their sexual partners. Members of key affected populations and people living with HIV continue to face stigma and discrimination when accessing health services, and the quality of services provided can be variable. Access to PMTCT services is still compromised by late attendance at antenatal services,

[1] Defined as male clients of sex workers.
[2] Among FSW, 9%; MSM, 30%; waria, 36%, PWID, 20% (IBBS 2011).

as well as inconsistent implementation of the relevant guidelines. In Tanah Papua, much of the widely dispersed population has limited access to scarce health services.

The Government of Indonesia has moved to accelerate the response by intensifying the implementation of the prevention of sexual transmission (PMTS) programme; initiating the continuum of care approach at the district level; scaling up HIV testing and access to ARV through the adoption of four key strategic policies: the WHO's 2010 guidelines on using a CD4 count of 350 as the threshold for eligibility to ART; adopting the Roadmap for the Strategic Use of ARV (2013-15), which will expand ART eligibility to all HIV positive members of key populations irrespective of their CD4 count ('test and treat'); and adopting PMTCT option B+ (providing lifelong ART for all HIV positive mothers).

Other policy strengthening actions that support the response include the launch of the National Social Security System (which includes coverage of the cost of opportunistic infections and STI treatment for PLHIV), and the rollout of gender-sensitive planning and budgeting at national and sub-national levels. At the local level, however, gaps remain in local policies and/or regulations that support access of key affected populations (KAP) and PLHIV to services.

Management and coordination structures for the HIV response have been established at national, provincial and district levels. However, there is a need to build capacity to analyse, use and disseminate strategic information to guide provincial and district-level programming and advocate for support. Moreover, more than 50% of district/city AIDS Commissions are supported by external funding, raising concerns about their sustainability.

CSOs have been supported and enabled, and national networks of key populations established. However, at the subnational level, community involvement tends to be restricted to technical matters. As well as increasing their participation at the policy level, CSOs and community-based organizations need further strengthening in order to expand their role in: education and prevention activities; the implementation of the strategic use of ARV and continuum of care approaches; intensifying case finding and testing; and increasing retention of PLHIV in care.

Although Government spending increased by a substantial 76% between 2009 and 2012 from USD 21 million to USD 37 million, the response is still largely dependent on external funding. Moreover, the funding gap for the National HIV programme is substantial and increasing. Indonesia is taking steps to address this by developing an HIV investment case to support resource mobilisation; exploring innovative funding sources and mechanisms, including from the private sector; and seeking opportunities to increase efficiency and reduce costs. Nevertheless, continued support is clearly needed if Indonesia is to meet its NASAP targets.

To derive maximum benefit from such support, targeted technical support will be needed. Priority technical support and capacity building areas include strengthening: the quality and rigour of outreach work; local leadership and coordination; supportive supervision; and monitoring and evaluation (M&E) of activities. Slightly less urgent needs are strengthening of: the financial management and procurement & supply management systems; community systems; and the harm reduction, STI and ART programmes. Legal and policy frameworks, particularly regulations that restrict the rights of PLHIV and KAPs to harm reduction and health

services, as well as those that constrain CSOs' access to public funding, also need to be addressed.

The principal sources of the data in this report are the 2011 IBBS, programme monitoring data from 2013-14, the 2012 Size Estimation of Key Affected Populations, the Estimates and Projections of HIV/AIDS 2011-2016, the NASA 2011-2012, the NCPI 2014 as well as the Mid-Term Review of the National AIDS Strategy and Action Plan 2010-2014 and the 2011-2012 Country Report on the Follow up to the Declaration of Commitment on HIV/AIDS (UNGASS).

Abbreviations

AEM	:	Asian Epidemic Model
AIDS	:	Acquired Immune-Deficiency Syndrome
ANC	:	Ante-natal Care
ART	:	Anti-Retroviral Therapy
ARV	:	Anti-Retroviral
Australia Aid	:	The Australian government's overseas aid programme
Bappeda	:	Regional Development Planning Agency (In Indonesian: *Badan Perencanaan Pembangunan Daerah*)
Bappenas	:	National Development Planning Agency (In Indonesian: *Badan Perencanaan Pembangunan Nasional*)
BNN	:	National Narcotics Agency ((In Indonesian: *Badan Narkotika Nasional*)
BPS	:	National Statistics Bureau (In Indonesian: *Badan Pusat Statistik*)
CBDDT	:	Community-Based Drugs Dependency Treatment (in Indonesian: *PBAM)*
CCM	:	Country Coordinating Mechanism
CHAI	:	Clinton Health Access Initiative
CHC	:	Community Health Centre
CSO	:	Community Service Organization
DAC	:	District AIDS Commission
DFID	:	United Kingdom Department for International Development
DFSW	:	Direct Female Sex Workers
(I)DHS	:	(Indonesian) Demographic and Health Survey (*SDKI*)
FSW	:	Female Sex Worker
GBV	:	Gender Based Violence
GARPR	:	Global AIDS Response Progress Reporting
GFATM	:	The Global Fund to fight AIDS, TB and Malaria
GWL-Ina	:	Gay, MSM, and Transgender Network (In Indonesian: *Gay, Waria, Lesbian Indonesia*)
HCPI	:	HIV Cooperation Program for Indonesia (Australian-supported programme in Indonesia)
HCT	:	HIV Counselling and Testing
HIV	:	Human Immunodeficiency Virus
HRM	:	High-risk men (male clients of sex workers)
HTC	:	HIV testing and counselling
IBBS	:	Integrated Biological and Behavioural Survey
IDFSW	:	Indirect Female Sex Workers
IEC	:	Information, Education and Communication
IPF	:	Indonesia Partnership Fund
IPPI	:	Indonesian Women with HIV Network (In Indonesian: *Ikatan Perempuan Positif Indonesia)*
KAP	:	Key Affected Population(s)
KIE	:	Knowledge, Information and Education
LKB	:	Comprehensive Integrated Decentralized HIV Services (In Indonesian: *Layanan Komprehensif Berkesinambungan/LKB*)
MCH	:	Maternal & Child Health
MDG	:	Millennium Development Goals
M&E	:	Monitoring and Evaluation
MoH	:	Ministry of Health
MoSA	:	Ministry of Social Affairs

MSM	:	Men who have Sex with Men
NAC	:	National AIDS Commission
NASA	:	National AIDS Spending Assessment
NASAP	:	National AIDS Strategy and Action Plan
NCPI	:	National Composite Policy Index
NSP	:	Needle and Syringe Programme
NU	:	Nadhlatul Ulama (a Principal Recipient of Global Fund grants in Indonesia)
OI	:	Opportunistic Infection(s)
OST	:	Opioid Substitution Therapy
PABM	:	Community-Based Drugs Dependency Treatment (In Indonesian: *Pemulihan Adiksi Berbasis Masyarakat*)
PAC	:	Provincial AIDS Commission
PHC	:	Primary Health Centre
PITC	:	Provider-Initiated (HIV) Testing and Counselling
PKBI	:	Perkumpulan Keluarga Berencana Indonesia (Indonesian Planned Parenthood Association - a Principal Recipient of Global Fund grants in Indonesia)
PKNI	:	PWID Network (In Indonesian: *Perkumpulan Korban Napza Indonesia*)
PLHIV	:	People Living with HIV
PMTCT	:	Prevention of Mother to Child Transmission
PMTS	:	Comprehensive approach to prevention of sexual transmission (In Indonesian: *Pencegahan Infeksi HIV Melalui Transmisi Seksual)*
PR	:	Principal Recipient of Global Fund grant
PWID	:	People Who Inject Drugs
RPJMN	:	National Medium-Term Development Plan (In Indonesian: *Rencana Pembangunan Jangka Menengah Nasional*)
SIHA	:	HIV and AIDS Information System (In Indonesian: *Sistim Informasi HIV dan AIDS*)
SOP	:	Standard Operating Procedures
SR	:	Sub-Recipient of Global Fund grant
SRH	:	Sexual and Reproductive Health
STI	:	Sexually Transmitted Infection
SUFA	:	Strategic Use of ARV
TB	:	Tuberculosis
UA	:	Universal Access
UNAIDS	:	Joint United Nations Programme on HIV and AIDS
UNDP	:	United Nations Development Programme
UNESCO	:	UN Educational, Scientific and Cultural Organization
UNFPA	:	UN Fund for Population Activities
UNICEF	:	United Nations Children's Fund
UNGASS	:	United Nations General Assembly Special Session
UNJT	:	United Nations Joint Team
UNTG	:	United Nations Theme Group
USAID	:	United States Agency for International Development
USD	:	US Dollars
VCT	:	Voluntary Counselling and Testing
Waria	:	Indonesian term for transgender people (from *wanita* [woman] and *pria* [man])
WHO	:	World Health Organization

Contents

Executive Summary 1
Abbreviations 4
FOREWORD 8
I. Status at a Glance 9
1. The Inclusiveness of Stakeholders in the Report Writing Process 9
2. Status of the Epidemic 9
3. Policy and Programmatic Response 10
4. Overview of Indicators 12
II. Overview of the AIDS Epidemic 15
III. National Response to the AIDS Epidemic 19
1. Prevention, Care, Treatment and Support 19
2. Knowledge and Behaviour Change 24
3. Impact Alleviation 26
4. National Commitments and Policy Instrument (NCPI) 26
IV. Best Practices 34
1. Drug dependency treatment in the community 34
2. Making *lokalisasi* safer 35
V. Major Challenges and Remedial Actions 38
1. Policy, resources and institutional structure 38
2. Prevention 39
3. Health system strengthening for care, support, and treatment of PLHIV 41
VI. Support from the Country's Development Partners 43
1. Key support from development partners 43
2. Actions needed to ensure achievement of targets 44
VII. Monitoring and evaluation environment 46
1. Overview 46
2. Planned actions 48
Annex 1. National Commitments and Policy Instrument (NCPI) 49
Annex 2. Domestic and International AIDS Spending 107
Annex 3. National AIDS Spending Assessment (NASA) Matrix 111
Annex 4. List of GARP Indicators Reported by Indonesia, 2014 134
Annex 5. List of Documents Consulted 138

List of Tables

Table 1. Status of Indonesia's AIDS Response by Targets and Indicators

Table 2. Estimation and Projection of People Living with HIV, New HIV Infections, AIDS Deaths and ART Needs among Adults age ≥ 15 years by Gender, in Indonesia, 2011-2016

Table 3. Estimation and Projection of People Living with HIV, New HIV Infections, AIDS Deaths and ART Needs among Children aged 0-14 years old by Gender, in Indonesia, 2011-2016

Table 4. Results of NCPI 2013 Part A: Government Officials

Table 5. Results of NCPI 2013 Part B: Representatives of NGOs, bilateral organizations and UN agencies

Table 6. HIV and AIDS Spending by Beneficiary, 2011-2012

Table 7. Risk Behaviour from BBV-TRAQ

Table 8. Overview of Intervention Components by Site

Table 9. Trends in HIV and AIDS Expenditure in 2009-2012 (in USD)

List of Figures

Figure 1. HIV Prevalence by Geographical Area in Indonesia, 2012

Figure 2. HIV Prevalence by Population, 2007 and 2011 IBBS

Figure 3. Estimated and Projected Annual Number of New HIV Infections by Population Sub-group, Indonesia 2014

Figure 4. Population Distribution by Condom Use During Last Commercial Sex, 2011 IBBS

Figure 5. Population Distribution by Condom Use at Other Unsafe Sex, 2011 IBBS

FOREWORD

The Republic of Indonesia's Global AIDS Response Progress Report or GARP presents information focusing specifically on the achievements made by the Government and the people of Indonesia over the past two years, 2012 to 3013, with regard to the Declaration of Commitment on HIV and AIDS in the UNGASS. This report is a collaboration that reflects the perspective of both Government and the general public.

In this reporting period, UNAIDS set 10 indicators for the global targets for 2015, broken down into 31 sub-indicators, to measure the extent to which this nation has responded to HIV and AIDS. Indonesia has reported on indicators relevant to a concentrated epidemic. However, information on certain indicators that refer to aspects of a general epidemic are not available for Indonesia, with the exception of the provinces of Papua and West Papua.

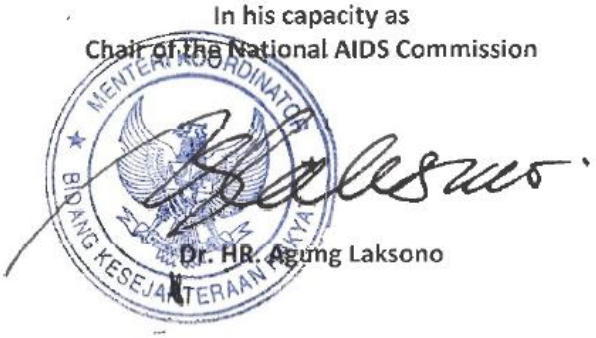
The Government has made a commitment to embark on and maintain an effective response, and has encouraged and supported a range of activities undertaken by a wide range of stakeholders. Presidential Instruction No. 3 of 2010 on Equitable Development Programmes has provided a cornerstone for the Indonesian Government to accelerate the achievement of the MDGs, including those related to HIV and AIDS. This policy guarantees synergy between ministries, central and local governments, and society, and identifies the financing mechanisms that allow the allocation of budgets and incentives to respond to HIV and AIDS.

Although there are a number of aspects that remain in need of improvement, rapid progress has been made within the last two years. Indonesia appreciates the contribution of various stakeholders, such as Government, the private sector and non-governmental organizations (both national and international), that have assisted the country in responding to the challenges of the HIV epidemic.

Interventions and services to address the needs and aspirations of the people infected and affected by HIV have also become more diverse and more easily accessible.

Indonesia is very pleased to be part of a global process. We hope that the publication and dissemination of this report is not merely the fulfilment of our obligations as a member of the United Nations, but will also bring positive changes in the national monitoring and evaluation system, as well as provide accurate evidence and data to support continued efforts to combat HIV and AIDS that are ethical, equitable, humane and effective.

Coordinating Minister for People's Welfare
In his capacity as
Chair of the National AIDS Commission



Dr. HR. Agung Laksono

I. Status at a Glance

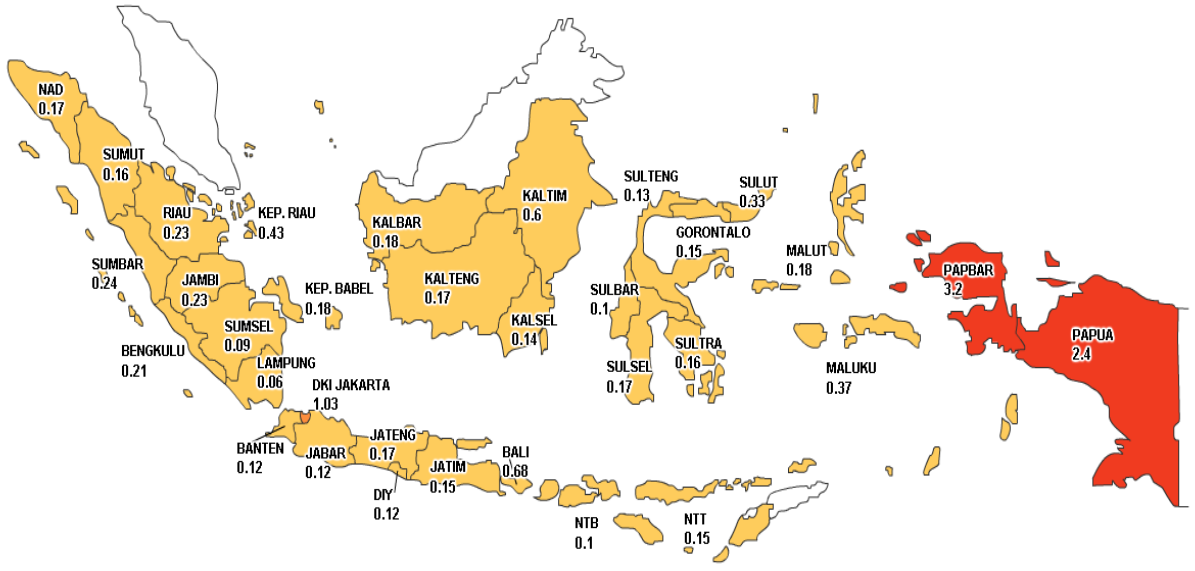
1. The Inclusiveness of Stakeholders in the Report Writing Process

The preparation of the Indonesia Country Progress Report was led by a core group consisting of representatives from the NAC, MoH, WHO, UNAIDS and UNICEF. The process of data collection and validation for reporting on the core indicators was conducted through a series of consultations, interviews and discussions, and the NAC M&E Working Group was consulted to verify the data quality. The National Commitments and Policy Instrument was completed during a workshop at which Government and civil society stakeholders discussed each question on their respective questionnaires and arrived at a consensus on the responses. If there was wide variation in opinion, this was noted. The various components of the report and the final complete drafts were submitted for approval to senior officials, including the Minister of Health, as well as to the core group, and their comments were incorporated into the final draft.

2. Status of the Epidemic

Indonesia is experiencing a dual epidemic of HIV: concentrated throughout most of the country in key populations but more generalised in the provinces of Papua and West Papua, where HIV prevalence was 2.3% in 2013.[1] Nationally, prevalence among the adult population was estimated at 0.4% in 2013,[2] based on AEM modelling, but there is considerable variation within and between districts and provinces, reaching 55% among people who inject drugs (PWID) in Jakarta and 56% among female sex workers in the central highlands of Papua.[3]

Figure 1. HIV Prevalence by Geographical Area in Indonesia, 2012 (Source: MoH, 2012)



Estimated HIV prevalence: Indonesia 0.4%, Tanah Papua 2.3%

The IBBS 2011 results amongst Key Affected Populations shows that prevalence continues to be high, at 41% among people who inject drugs, 8% and rapidly rising among men who have sex with men (MSM), 10% among direct female sex workers, and 3% among indirect female sex workers.[4]

A total of 21,511 new adult HIV infections were reported in 2012, although the actual number of new adult infections is estimated at 71,879.[5] Asian Epidemic Model (AEM) projections indicate that without additional and/or improved interventions, the annual number of new adult HIV infections could rise to 67,217 in 2015. The epidemic is expected to grow fastest among men who have sex with men (MSM), who are projected to account for 23.6% of new infections in 2015. Clients of sex workers, who are the largest risk group by number, are also expected to account for a substantial number of new infections, thus increasing the vulnerability of their regular sexual partners.[6] Accordingly, 30.6% of new infections are projected to occur among 'low-risk' women[7] in 2015, which could lead to an increase in mother-to-child HIV transmission.

The highest numbers of reported new infections per 100,000 population are recorded in the two provinces of Tanah Papua, which is experiencing a low-level generalized epidemic driven by sexual transmission.[8] Although over the last 7 years there has been a slight reduction in high-risk sexual behaviour such as paid sex, casual sex, queue sex and alcohol use before sex,[9] in 2013, 12.7% of married men and 3.6% of married women reported having pre- or extramarital sex in the previous year, compared to18.2% and 5.3%, respectively, in 2006.[10]

3. Policy and Programmatic Response

The national response to HIV and AIDS is guided by the National AIDS Strategy and Action Plan (NASAP) 2010-2014. The NASAP specifies Key Result Areas and targets that are designed to lead the response towards Universal Access, addressing key cross-cutting issues such as human rights and stigma and discrimination, and supporting the establishment of an enabling environment. Government ministries, provincial and district administrations are expected to translate the national strategy into appropriate sectoral and local responses through the formulation of their own respective Action Plans.

The overall goals of the NASAP 2010-2014 are to prevent and reduce the risk of HIV transmission; to improve the quality of life of People Living with HIV (PLHIV); and to reduce the social and economic impact of HIV and AIDS among individuals, families and communities, enabling them to participate fully as valuable, productive members of society. The strategy specifies four Key Result Areas: 1) Prevention, 2) Care, Support and Treatment, 3) Impact Mitigation, and 4) the Establishment of Conducive Environments.

The objectives of the NASAP 2010-2014 are to:

1) Provide effective HIV prevention for all key populations and their partners, and to improve programme effectiveness where needed;
2) Provide quality care, support and treatment services that are accessible, affordable and client-friendly for all people living with HIV who need services;

3) Increase access to economic and social support for PLHIV, children and affected families who are living in hardship;
4) Create an enabling environment that promotes an effective response to HIV and AIDS at all levels, particularly one that empowers civil society to have a meaningful role and reduces stigma and discrimination towards people of key populations and all people living with HIV and affected by AIDS. This includes developing policies, programme coordination, management, monitoring and evaluation, including monitoring of behaviour and status of the epidemic and operational research.

These objectives require an: increase of ART coverage; increase of harm reduction activities; increase in condom use among key populations; increase in the effectiveness of outreach services; and an improved data collection and analysis system.

The response prioritises key affected populations and geographical areas with the highest burden of disease. The key targets for 2014 are to reach 80% of key populations with effective programmes, with sixty percent (60%) of them engaging in safe behaviour; source 70% of funding for the targeted response from domestic budgets.

Since 1994, Indonesia's multi-sectoral response has been led and coordinated by the National AIDS Commission (NAC). The NAC Board is chaired by the Coordinating Minister for People's Welfare. Provincial and District AIDS Commissions have been established in all provinces. Key sectoral actors in the response are the Ministries of Health, Social Affairs, Manpower and Transmigration, Home Affairs, Development Planning and People's Welfare. Other Ministries support limited activities within their scope of responsibility. The National AIDS Strategy and Action Plans are developed within the National Medium-Term Development Plan Framework and are closely aligned with health sector strategic planning.

During the first four years of implementation of the NASAP 2010-2014, coverage of HIV services has expanded to all provinces as well as priority districts and cities, delivered by government and non-government agencies. As of the end of 2013, there were 990 HIV counselling and testing (HCT) facilities; 446 ART sites in public and private hospitals and primary health centres offering care, support and treatment services; 969 STI service sites, 215 needle and syringe (NSP) service sites and 87 sites offering opioid substitution therapy (OST). By 2012 there were 223 facilities providing TB-HIV services and 127 prisons with HIV referral systems in collaboration with district health offices. HCT was available in 78 prisons and OST in nine prisons.[11]

Nevertheless, consistent condom use among direct female sex workers and their clients is very low (35% among FSW and between 6% and 18% among different groups of clients), and coverage of ART and PMTCT are still limited. With the exception of PWID in some cities, there has been limited decline of HIV prevalence among key populations, and prevalence among MSM is increasing.[12] Projections based on AEM modelling suggest that without improved and/or additional interventions, the epidemic will continue to grow.

To address these challenges, the Government has moved to accelerate the response with a renewed emphasis on reducing HIV-related mortality and morbidity by intensifying the implementation of the prevention of sexual transmission (PMTS) programme; initiating the continuum of care (LKB) approach at the district level, and scaling up HIV testing and access to ARV through the adoption of four key strategic policies: the WHO's 2010 guidelines on using a CD4 count of 350 as the threshold for eligibility to ART; adopting the Roadmap for the Strategic Use of ARV (2013-15), which will expand ART eligibility to all HIV positive members of key populations irrespective of their CD4 count ('test and treat'); and adopting PMTCT option B+ (providing lifelong ART for all HIV positive mothers). These strategies will be at the core of the NASAP 2013-2019.[13]

4. Overview of Indicators

Indonesia reported on 45.4% of the indicators for the 2014 Country Progress Report.

1. Indicators for prevention of sexual transmission among the general population.
   The data in the current DHS report (2013) are not comparable with the previously reported data as the indicators were defined differently. Since they are not comparable, these indicators are not reported this year.
2. Indicators for prevention of sexual transmission among key affected populations.
   Data from the 2011 IBBS are used for these indicators. Although IBBS were conducted in 2013, the samples were not drawn from the same sites as the 2011 IBBS, and the results are therefore not comparable. Some results from the 2013 IBBS are presented in the narrative for illustrative purposes only, as the results have not yet been formally published. An IBBS will be conducted among KAPs in the 2011 sites later this year (2014).

Due to the constraints above, the findings in this report may not fully reflect the current status of either Indonesia's HIV epidemic or the response.

The full list of indicators reported by Indonesia in 2014 is presented in Annex 4.

Table 1. Status of Indonesia's AIDS Response by Targets and Indicators

Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015			
	Indicator	**GARPR 2013**	**GARPR 2014**
	Number of women and men aged 15 and older who received HIV testing and counselling in the past 12 months and know their results	**886,825**	**1,042,550**
	HIV+ out of number tested	**21,511**	**29,037**
	Number of pregnant women aged 15 and older who received testing and counselling in the past 12 months and received their results	**42,276**	**100,718**
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015			
	Indicator	**GARPR 2013**	**GARPR 2014**
2.1	People who inject drugs: Number of needles/IDU	**21**	**26**
2.6	People on opioid substitution therapy	**5,332**	**5,329**

2.7	NSP and OST sites	**83 OST** **194 NSP**	**87 OST** **215 NSP**

Indicators on Condom use, Safe injecting practices, HIV Testing and HIV Prevalence are not reported this year. The IBBS among KAPs at the same sites will be conducted in 2014

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

	Indicator	**GARPR 2013**	**GARPR 2014**
3.1	Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission	**21.6%**	**27%**
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	N/A	**7.3%**
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	**34.2%**	**34.3%**

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

	Indicator	**GARPR 2013**	**GARPR 2014**
4.1	ART coverage (adults and children)*, including number of eligible adults and children who are currently receiving antiretroviral therapy during the reporting period (2013)	**31,002** Current estimate of eligible PLHIV: **71,470** at CD4<200 based on 2008 modelling	**39,418** Current estimate of eligible PLHIV: **201,184** at CD4<350 based on 2012 modelling
4.2a	HIV Treatment: 12 months retention	**66.2%**	Data currently being validated with HIV services
4.2b	HIV Treatment: 24 months retention	**61.9%**	Data currently being validated with HIV services
4.2c	HIV Treatment: 60 months retention	**44.3%**	Data currently being validated with HIV services

Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015

	Indicator	**GARPR 2013**	**GARPR 2014**
5.1.	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	**4,209** Current estimation of total TB incidence among PLHIV 27,939 with 15% based on national 2012 Stop Global TB report and 2009 size estimation of KAPs	**4,602** Current estimation of total TB incidence among PLHIV 49,348 with 7.5% based on national 2013 Stop Global TB Report and 2012 size estimation of KAPs

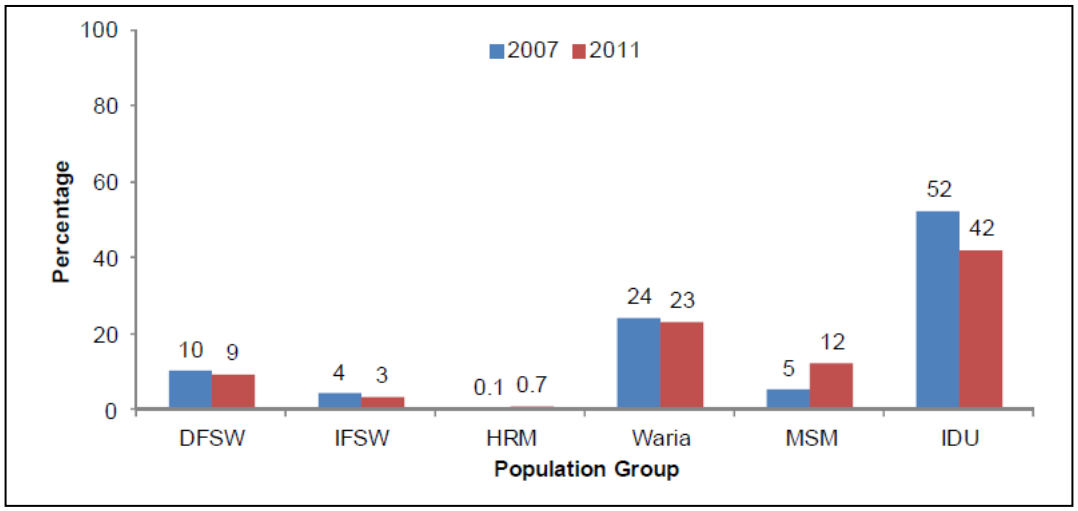
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries			
	Indicator	**2011**	**2012**
6.1	AIDS Spending - Domestic and international AIDS spending by categories and financing sources	**USD**	**USD**
	Total	**69,146,880**	**87,002,694**
	Public Sources	**27,779,280**	**36,851,918**
	International Sources	**41,367,600**	**50,150,779**
Target 8: Eliminate stigma and discrimination			
	Indicator	**GARPR 2013**	**GARPR 2014**
8.1	Discriminatory attitudes towards people living with HIV	**-**	**-**
Target 10: Strengthen HIV integration			
	Indicator	**GARPR 2013**	**GARPR 2014**
10.1	Orphans and non-orphans school attendance* (previously 7.3)	**87.2%**	Question on this indicator no longer on DHS
10.2	Economic support for eligible households (previously 7.4)	**70%** (DHS 2007)	73.60% (Social Protection Program, National Poverty Alleviation Acceleration Team)

II. Overview of the AIDS Epidemic

The Ministry of Health (MoH) estimated HIV prevalence among people aged 15-49 years at 0.4% in 2013,[14] based on AEM modelling. Throughout most of the country, the HIV epidemic is concentrated among female sex workers and their clients, men who have sex with men, transgender people, and people who inject drugs, but the provinces of Papua and West Papua are experiencing a low-level generalized epidemic with HIV prevalence of 2.3% in 2013.[15] Nationally, estimates of HIV prevalence by province range from 0.1% to over 3%. There is considerable variation within and between districts and provinces, with HIV prevalence estimated at up to 56% among female sex workers in the central highlands of Papua and up to 55% among people who inject drugs in Jakarta, while other districts may have very low prevalence.[16] In 2012, 21,511 new adult HIV infections were reported, while total new adult infections among adults and children in the same year were estimated at 69,179.[17]

The results from the 2011 IBBS among Key Affected Populations (KAPs) indicate slightly declining HIV prevalence among direct and indirect female sex workers and transgender people, known in Indonesia as *waria*, and a more substantial decline among PWID, from 52.4% in 2007 to 42.4% in 2011. In contrast, HIV prevalence among MSM underwent a marked increase from 5.3% in 2007 to 12.4% in 2011.[18]

Figure 2. HIV Prevalence by Population, 2007 and 2011 IBBS
(Source: MoH)



An IBBS was conducted in 2013[19] among KAPs in the same sites as an IBBS conducted in 2009. The results from the 2013 and 2009 IBBS cannot be compared directly with the results from the 2011 and 2007 surveys as they were conducted in a different set of provinces and districts. A comparison of the 2009 and 2013 results shows that HIV prevalence among people who inject drugs (PWID) in five cities increased from 27% in 2009 to 39.5% in 2013. Among PWID in Pontianak, West Kalimantan, prevalence was recorded at an alarming 61%, an increase from 32% in 2009. There was a slight decrease in prevalence among both direct and indirect sex workers, falling from 8% to 7.2% among direct female sex workers (DFSW) and from 3% to 1.6% among indirect female sex workers (IDFSW). Among men who have sex with men (MSM), HIV prevalence increased on average from 7% in 2009 to 12.8% in 2013, reaching 19% and

20% in Tangerang and Yogyakarta, respectively. Prevalence among waria decreased from 9.2% in 2009 to 7.4% in 2013. HIV prevalence among prison inmates was recorded at 1.2%, much the same as that in the 2010 national prison survey of 1.1%. There was a slight drop in prevalence among high-risk men (mostly clients of sex workers) from 0.4% in 2009 to 0.2% in 2013.

These trends for the most part correspond with the trends revealed by the 2007 and 2011 surveys in different locations, with HIV prevalence among waria, DFSW and IDFSW remaining stable or decreasing slightly, while rising significantly among MSM. The only major divergence is the rising trend of HIV prevalence among PWID in contrast to the decline indicated by the 2011 survey. This was largely due to a sharp increase in prevalence in two cities, Pontianak and Tangerang, Further investigation among the PWID communities and service providers in the cities concerned revealed a number of contributing factors, including low coverage of harm reduction programmes and the poor quality of the commodities provided, changes in patterns of drug use between 2009 and 2013, the lack of access to sterile injecting equipment among people in prison and OST clients,[20] and inconsistent implementation of regulations that support harm reduction.[21] Overall, both rounds of IBBS (2011 and 2013) confirm that HIV prevalence among PWID remains very high across the country.

A situation analysis conducted by the University of Indonesia for the MoH in May 2013 demonstrated the concentration of the epidemic in a few provinces.[22] Numbers of new reported cases are highest in Jakarta, while the numbers per 100,000 population are highest in Papua provinces, which are experiencing a generalized epidemic. Similarly, the study demonstrates the concentration of the epidemic in risk groups, which include sex workers (DFSW, IDFSW) and their clients (including waria clients) and MSM. It also indicates that there is a high potential risk for the spread of HIV among the large groups of clients of sex workers and their intimate sexual partners.

Table 2. Estimation and Projection of People Living with HIV, New HIV Infections, AIDS Deaths and ART Needs among Adults aged ≥ 15 years by Gender, in Indonesia, 2011-2016 (Source: MoH 2014)

	2011	2012	2013	2014	2015	2016
PLHIV						
Male	347,030	367,086	386,037	403,867	421,031	438,115
Female	185,664	203,473	219,807	234,462	247,467	259,027
Total	**532,694**	**570,559**	**605,844**	**638,329**	**668,498**	**697,142**
New HIV Infections						
Male	39,164	38,867	39,513	40,220	41,863	43,649
Female	26,173	26,252	25,928	25,537	25,353	25,208
Total	**65,337**	**65,120**	**65,441**	**65,757**	**67,217**	**68,857**
AIDS Deaths						
Male	16,522	18,811	20,562	22,391	24,699	26,565
Female	7,066	8,443	9,594	10,882	12,349	13,648
Total	**23,588**	**27,254**	**30,156**	**33,273**	**37,048**	**40,213**
ART Needs						
Male	88,107	97,850	200,787	216,102	231,816	247,378
Female	41,591	48,471	67,863	74,677	81,032	86,954
Total	**129,698**	**146,321**	**268,650**	**290,779**	**312,848**	**334,333**

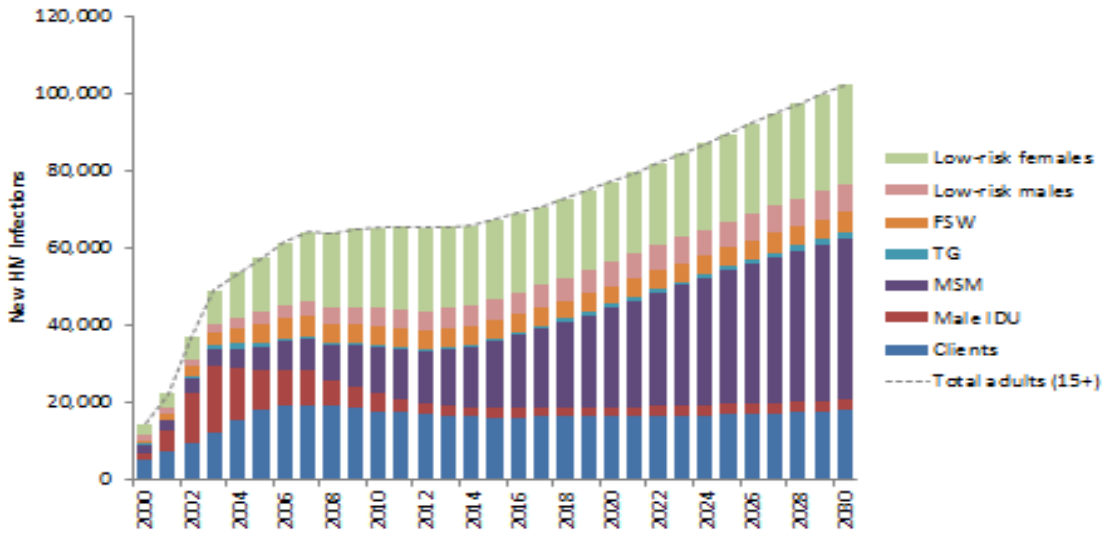
Table 3. Estimation and Projection of People Living with HIV, New HIV Infections, AIDS Deaths and ART Needs among Children aged 0-14 years by Gender, in Indonesia, 2011-2016 (Source: MoH 2014)

	2011	2012	2013	2014	2015	2016
PLHIV						
Male	6,700	7,873	9,081	10,304	11,523	12,707
Female	6,385	7,512	8,672	9,848	11,019	12,158
Total	**13,085**	**15,385**	**17,753**	**20,152**	**22,542**	**24,865**
New HIV Infections						
Male	1,905	2,077	2,233	2,371	2,482	2,562
Female	1,817	1,982	2,131	2,262	2,369	2,445
Total	**3,722**	**4,059**	**4,364**	**4,633**	**4,851**	**5,007**
AIDS Deaths						
Male	755	851	964	1,073	1,174	1,265
Female	722	814	922	1,027	1,124	1,211
Total	**1,477**	**1,665**	**1,886**	**2,100**	**2,298**	**2,476**
ART Needs						
Total	**9,994**	**11,465**	**12,904**	**14,250**	**15,528**	**16,752**

The Asian Epidemic Model (AEM) projections indicate that without additional and/or improved interventions the annual number of new adult HIV infections in Indonesia could rise from an estimated 65,337 in 2011 to 67,217 in 2015 (Table 2). In that case, the estimated number of adult PLHIV would increase from 532,694 in 2011 to 668,498 in 2015, with overall HIV prevalence rising to 0.35%. HIV prevalence among pregnant women is projected to rise to 0.37% in 2015.

The epidemic is expected to grow fastest among MSM, who are currently (2013) estimated to account for 20.2% of new HIV infections, rising to 23.6% in 2015, while "low-risk" women[23] will continue to account for the largest number of new infections (32.3% of new infections in 2013 and 30.6% in 2015), with the accompanying risk for mother-to-child HIV transmission. Substantial numbers of HIV infections are predicted to occur amongst men who are clients of sex workers, who are by far the largest risk group and a bridge from sex work to their intimate sexual partners.[24]

Figure 3. Estimated and Projected Annual Number of New HIV Infections by Population Sub-group, Indonesia 2014 (Source: MoH)



In Tanah Papua, the HIV epidemic is driven largely by sexual transmission. The results of the 2013 IBBS have not yet been published, but the data indicate a slight reduction in high-risk sexual behaviour among adults since the 2006 survey and an increase in condom use at last paid sex. Nevertheless, 12.7% of married men and 3.6% of married women reported having pre- or extramarital sex in the previous year, and consistent condom use declined slightly.[25] There is a significant difference in HIV prevalence among circumcised males (0.1%) and uncircumcised males (2.4%) aged between 15 and 49 years (95% confidence interval). In 2013, HIV prevalence in Tanah Papua was 2.3% among men and 2.2% among women, compared to 2.9% and 1.9%, respectively, in 2006.[26]

III. National Response to the AIDS Epidemic

1. Prevention, Care, Treatment and Support

1.1 Preventing sexual transmission of HIV

The 2011 IBBS shows a declining trend of HIV prevalence among direct and indirect sex workers and waria, although this may not reflect the full impact of the focused interventions implemented under the Prevention of Sexual Transmission of HIV (PMTS) programme. The four key components of PMTS are: mobilising stakeholders; implementing BCC; improved management and distribution of condoms and lubricant, including to clients of sex workers; and comprehensive management of STI, which in several sex work sites are extended through the provision of mobile clinics. These mobile facilities also offer HIV Testing and Counselling (HTC). PMTS appears to be having an impact: programme data over the reporting period indicate a decline in the prevalence of active syphilis among sex workers from 7.9% to 6.8%. IBBS data from 2011 show that 64% of DFSW and 23% of IDFSW had visited STI services in the previous three months. A recent study of PMTS implementation in selected locations indicated regular attendance at STI clinics in sites where there was strong, well-coordinated interventions and quality services.[27] The MoH has now launched a revitalisation of the national STI programme, which includes a community syphilis component.[28]

In 2013, the decision was made to scale up PMTS and broaden its focus from sex workers to include MSM and high-risk men (HRM), among whom HIV prevalence is increasing (IBBS 2011). As of mid-2013, PMTS was being implemented in 72 sex work settings in 15 provinces,[29] with plans to expand coverage to 137 sex work settings by 2015. A review of PMTS was initiated in June 2013. However, the benefits of the programme have already been demonstrated in a number of locations (see Chapter 4).

Use of condoms, which are obtained free or purchased from commercial outlets, is increasing. In several hotspots across Indonesia, brothel owners provide condoms directly to clients. The MoH has launched a programme to integrate condom distribution into STI, OST and ART services. According to a Rapid Behaviour Survey in 2011 (SCP 2011), 73% of sex workers used a condom at last sex and 81% received information regarding condoms. Consistent condom use, however, is still insufficient, remaining below 50% among the populations at greatest risk of sexual transmission (female sex workers and their clients, men who have sex with men, transgender people, and people who inject drugs), according to the 2011 IBBS.

Despite the evidence above, Indonesia reported in its Country Progress Reports for 2012 and 2013 that prevention coverage of FSW was just 18.5% (IBBS 2011). This was based only on whether the respondents knew where to access VCT, and whether they had received condoms in the last 12 months. In fact, mobile VCT services are widely available to cater to sex workers who do not know where to get an HIV test, and both clients and sex workers have ready access to condoms not only through outreach but through other channels as well. Moreover, the data on condom use, uptake of STI services and HIV testing suggest a much higher level of prevention and testing programme coverage than indicated in the Country Reports: condom use during last commercial sex was 61% among direct FSW and 68% among indirect FSW, while 64% of direct

FSW had visited an STI clinic in the last 3 months, and 57% of direct FSW had had an HIV test (IBBS 2011).

Social and religious conservatism as well as restrictive local legislation may be constraining condom promotion and access to condoms for vulnerable groups and young people. UNAIDS has supported a comprehensive review of punitive laws, including a review of the legal constraints on condom distribution and sex work.[30]

The epidemic continues to expand among MSM. HIV prevalence doubled to 8% in 2011, with rates of up to 17.2% recorded in Jakarta. Consistent condom use, as reported in the 2011 IBBS, was low (22%). The GARP indicators for MSM show prevention coverage of 23.4%. However, as for the sex workers, this figure is based on data that do not capture the reality of the programme in Indonesia, where a larger proportion of MSM (49%) purchase condoms from outlets than obtain them from NGOs, and where MSM, waria and MSW are also increasingly being reached through social media, which is not recorded in the IBBS.[31] Reported condom use at last sex was high (60%) and increasing, and 64.5% of MSM reported having had an HIV test, while MoH programme data show a sharp increase in the number of HIV tests by MSM between 2010 and 2012.[32] All these factors indicate good coverage of prevention interventions. As reported above, the PMTS programme is now increasing its emphasis on MSM, and while STI rates remain high overall, the presence of active syphilis among MSM fell from 21.9% to 19.9% over this reporting period, which could suggest an increase in condom use and better access to STI services. GWL-INA, the network of CSOs working with MSM and waria, has also contributed to improving the extent and quality of coverage, including better linkages and referral systems between CSOs and HIV-related services; resource mobilisation; and capacity building for CSOs. To further strengthen collaboration between local authorities and MSM and waria CSOs, a national MSM programme manager has been appointed to the NAC, along with MSM programme officers in local AIDS Commissions in priority districts and cities, although further work is needed to clarify the support they can provide.[33]

1.2 Preventing HIV transmission among People Who Inject Drugs

There has been a decline in HIV prevalence among PWID in cities with the highest burden of HIV, excluding Jakarta, from 52% in 2007 to 41% in 2011. This reflects the behavioural surveillance data, which indicate that 88% of drug users do not share injecting equipment (IBBS 2011). In 2012, the prevention programme reached 64,259 PWID,[34] which at the time was 87% of the estimated number of PWID. However, in Jakarta, prevalence among young drug users (those who had been injecting for less than two years), rose from 33% to 44% between 2007 and 2011. This may be due to a combination of low levels of comprehensive knowledge about HIV transmission and prevention among young PWID (14% of PWID aged 15–19 and 29% of PWID aged 20–24, IBBS 2011), little knowledge of the HIV and hepatitis C risks of injecting, and low awareness of and access to local NGO services for drug users.[35] Although not yet formally released. the findings from the 2013 IBBS, which was not conducted in the same cities as the 2011 IBBS, indicated a significant overall increase in HIV prevalence among PWID from 27% to 39.5%.[36] Most of the increase was accounted for by two cities where NSP coverage is limited.

The reach and coverage of harm reduction services continues to grow, with 215 NSP sites and 87 OST sites in priority districts and cities in 2013 (programme data), as well as Community-Based Drugs Dependency Treatment (CBDDT) programmes operated by 16 organizations in 10

provinces. OST services, which in 2013 were being accessed by 5,329 people, are being increasingly integrated into public health settings and are also available in some prisons. However, the availability and quality of a complete package of services remains variable. Despite the increasing provision of services in community health centres, the majority of staff do not receive formal training on NSP, and the lack of understanding about addiction and harm reduction acts as a constraint on effective service delivery, with most people who inject drugs preferring to receive NSP from CSO outreach workers.[37]

The number of needles distributed per injector per year has increased from 21 to 26 over the reporting period (NAC reports), but this figure does not reflect the large number of sterile needles and syringes purchased privately, which was reported by two thirds (58%) of respondents in 2011 (IBBS 2011). There is a need to allow PWID to purchase needle syringes from pharmacies in Indonesia without a prescription from a doctor. Reports that OST clients continue to inject, particularly in the early months of treatment, but do not have access to NSP, suggest that NSP services should be better integrated with the OST programme.[38]

The CBDDT programme was initiated in 2009 in close coordination with civil society, BNN (the National Narcotics Agency), the Ministry of Social Affairs and MoH. An evaluation in 2012 indicated that CBDDT had contributed to minimising risk behaviour and led to significant improvements in quality of life, both during and after treatment (see Chapter 4).

National-level legislation was enacted in 2011 in support of harm reduction, including regulations that facilitate the diversion of drug users into drug treatment. New guidelines are being developed on harm reduction to provide greater clarity on NSP and OST service delivery and on supply chain and prescription practices for methadone and syringes.[39]

As of 2012, HIV education programmes were being implemented in 147 prisons/detention centres, HIV counselling and testing in 78 prisons/detention centres and OST in nine prisons/detention centres.[40] More than half of the inmates with drug-related offences (55%) had received an HIV test in prison.[41] Comprehensive guidelines on HIV and AIDS and STI services in prisons were launched in 2012. A key challenge for the programme is that even though drug use is illegal in prisons, almost one-third of imprisoned PWID continue to inject while incarcerated, using shared equipment.[42]

1.3 Improving access to HIV counselling and testing

The improved access to HIV counselling and testing is an indication of the increasing reach of services, and there were a total of 990 VCT clinics (including facilities in prisons) at the end of 2013.[43] HTC has been well integrated with sexual and reproductive health, TB and MCH services, but less so with general outpatient care.[44] Risk assessments for HIV, STI and TB are now conducted routinely in some PHCs to identify cases of HIV and co-infection at an earlier stage, and link patients to appropriate care and treatment services.[45] The number of adult women and men who received HTC in the past 12 months and know their results increased 12.8% from 886,825 in 2012 to 1,042,550 in 2013 (MoH). This is continuing the upward trend reported through surveillance, with testing increasing from 53% to 57% for Direct Sex Workers; from 64% to 72% for waria and from 50% to 63% for PWID (IBBS, 2011).

1.4 Preventing mother-to-child transmission of HIV

The MoH adopted PMTCT Option B+ in 2011. Strong policy, decrees and the updating and implementation of comprehensive guidelines since 2012, including the embedding of PMTCT in ANC services and training on the use of provider-initiated counselling and testing (PITC), have strengthened the coverage and implementation of PMTCT and led to an increase in the detection of pregnant women with HIV. Thus more than 100,718 pregnant women aged 15 and above received HTC and their test results in the past 12 months, more than doubling the previous year's coverage of 42,276. However, of the women who tested positive, only 27.% received ART to reduce the risk of mother-to-child transmission (1,551 out of 5,740), an increase from 21.6% in 2012. Just over 25% of infants born to HIV-positive women received a virological test for HIV within 2 months of birth in 2013 (this figure was not reported previously). As of mid-2013, PMTCT was available in 92 hospitals and 13 PHCs in 31 provinces.

In addition to the adoption of Option B+, further support for PMTCT is provided by the new Ministerial Decree on HIV Prevention (Permenkes 21/2013), which stipulates that HTC should be routinely offered in antenatal care to all pregnant women in concentrated and generalised epidemic areas; and in low epidemic areas, to all pregnant women with STI and/or TB symptoms.

In spite of this progress, PMTCT coverage remains below 27% of the estimated number of HIV positive pregnant women, although this should improve as PMTCT integration into ANC continues. Moreover, this figure does not account for the number of women accessing PMTCT from private clinics, which is not recorded. Coverage continues to be challenged by the small size, but wide dispersion, of the population of pregnant women with HIV; additionally, not all pregnant women access ANC services.[46] Further constraints are imposed by the Population and Family Development Law (52/2009) and Health Law (36/2009), which exclude adolescent and unmarried women from reproductive health services.

Strengthened linkages with other programmes and initiatives are contributing to programme implementation; for example, JAMPERSAL (the national insurance scheme for pregnant women) now covers the cost of delivery (caesarean and vaginal) for HIV positive pregnant women. In Tanah Papua, an MoH-Clinton Foundation programme to increase access to services for pregnant women in remote areas includes the promotion of PITC in HCT.

Guidelines are being developed on couples counselling and syphilis screening and treatment, among others.

1.5 Improving access to treatment, care and support

Several new initiatives have been launched to increase coverage of treatment, care and support. These include LKB, a continuum of care programme that expands HIV testing and effective linkages with HIV care, with services delivered up to PHC level through a closer collaboration between health services, CSOs and district administrations; and the Roadmap for the Strategic Use of ARV. Focusing initially on districts with a high burden of HIV and/or concentrations of KAPs, the strategy aims to accelerate ART coverage according to the recently updated guidelines (<350 CD4 threshold) and expand ART eligibility to all PLHIV in specific groups (pregnant women, through the adoption of Option B+; HIV sero-discordant couples; FSW; MSM; PWID; prisoners; and PLHIV who are co-infected with TB), regardless of their CD4 count. These two

programmes are expected to expand annual HIV testing from 800,000 in 2012 to over 3 million people in 2015 and ART coverage to over 160,000 by 2015.

Although phased implementation of accelerated access began only in 2012, the number of health facilities offering ART has increased by almost one-third over the reporting period from 338 (284 public + 54 private) to 446 (384 public + 62 private). This expansion includes a scaling up of services at the community level through the provision of 114 satellite ART facilities at PHCs.[47] Paediatric ART is offered at 98 (85 public + 13 private) facilities.

The number of adults and children enrolled in HIV care at the end of the reporting period was 141,360 (ART reports). ART coverage of adults and children rose from 31,002 to 39,418 during the reporting period, an increase of 27%. However, the denominator for 2013 has risen from 178,000 to 201,184 due to the new AEM projections of the number of PLHIV who are eligible for ART. As noted above, HIV testing is already being scaled up to reach the target set by the Strategic Use of ARV (SUFA) strategy, introduced in November 2013.

Thirteen districts were selected for the initial rollout of the SUFA strategy. These sites will serve as demonstration sites from which lessons can be learned and applied to the expansion of SUFA to a total of 75 districts by the end of 2014. As of February 2014, facilitators had been appointed, orientations held and action plans developed in all 13 districts, and tools have been developed to monitor implementation at district level.

Enhanced access to treatment, care and support services is being piloted through PHCs under the LKB (Continuum of Care) programme, which is one of the central components of the SUFA strategy. The CoC is essentially a network of health providers, NGOs, PLHIV and community stakeholders, coordinated by a focal point the (head of the City/District Health Office). As well as HTC and ART, participating sites provide screening and treatment of TB and STI; youth reproductive health services; harm reduction services, including methadone & NEP; adherence support; and referrals for complicated cases, all in a one-stop-one-day service. As well as improving access for PLHIV, it is expected that mainstreaming services will contribute to a reduction of HIV-related stigma and discrimination against PLHIV. According to the LKB guidelines, these satellite services could be provided not only at PHCs but also through private clinics, prison clinics and other community clinics, tailored to the needs of the community.[48]

Various procurement and supply management issues have been addressed, resulting in a reduction of ARV stock-outs from 1% to 0%. In 2012, in an attempt to offset the high cost of drugs, the Government authorised local manufacturers to produce second line ARVs as well as two antiretroviral medications for the treatment of hepatitis B.[49]

Despite the considerable expansion of coverage, the majority of patients are initiated on ART at a CD4 count of less than 100, which is less than optimal in terms of both treatment outcomes and maximising the potential prevention effect of treatment. Another challenge is the delay in getting eligible people into treatment once tested. This may reflect the persistent discrimination from health workers alongside fears of medication side effects and stock-outs, as well as the costs of transport, which may be prohibitive for some. Improvements are expected as LKB and the Roadmap are rolled out. ART is provided free of charge by the Government, and OI and STI treatment for HIV patients is covered by the newly launched National Health Insurance scheme.

However, patients are still required to make out-of-pocket payments for laboratory tests. As yet, there is no provision for these costs to be covered by the national insurance scheme but the NAC and others are advocating strongly for them to be included.

1.6 Preventing/managing TB/HIV co-infection

A pilot programme for TB/HIV collaboration began in 2011 and TB/HIV working groups have been established at the provincial level to facilitate coordination between TB and HIV units. Collaboration between HIV and TB services has also been strengthened in prisons. The percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV increased over the reporting period. Although the majority of adults and children enrolled in HIV care have their TB status assessed and recorded, the percentage whose status was assessed and recorded during their last visit fell from 92% to 84% during the reporting period, which may reflect the revised estimates of HIV prevalence.

2. Knowledge and Behaviour Change

2.1 Knowledge about HIV transmission

Surveillance indicates that the majority of people (more than 60%) in nearly all key population groups know that using condoms and staying faithful can prevent HIV infection (IBBS 2011), more than 80% are aware that HIV can be transmitted by sharing needles and more than 70% know that it can be transmitted during childbirth. The exception is prisoners, whose level of knowledge is generally lower.[50] Some misperceptions persist among most population groups, including the belief that HIV transmission can be prevented by taking antibiotics or eating nutritious food.

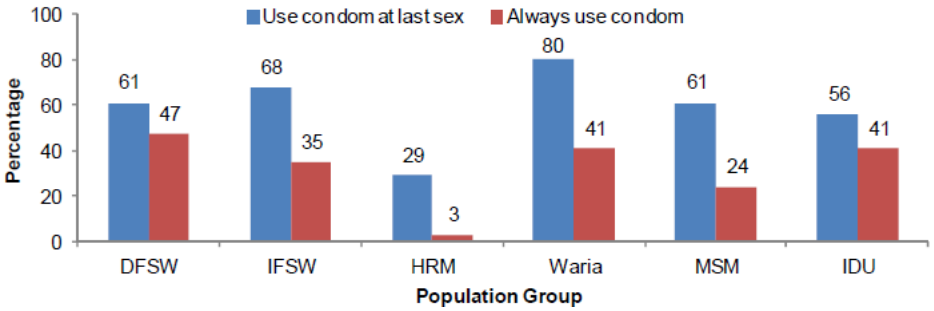
A rapid study carried out in 2011 indicated an increase in comprehensive knowledge about HIV and AIDS among youth (aged 15-24 years) in the general population from 11.4% in 2010 to 20.6% in 2011, with no disparity in knowledge between males and females.[51] This suggests that the NASAP 2010-1014 target of 80% of youth in school and out of school being reached with effective prevention programmes is not being met. Information related to STI and HIV and AIDS is included in various national programmes aimed at youth implemented by the Ministries of Health, Education and Culture, and Religious Affairs, and the National Board of Population and Family Planning (BKKBN). Although the Ministry of Manpower and Transmigration and the Ministry of Social Affairs have initiated programmes to target the 40% of youth who are in employment rather than in school, there is a lack of coverage for those who are neither in school nor employed. The Government has taken steps to address the gaps in coverage and quality suggested by the above data through a Commitment on Enhancing Comprehensive Knowledge on HIV among 15-24 year-olds signed by five ministries at the end of 2012. In addition, UNESCO is currently developing ITGCE, a description of the investment needed for comprehensive sexual education.

2.2 Condom Use

Knowledge about condoms is reflected in the generally high rates of reported condom use among key populations at the last sex with either a commercial or a casual partner (see Figures 4 and 5), although consistent condom use with regular partners remains low overall. Among

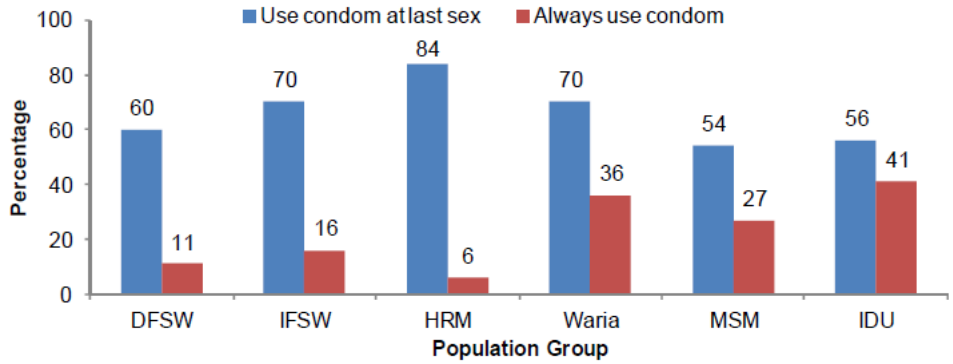
HRM, both consistent condom use and condom use at the last sex remains very low (3% and 29%, respectively), which increases the potential for transmission from this large bridging population into the general population, namely their wives and girlfriends, and, in turn, their babies.

Figure 4. Population Distribution by Condom Use During Last Commercial Sex, 2011 IBBS



These figures, from 2011, do not reflect the scaled up implementation of PMTS since 2013. A recent study of PMTS implementation in selected sex work locations revealed generally high and increasing levels of condom use, with supportive regulation and strong community support, and indications that this—alongside regular use of STI services—may be having an impact on declining STI and HIV transmission.[52]

Figure 5. Population Distribution by Condom Use at Other Unsafe Sex, 2011 IBBS



2.3 Safer behaviour among people who use drugs

Surveillance data indicate that 88% of drug users are not sharing injecting equipment, which is reflected in the reduction of HIV prevalence among PWID. This suggests that the harm reduction programme and more supportive regulation[53] are having an impact. However, there are indications that 39% of OST clients continue to inject while on treatment, particularly in the early months, which is common.[54] As those enrolled in OST do not have access to needle and syringe programmes, they may be resorting to using shared equipment to inject.[55] Sharing needles and syringes also seems to be more prevalent among younger users who are experimenting with drugs for the first time;[56] younger users are also reported to have low awareness of the HIV and hepatitis C-related risks of injecting.[57] Other causes for concern are indications of increasing alcohol and non-injecting drug use, low condom use, particularly

among younger, sexually active injecting drug users: there is anecdotal evidence that PWID who use sterile injecting equipment feel that they are not at risk, and therefore do not need to use condoms.[58] Low rates of condom use are also reported among women who inject drugs, some of whom sell sex in order to be able to buy drugs. All these factors may be contributing to an increase in sexual transmission among PWID.[59] There is a clear need to ensure that younger users, in particular, are better informed about both the risks of unsafe sex, and where to access HIV prevention and SRH services.

3. Impact Alleviation

Existing social protection schemes in Indonesia—primarily the various health care schemes for the poor—do not specifically address the needs of PLHIV and there is still widespread discrimination against PLHIV in the delivery of such assistance. Currently, only limited social assistance is provided by the Ministry of Social Affairs (MoSA).

MoSA provides some support for national CSOs and CSO networks and works with them to mitigate the impact of HIV and AIDS by providing livelihood improvement and rehabilitation shelters for PLHIV; IEC activities and income generating activities for waria; empowerment training; and some economic and psychosocial support for children and families living with HIV and AIDS, particularly in high burden areas such as Papua. In 2011, 70% of eligible households were reported to be receiving economic support, and school attendance by both orphans and non-orphans was reported at 87.2%. However, programmes tend to be sporadic and/or case-based, with no built-in sustainability.[60]

The National Social Security System is being phased in from the beginning of 2014, and will cover healthcare, occupational accidents, death and pension benefits for all. The scheme covers some elements of treatment (OI and STI) for PLHIV patients; the cost of ARV drugs is already fully covered by the Government. As yet, the costs of medical monitoring for ART patients (CD4, viral load, liver function etc.) are not included. Moreover, access to treatment for drug users will be impaired by the provision that the system does not support treatment related to self-inflicted diseases, drugs and alcohol.[61]

4. National Commitments and Policy Instrument (NCPI)

An analysis of the National Commitments and Policy Instruments from the current and prior reporting periods shows that, overall, there has been little change in the perceptions of either the Government or the civil society partners. Improvements have been noted in overall programme implementation and HIV-related M&E, political support for the response and evaluation of the impact of HIV in the broader development planning context. The overall level of political support is perceived as good to improving, although this is not reflected in increased budgetary support: domestic funding remains at 43%, only a slight increase from the 40% reported in 2011.

The civil society perception of the general level of HIV programme implementation is slightly lower than that of the Government. Civil society and Government perceptions diverge more noticeably on civil society access to technical and funding support from the NAC, and the extent of legal protection for vulnerable populations.

The discussion and scores on both parts of the instrument indicate that additional attention will need to be focused on ensuring a more meaningful role for civil society; review and revision of laws and regulations; and the achievement of universal access. Progress to date in these three areas is discussed in more detail below. Responses to the key questions on the NCPI are summarised in Tables 4 and 5.

4.1 Civil society participation

Supported by Presidential Regulation No. 75/2006 on the National AIDS Commission, civil society coordination and participation in national-level strategic planning with the MoH, NAC and INGOs has been improving over recent years. Civil society was involved at all stages of preparation of the NASAP and the recent Mid-Term Review, and they regularly participate in technical, strategic and consultative meetings at the national level, including through the mechanisms of the Technical Working Groups and the Global Fund Country Coordinating Mechanism. Civil society partners are also involved in budget discussions when they concern foreign sources of funding such as the Global Fund, Australia Aid or IPF, but not government funding. At the subnational level, however, community involvement is restricted to technical consultation, and there is little involvement in strategic policy discussions. In particular there is a need for greater recognition of the critical role of community organisations and civil society in the implementation of the CoC service delivery model.

Communities are involved in M&E working groups and they are beginning to use evidence-based data in proposals and advocacy, but overall capacity to use data to inform programming remains limited.

4.2 Enabling environment: law and regulations

Law No.39/1999 on Human Rights guarantees basic human rights for all, and there are a number of laws and government regulations to protect particular categories of PWID, youth, prisoners, and migrant populations from discriminatory acts, but overall, explicit legal protection for PLHIV and KAPs is limited. Drug use is still criminalised, and in some cases service delivery is constrained due to concerns that service providers will be charged with abetting a crime. However, the amended narcotics law (Law 27/2009) guarantees the provision of medical and social rehabilitation for PWID. Sex work and male-to-male sex are criminalised to a certain extent, particularly by local legislation. Sex workers, waria and MSM often face arbitrary arrest, detention, harassment and violence by law enforcement officers, which can discourage them from accessing HIV-related services.

Individuals whose rights are violated have recourse to the National Commission on Human Rights as well as to various legal aid services, but in practice there is little precedent for the use of these mechanisms for HIV-related rights violations. Efforts are being made to improve the documentation of AIDS-related discrimination against PLHIV and KAPs.

A number of new laws and policy initiatives were launched during the reporting period to strengthen the response. At the end of 2012 five ministries (Health, Home Affairs, Education & Culture, Social Affairs and Religious Affairs) signed a Commitment on Enhancing Comprehensive Knowledge on HIV among 15-24 year-olds. Indonesia also moved to make HIV and hepatitis B treatment more accessible by authorising compulsory licenses for the local production of certain antiviral and antiretroviral drugs (Presidential Regulation 76/2012). In

2013 the Ministry of Home Affairs issued Instruction no.444.24/2259/SJ 2013 on Institutional Strengthening and Community Empowerment for the AIDS Response at Provincial and District Levels. The Ministry of Public Works issued a policy letter as well as Decree No 3/2013 on the AIDS Response in Construction Sites, while the Ministry of Manpower and Transmigration released its VCT@work policy. While these initiatives reflect the improvement in political support and a strengthening of the multisectoral response, monitoring implementation of policies and laws remains a challenge, particularly at the provincial and district levels. This is highlighted by recent actions taken by some local governments to close down well-established brothel areas[62] despite the fact that that in many such sites, the sex workers, establishment owners, local communities, NGOs and law enforcement authorities are leading the way in implementing coordinated, structural HIV prevention interventions (see Chapter IV: Best Practices).

Indonesia's national health insurance scheme, launched in 2014 as the implementation of Law 40/2004 and Presidential Regulation 12/2013, is intended to provide universal healthcare, but as yet there are significant gaps in coverage for KAPs and PLHIV. Advocacy is ongoing to address these issues.

4.3 Universal Access

Perceptions of civil society and Government and on the delivery of prevention services are broadly similar and indicate that there has been little change since the previous reporting period.

To support universal access to prevention, treatment, care and support, the PMTS programme has been scaled up; working groups on Research, Young People, Gender, Papua and M&E have been established in the NAC and other sectors; strategies have been launched and implemented to scale up access to ART through the Strategic Use of ARV and Continuum of Care (LKB); there has been some integration of HIV care and treatment into the social health insurance scheme; and an agreement has been signed between five Ministries on the Comprehensive HIV Knowledge of Young People aged 15 – 24 years.

Nevertheless, performance could be improved through: increased access to condoms, particularly for young people; strengthening the dissemination of information on HIV counselling and testing; optimizing the use of strategic information, including reports and other documentation; strengthening cross-sectoral coordination, including the implementation of the 5 Ministries agreement; introducing policy reforms that will guarantee the rights and access of PLHIV and KAPs to health and afford greater protection against discrimination; and increasing the commitment of national and sub-national stakeholders, including through increased allocations of funding.

Table 4. Results of NCPI 2013 Part A: Government Officials

(2011 response shown in parentheses if different)

I. Strategic Plan		**Remarks**
1. Has the country developed a national multisectoral strategy to respond to HIV?	Yes	
2. Has the country integrated HIV into its general plans?	Yes	

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning?	Yes ('No')	
1.5 Does the country have a strategy for addressing HIV issues among its national uniformed services?	Yes	
4. Does the country have a plan to strengthen health systems?	Yes	
5. Are health facilities providing HIV services integrated with other health services?	Frequently in SRH, TB, ANC/MCH; plus some HCT & ART in general outpatient care	
Strategy planning efforts in your country's HIV programmes in 2011/2013:	7/10	
II. Political Support and Leadership		
1. Do the following high officials speak publicly and favourably about HIV effort in major domestic forums at least twice a year		
A. Government ministers	Yes	
B. Other high officials at sub-national level	Yes	
2. Does the country have an officially recognized national multisectoral HIV coordination body?	Yes	
3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programs?	Yes	
4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?	14%	
5. What kind of support does the National HIV commission provide to civil society organizations for implementation of HIV-related activities?	Yes for Capacity Building, Coordination with other implementing partners, Information on priority needs, Procurement and distribution of medicine or other supplies, and Technical Guidance	Contrasts with civil society perception that they have limited access to funding and technical support
6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National HIV Control policies?	Yes	
Political support for the HIV programme in 2011/2013:	8/10 (7/10)	
III. Human Rights		
1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups?	Yes for PLHIV, Migrants/ mobile populations, OVC, People with disability, PWID, Prison inmates, Women and girls, and Young women/young men	Contrasts with civil society perception that there is no specified protection for PLHIV or young (but there is agreement on the lack of protection for MSM, SW & waria)
1.2 Does the country have general law on discrimination?	Yes	
2. Does the country have laws, regulations or policies that present obstacle to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?	Yes	
Which populations?	MSM, SW, waria, young people	
IV. Prevention		
1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to general population?	Yes	
2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?	Yes	
3. Does the country have a policy or strategy to promote information, education and communication	Yes	

and other preventive health interventions for key or other vulnerable sub-populations?		
Policy efforts in support of HIV prevention in 2011/2013:	7/10	
4. Has the country identified specific need for HIV prevention programmes?	Yes	
Efforts in the implementation of HIV prevention programmes in 2011/2013:	7/10 (6/10)	Civil Society: 6/10
V. Treatment, Care and Support		
1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?	Yes	
2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?	Yes	
3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?	Yes	
4. Does the country have access to regional procurement and supply management mechanisms for critical commodities?	Yes	
Efforts in the implementation of HIV treatment, care, and support programmes in 2011/2013:	7/10	Civil Society: 6/10
5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?	Yes	
Efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011/2013:	6/10	
VI. Monitoring and Evaluation		
1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?	Yes	
2. Does the national Monitoring and Evaluation plan include?	Yes to all items	
3. Is there a budget for implementation of the M&E plan?	Yes: 5% of total HIV budget. (10%)	
4. Is there a functional national M&E unit?	Yes	
5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?	Yes	
6. Is there a central national database with HIV-related data?	Yes	
8. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?	Yes	
9. How are M&E data used?	For program improvement, In developing/revising the national HIV response, For resource allocation, and for others	
10. In the last year, was training in M&E conducted?	Yes at the national level and sub-national level	
HIV-related monitoring and evaluation (M&E) in 2011/2013:	8/10 (7/10)	

Table 5. Results of NCPI 2013 Part B: Representatives of NGOs, bilateral organizations and UN agencies

(2011 response shown in parentheses if different)

I. Civil Society Involvement		**Remarks**
To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?	3/5 (2/5)	
2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity	3/5 (2/5)	
4. To what extent have civil society representatives been involved in the monitoring and evaluation of the HIV response:		
a. Developing the national M&E plan?	1/5	
b. Participating in the national M&E committee/working group responsible for coordination of M&E activities	1/5	
c. Participate in using data for decision-making?	1/5 (2/5)	
8. How would you rate the efforts to increase civil society participation in 2011/2013?	5/10	
II. Political Support and Leadership		
1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and program implementation?	Yes	
III. Human Rights		
1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations?	Yes for MMP, OVC, People with disabilities, PWID, Prison inmates, Women and girls (no for PLHIV, MSM, SW, waria, young people)	
1.2. Does the country have a general law on non-discrimination?	Yes	
2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?	Yes	
Which populations?	MSM, PWID, SW, waria, young people	
3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?	Yes	
4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?	Yes	
5. Is there a mechanism to record, document and address cases of discrimination experienced by PLHIV, key populations and vulnerable populations?	No (no specific formal mechanism for PLHIV) (Yes)	
6. Does the country have a policy or strategy of free services for the following?	Yes for ART and HIV prevention services; and provided but only at a cost for HIV-related care and support interventions	
7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?	Yes	
8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?	No (Yes)	
9. Does the country have a policy or law prohibiting HIV screening for general employment purposes?	Yes (No)	
10. Does the country have the following human rights	Yes (No)	

monitoring and enforcement mechanism?		
11. In the last 2 years, have there been the following training and/or capacity-building activities	Yes	
12. Are the following legal support services available in the country?	No for legal aid system for HIV casework, and Yes for private sector law firms or university-based centres to provide free or reduced-cost legal services to PLHIV	
13. Are the programmes in place to reduce HIV-related stigma and discrimination?	Yes	
How would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011/2013?	3/10	
How would you rate the effort to implement human rights related policies, laws and regulations in 2011/2013?	2/10	
IV. Prevention		
1. Has the country identified the specific needs for HIV prevention programmes?	Yes	
How would you rate the efforts in the implementation of HIV prevention programmes in 2011/2013?	6/10	Government: 7/10
V. Treatment, Care and Support		
1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?	Yes	
1.1 The majority of people in need have access to:	PEP for occupational exposure, STI management, TB infection control HIV treatment and care facilities, TB preventive therapy for PLHIV, TB screening for PLHIV, and treatment of common HIV-related infections (+ Psychosocial support for PLHIV and their families)	
How would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?	6/10 (7/10)	Government: 7/10
2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?	Yes	

4.4 Resourcing the response: a summary of the NASA 2011-2012

There was a slight increase in the total expenditure for the HIV and AIDS programme in 2012 compared to 2011, continuing the upward trend from 2009. In 2011, international partners contributed 59% of the total spending for HIV and AIDS, with the remaining 41% from the Government, while in 2012, the Government contribution increased to 42%. Government spending increased from USD 21 million in 2009 to USD 37 million in 2012. International partners increased their contribution from USD 43.8 million in 2011 to USD 50.1 million in 2012. More than 70% of the Government contribution was from central sources, with more than 76% spent by the Ministry of Health in 2011, increasing to 83% in 2012. Some 89% of MoH expenditures were devoted to drugs procurement.

The Global Fund is the largest funding source, covering 64.1% in 2011 and 49.6% in 2012 of all HIV and AIDS spending from international partners (multilateral and bilateral). However, this support is scheduled to end in 2015. The Government of Australia is the second largest funding source, donating more than USD 8 million in 2011 and more than USD 16 million in 2012 through Australia Aid. Fifty percent of these funds were disbursed through the HIV Cooperation Program for Indonesia (HCPI) to support programme activities in collaboration with national

implementers, with the remainder disbursed through CHAI, NAC, UNDP and others. The US Government contributed, through USAID, USD 3.7 million in 2011 and USD 5.7 million in 2012.

Government spending was focused more on support and treatment, while external partners targeted prevention programmes. The highest proportion of spending in 2011 went to non-targeted interventions, PLHIV and KAPs (33%, 26% and 24% respectively), while in 2012 the breakdown was PLHIV, KAPs and non-targeted population (34%, 27% and 24% respectively). More than 82% of program interventions in 2011 and around 71% in 2012 were implemented by public sector providers (central and provincial/district government-owned organizations such as ministries/national agencies and provincial/district health and non-health organisations).

A more detailed summary of the NASA is provided in Annex 2, and the NASA results are in Annex 3.

Table 6. HIV and AIDS Spending by Beneficiary, 2011-2012

Beneficiary	**2011**		**2012**	
	USD	%	USD	%
PLHIV	18,811,838	25.93	29,470,740	33.87
KAP	17,379,143	23.96	23,692,860	27.23
Other key populations	2,744,656	3.78	1,626,325	1.87
Specific 'accessible' populations	5,857,475	8.07	8,639,351	9.93
General population	2,366,704	3.26	1,854,768	2.13
Non-targeted interventions	24,020,626	33.11	20,661,336	23.75
Specific targeted population n.e.c.	1,363,514	1.87	1,057,316	1.22
	72,543,623	100	87,002,697	100

IV. Best Practices

The following cases of best practice illustrate how community-led interventions are resulting in outcomes that could make an impact on reversing the spread of HIV in Indonesia.

1. Drug dependency treatment in the community

In 2009, the National AIDS Commission (NAC), in an attempt to meet the high demand for addiction recovery services, rolled out a Community-Based Drugs Dependency Treatment (CBDDT) programme that sought to optimize the various approaches to drug dependency treatment and rehabilitation that were being implemented by NGOs. Working alongside existing treatment programmes, CBDDT has helped to increase coverage of rehabilitation services for people who inject drugs and ease the financial burden on their families. As of the beginning of 2014, CBDDT programmes were being operated by 16 organizations in 10 provinces, with a total of 300 clients per year supported by Global Fund funding.

Run by NGOs with experience of working with people who inject drugs (PWID), CBDDT consists of two components, Positive Community Participation and Dependency Treatment. For the Positive Community Participation component, both NGO and clients interact with the community, including on CBDDT activities, to reduce stigma and discrimination and to raise awareness about addiction as a health issue.

The second component, Dependency Treatment, has two phases: intensive (in-patient) and non-intensive (outpatient). Minimum standards have been established for the therapy and the programme, but beyond these every CBDDT programme can tailor their activities to suit the needs of the clients and the approach of the NGO, recognizing that there is no single therapy that will fit all individuals. The minimum standards are set out in the CBDDT guidelines, a living document that was most recently updated in 2013 by various stakeholders, including participating NGOs and related sectors, facilitated by the NAC.

The CBDDT programme was evaluated in 2012 after three years of implementation, covering both the programme process and the perceptions and progress of the clients, post-programme.[63] Similar evaluations will be conducted every two years. The 2012 evaluation was conducted simultaneously at 11 institutions. Respondents included counsellors, CBDDT implementing agencies and local stakeholders, as well as 341 current and former clients of the programme. The evaluation included an analysis of the routine client data kept by each CBDDT implementing agency.

Local stakeholders generally received the CBDDT programme positively, while counsellors and those responsible for the programme believed that the clients benefit and that both clients and their families have a high level of confidence in the programme.

Among the clients themselves, the outcomes were also encouraging. Three out of every five of the former clients had been able to complete the programme as planned, indicating a retention rate of 60%. Using the WHO Quality of Life instrument, significant increases were perceived in all four domains (physical, psychological, social and environmental) of quality of life. More than 60% of the respondents reported that they had not injected in the last 30 days, while a small

proportion had engaged in risky sexual behaviour.

Table 7. Risk Behaviour from BBV-TRAQ (Source: NAC)

Risk behaviour in the last 30 days	Average score	Std. Deviation	Median score	Min-Max
Injecting (n=183)	11	17	1	0 – 74 (max. score 100)
Sexual (n=337)	3.3	5.2	0	0 – 35 (max. score 40)
Other skin penetration (n=340)	2.1	3.1	0	0 – 10 (max. score 30)

These results indicate that CBDDT can contribute to minimising risk behaviour and lead to significant improvements in quality of life, thus yielding both direct and indirect positive impacts that continue to be felt once the client completes the programme. Following the evaluation, a number of improvements were made to the guidelines, and their impact will be assessed at the end of 2014. However, these programs have limited impact on the HIV epidemic due to the low numbers of individuals involved and the intensive resources required for limited outcomes for harm reduction. Needle Syringe Programs still remain the most effective way to impact on the HIV epidemic for large numbers of PWID.

2. Making *lokalisasi* safer

Regional experience has demonstrated that HIV epidemics can be halted and reversed when condom use in sex work is increased to high levels and STI prevalence is reduced.[64] High condom use in sex work is potentially associated with structural interventions, such as brothels requiring clients to use condoms, and strong peer interventions with a high level of community mobilisation. Reduced STI prevalence is often associated with high levels of condom use, regular clinic check-ups and periodic presumptive treatment (PPT).

Indonesia's national programme on HIV Prevention through Sexual Transmission, known as PMTS,[65] has been implemented by the NAC and MoH since 2009. This comprehensive programme is based on four principal components: 1) community mobilization and strengthening of stakeholders, 2) behaviour change interventions, 3) condom supply management, and 4) STI and HIV services. The components include both biological and social approaches to HIV programming in sex work settings.

In 2013, a review was undertaken of PMTS programme implementation in *lokalisasi*, or brothel areas, in five cities in Indonesia to better understand the factors that facilitate condom use and STI control among direct sex workers.[66] Interviews were held with sex workers, owners and managers of sex establishments, health workers and outreach teams on three broad themes: condom use and support, STI/HIV services and access, and empowerment, enabling and coverage. At the same time, various data were reviewed, including outcome data on condom use, STI and HIV prevalence and reports on outreach contacts and clinic attendance. Biological and behavioural survey data as well as routine clinic data were examined for condom use and STI trends.

The review, which was conducted in Denpasar (Bali), Jayapura (Tanah Papua), Tanjung Pinang (Riau Islands) and Malang and Surabaya (East Java), revealed evidence of safer behaviours and

declining disease transmission. All sites demonstrated a growing engagement of key stakeholders and coordination through working groups, with support from local politicians. There was also evidence of close coordination between the MoH and the NAC, which typically resulted in a more comprehensive response with service delivery reinforced by structural changes that supported a more enabling environment.

In nearly all sites, sex workers reported strong support for condom use and regular STI check-ups, describing the services as friendly, confidential and high quality, and reported having some involvement in peer interventions and working groups. In most cases, health department staff from the facility, district and province levels were working actively with stakeholders to increase access to STI/HIV services and sharing routine monitoring data with local stakeholder working groups (*pokja*), but there is scope for improvement in terms of capacity to analyse and use data to enhance implementation.

Table 8. Overview of Intervention Components by Site (Source: Steen/WHO)

	Structural Interventions		**Direct health services**		**Enabling environment**	
	Pokja, MoU with stakeholders	Local regulations, political support	Condom promotion and availability	STI/HIV checkups and services	Peer interventions community mobilisation	Stakeholder involvement in physical safety
Denpasar	+	+	+	+	+/-	+
Jayapura	+	+	+	+	+/-	+
Malang	+	+	+	+	+/-	+
Surabaya	+	+/-	+	+	+/-	+/-
Tanjung Pinang	+	+	+	+	+	+

In all cases, the presence of enabling factors was believed to have been critical to the success of the interventions. In most cases, local regulations had been introduced to support the condom interventions and regular STI check-ups, with fairly high levels of compliance reported in most cases. Another important enabler was the support of *lokalisasi* owners and managers for interventions to increase condom use and STI screening. For example, in Bali, Jayapura and Malang, sex workers who turned away clients who refused to use condoms reported that they were backed up by their managers, and in Jayapura this is reinforced by an association of establishment owners.

Broad community engagement through working groups, or *pokja*, was believed to have contributed to better results. In Malang and Surabaya, partnerships have been enhanced by the existence of local MOUs that define the roles and responsibilities of stakeholders and *pokjas*, which has been found to facilitate collaboration. *Pokjas* typically comprise sex workers, pimps, establishment owners/managers, NGOs and other community members. In Malang, collaboration through *pokjas* on combined interventions was credited promoting high condom use in *lokalisasi*. Similarly, in Jayapura, high clinic attendance was attributed to the involvement of bar and massage establishment managers and NGO outreach workers. In Surabaya, sex workers reportedly have equal input on the decisions of a number of *pokjas*, each of which focuses on a different programme area, such as condoms, STIs and security issues, while in

Tanjung Pinang, *pokja* members organise STI check-ups, monitor condom use, clinic attendance and STI rates, and maintain security at the *lokalisasi*. Community collaboration on security has in fact been an important factor in ensuring that working conditions in all the *lokalisasi* studied were safe, free from violence and relatively free from police harassment.

Other important programme components include good, user-friendly clinical services with regular check-ups. In Malang, Surabaya and Tanjung Pinang clinic attendance is supported by offering services through mobile clinics coordinated by NGO partners in the brothel areas as well as at community health centres.

In at least two cases, exposing local stakeholders directly to the issues made a critical difference by triggering the development or enforcement of local regulations and the strengthening of services and cooperation. In 2012, a delegation from Jayapura, which included the deputy mayor, local parliament members and health department officials, visited Merauke to observe its sex work programme. Following the visit, condom use regulations were strengthened and a new reproductive health clinic established where sex workers can get regular STI check-ups. In Malang, an important political turning point came in 2006 when the *lokalisasi* were visited by local politicians, who subsequently agreed to support prevention efforts; regulations supporting condom use and regular STI check-ups were passed soon afterwards.

In Surabaya, despite high levels of stakeholder engagement and programme activity, as well as regulations on condom use (including a Rp 1000 surcharge to clients to cover the cost of two condoms), condom use is still inconsistent and STI rates are on the rise. To increase compliance, the *pokja* recently endorsed an innovative approach that involves rewarding establishments that maintain low STI rates and imposing sanctions on those with high rates. This will be monitored through regular STI screening through the community health centre, and the sanctions will apply only to brothels, and not to individual sex workers.

While the study revealed high levels of programme implementation, generally high and increasing levels of condom use and declining STI and HIV transmission overall, the high mobility of sex workers and clients may be having an adverse impact on disease transmission trends as infections are introduced from outside the areas with strong interventions. Condom and STI programming therefore needs to be scaled up across more *lokalisasi* in order to slow transmission on a broader scale. In a good example of knowledge sharing, one of the community health centres providing services to *lokalisasi* in Surabaya is now formally providing technical assistance to support STI and HIV programmes at 11 other community health centres.

V. Major Challenges and Remedial Actions

In the two years since the previous Global AIDS Response Progress (GARP) report was submitted in 2012, progress has been made on a number of the key themes of the NASAP 2010-2014. Leadership, governance and multi-sectoral coordination at national level have been further strengthened. HIV service coverage has increased, prioritizing key populations in the highest burden districts, although services are available in all provinces, delivered by government and non-government agencies. The progress made towards overcoming the challenges reported in the last GARP country report is discussed below, along with the challenges that remain and the remedial actions needed.

1. Policy, resources and institutional structure

The funding gap for National HIV programme is substantial and increasing. Total expenditures for the HIV and AIDS programme in Indonesia increased from USD 72,543,623 in 2011 to USD 87,002,697 in 2012,[67] but this still leaves a significant funding gap. The cost of scaling up PMTS and accelerating the ARV programme, identified as the key strategies needed to accelerate the response, is estimated to require an additional USD 400 million from 2013 to 2015.[68]

Although Government spending increased by a substantial 76% between 2009 and 2012 from USD 21 million to USD 37 million, the Government contribution stood at 42% in 2012 (up from 41% in 2011), confirming that the response is still dependent on external funding.[69] While the MoH has committed USD 55.2 million until 2015 to support the scale-up of ARV access,[70] it is uncertain whether the national target of 70% of funding originating from domestic sources will be reached by 2014. Given the current uncertainty regarding future directions for HIV funding from Indonesia's key partners (particularly the Australian and US Governments and the Global Fund), and the level of investment needed to scale up PMTS and accelerate the ARV programme, the resource gap remains a source of concern.

Indonesia is taking steps to address this by developing an HIV investment case to support resource mobilisation and exploring innovative funding sources and mechanisms, including from the private sector. Advocacy and planning are underway to include coverage of HIV services under the new National Health Insurance Scheme.[71] Ways to reduce costs, which need further exploration, include: reducing service and commodity prices; rationalizing tasks; and simplifying and standardizing treatment.[72]

A number of important actions were taken between 2011 and 2013 with regard to policy strengthening. These included an MoH decree (21/2013) requiring private health insurance providers to cover, partly or entirely, the treatment costs of HIV positive policy holders.[73] Meanwhile, the addition of a Gender Specialist at the NAC, a review of the NASAP 2010-2014 by the NAC Gender and Human Rights Working Group in 2012 and a programme of Gender Responsive Budgeting and Planning for Ministries at national and subnational levels contributed to a strengthening of the policy environment with regard to gender.[74] As part of the Mid-Term Review of the NASAP 2010-2014, around 12 HIV programme and policy reviews were conducted during 2013.[75] The review will provide input for the development of the next NASAP and the country's new Medium Term Development Plan 2015-2019 (RPJMN). The

planning and budgeting of the response has now been integrated into the RPJMN, which assures some support from the national budget.

At the local level, however, gaps remain in local policies and/or regulations that support access of KAP and PLHIV to services, including recognition of the right to services and policies that are gender sensitive and address stigma and discrimination.[76] Moreover, some local governments have passed regulations relating to HIV, drug use, sex work and male to male sex that are not consistent with national or international-level guidelines and provisions on human rights, and there are numerous reports of actions by legislators, law enforcement agencies and faith-based organisations that abuse and violate the rights of KAPs.[77] A number of national laws restrict access to contraception and the dissemination of information relating to sexual and reproductive health.

The Ministry of Law and Human Rights, in partnership with MoH (supported by UNDP and UNAIDS), held a national consultation to review punitive laws and policies in 2013. The report on the 2013 Mid-Term Review of the Higher Level Meeting Targets recommends that this should be followed up with the repeal or adjustment of discriminatory regulations and that human rights training for health workers and police must be prioritised. Greater scope is also needed for groups representing PLHIV and KAP interests to participate more fully in the development of HIV and AIDS policy and programmes. The Government is continuing to roll out gender-sensitive planning and budgeting at national and sub-national levels, targeting the development of gender budget statements by all ministries by 2014.

In recent years, management and coordination structures for the HIV response have been established at national, provincial and district levels. Provincial AIDS Commissions (PAC) have been established in all provinces, and each province also has District AIDS Commissions (DAC) in districts with the highest HIV burdens. Decentralisation has increased provincial and district government responsibility for managing the HIV programme.[78] A 2013 review of key institutional and coordination challenges in coordinating the response[79] found that in general, provincial and district level AIDS commissions are fulfilling their planning and coordinating role, albeit with considerable variation between provinces and between districts. There is a need to build PAC and DAC capacity to analyse, use and disseminate strategic information to guide local programming and advocate for support.

Although by 2011, 159 local AIDS Commissions had budgets allocated by local government,[80] the review found that more than 50% of district/city AIDS Commissions are not adequately funded. The majority are supported by external funding, including the Indonesia Partnership Fund and the Global Fund, which raises concerns about their sustainability.

To address this, the review recommends that local AIDS Commissions should find some means of accessing a regular government budget allocation (such as being brought under the Bappeda[81] structure). NAC coordination and support are also needed to mobilise innovative financing sources, particularly through the private sector. Roles for coordination and guidance, particularly by the provinces, also need to be clarified.[82]

2. Prevention

Programme coverage for PWID has continued to expand, with needle and syringe exchange programmes (NSP) offered at 215 sites across the country. NSP is now offered at more public

health care settings than NGO sites. A considerable number of PWID also purchase sterile injecting equipment through private pharmacies. Opioid substitution therapy (OST) has been expanded to 87 sites. Community-Based Drugs Dependency Treatment (CBDDT) is now offered through 14 NGOs in 10 provinces with support from the Global Fund grant. As of June 2013, programme data indicate that 64,259 PWID were reached with prevention programmes, or 87% of the total estimated PWID population.[83]

Ongoing challenges include the uneven availability of a comprehensive package of harm reduction interventions and variable quality of services.[84] While NSP is increasingly offered in community health centres, the majority of staff do not receive formal training on NSP, and the poor understanding of addiction and harm reduction places constraints on service delivery.[85]

Despite signs that HIV prevalence among PWID was on the decline in most cities apart from Jakarta (IBBS 2011),[86] it remains high at 42%; moreover, the results of the 2013 IBBS, conducted in different cities, indicated a significant increase (from 27% to 39.5%), mainly due to two cities with limited NSP outreach.[87] This confirms the need for continued strengthening of harm reduction interventions. Outreach will continue to be critical: although the PWID population size estimate has reduced in recent years, there are indications of an increase in non-injecting drug use among young people.[88] Combined with amphetamine use, low levels of awareness and low condom use, this may lead to an increase in sexual transmission of HIV rather than through injecting drug use.

PMTS, the Government's comprehensive structural approach to preventing sexual transmission of HIV, involves stakeholder mobilisation, BCC implementation, improved management and distribution of condoms and lubricant, and comprehensive STI management. A 2013 review of PMTS implementation in five cities revealed high and consistent condom use and access to STI services in locations where interventions among sex workers have strong support from local authorities and communities, and that this is having some impact on disease transmission (see Chapter 4 on Best Practices). The lessons learned from these sites will need to be rolled out more widely, particularly through advocacy to districts where PMTS has not been fully implemented due to local budget restrictions, lack of coordination and a lack of understanding about channelling local budgets for PMTS.[89]

However, consistent condom use among key populations remains low overall, STI prevalence is rising and HIV prevalence among MSM, high risk men and their sexual partners is increasing. Moreover, the most recent estimates of HIV infection indicate that the epidemic will continue to expand, with a projected 67,217new infections among adults in 2015.[90] In response, the Government has reviewed and accelerated the implementation of PMTS and broadened its scope to include high risk men (through the workplace) and MSM in selected provinces. It has also introduced the Continuum of Care (LKB) approach in districts; adopted Option B+ for PMTCT; and adopted new treatment guidelines and the strategic use of ARV (set out in the Roadmap 2013-2015) that is expected to result in 312,848 adults and 15,528 children being eligible for ART by 2015,[91] which, it is hoped, will also contribute to prevention efforts.

The majority of new HIV infections are among young MSM, and consistent condom use remains low among MSM and waria (IBBS 2011). Both MSM and waria have been shown to be enthusiastic users of social media, and the use of this medium to reach these groups should be explored more intensively. MSM and waria continue to face stigma and discrimination when

accessing health services and training for service providers to improve their knowledge and attitudes when dealing with MSM is needed.

Considerable challenges to improving coverage and effectiveness of PMTCT include the absence of key linkages between HIV services in the health sector (which are grouped under infectious diseases) and SRH and MCH. The government has begun to address these challenges by putting in place a comprehensive set of policies, decrees and guidelines for PMTCT, including the embedding of PMTCT into ANC services, PMTCT option B+ and the allocation of a budget for training to link MCH to HIV prevention programmes.[92] The introduction of provider-initiated testing and counselling (PITC) in ANC services is also beginning to accelerate implementation.[93] Community mobilisation has been initiated to increase KAP awareness and use of PMTCT services.

Access to services is still compromised by attendance at antenatal services only late in pregnancy or during labour, if at all, as well as inconsistent implementation of the relevant guidelines.

A more intense response to the generalised epidemic in Tanah Papua is needed in locations where the epidemic is highest, although the epidemic overall has been well controlled so far. Access to HTC and ART, as well as other health services, are required and need improving for the widely dispersed population in Tanah Papua.[94]

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

To manage the growing caseload of HIV and AIDS as a result of scaled up HTC, both health services and CSO networks are being strengthened and measures to accelerate access to HIV prevention, treatment and care are being put in place. The Government adopted the 2010 WHO guidelines to initiate ART at a CD4 count of 350 and is currently studying WHO's 2013 guidelines which suggest raising the threshold to CD4 500, having already taken the significant decision to include all key populations in ART irrespective of their CD4 count, a step towards the 'test and treat' approach.

The adoption of the Strategic Use of ARV Roadmap in 2013 aims to reduce HIV-related morbidity and mortality and maximize the prevention benefits of ART through a rapid scale-up of HIV testing and treatment in high burden districts. LKB, an integrated, decentralized service delivery model, was introduced in 2012 to accelerate and expand the continuum of care approach in selected GF-supported districts as well as some non-GF supported districts,

However, linkages between health facilities and CSO/community-based organizations will need to be strengthened in order to improve prevention, intensify case finding and testing to ensure earlier introduction of ART and increase retention in care in order for these initiatives to achieve maximum impact. Institutional capacity and quality at health service facilities, including competencies of health service providers, also need to be improved.

CSOs have been considerably empowered and national networks of key populations established. Five such networks (IPPI, GWL-Ina, JOTHI, PKNI and OPSI) are receiving financial support from the NAC secretariat and donors, and are members of the NAC Board alongside Spiritia (a CSO

assisting PLHIV). One or two representatives from each network are assigned to take part in all national consultations on the HIV programme and the networks are also fully engaged in the planning and oversight of the GF-supported programmes through the CCM. However, at the subnational level, community involvement tends to be restricted to providing technical input, and they have little or no involvement in strategic or policy discussions at this level (see the NCPI in Annex 1). Given that community networks and activities are largely funded through donor support, there are concerns about sustainability when such assistance is phased out. One critical barrier is the legal restrictions on the types of NGO activities that can be funded by Government.

Despite increased community mobilisation and improved access to testing and treatment, the stigmatisation, discrimination and criminalisation of KAPs continue to act as constraints on HIV and AIDS prevention efforts and uptake of services. Support is needed for documentation of the impact of existing laws on the HIV and AIDS response on KAPs at both national and sub-national level.[95]

Community-based organizations are key to strengthening prevention and support interventions, particularly through the LKB/continuum of care approach. There are examples of strong cooperation between health and social services, such as the one-roof services in Malang, Yogyakarta and Mataram.[96] To strengthen CSO involvement in planning and monitoring as well as service delivery, there is a need to build CSO capacity to implement effective training, provide management support and involve stakeholders in mobilizing the community, and particularly to mobilise the PLHIV community to engage in peer outreach to improve uptake of STI, HTC, CST, PMTCT as well as to provide follow-up care in the community to support and strengthen treatment adherence. KAPs and PLHIV need support to advocate for their needs and rights with regard to Indonesia's new universal health coverage programme. Community empowerment also needs to be enhanced to address issues related to children infected and affected by HIV and AIDS, including nutrition, disclosure, socio-economic impact mitigation and family empowerment.[97]

Key challenges with regard to strategic information and M&E are discussed in Chapter 7 of this report.

VI. Support from the Country's Development Partners

1. Key support from development partners

Bilateral and multilateral international development partners have played a critical role in scaling up Indonesia's response to HIV and AIDS by providing support, both technical and financial, to government and civil society partners for capacity building, systems development and strategic information gathering. To ensure that external support is focused where it can achieve maximum impact in support of the response, international partners consult with the NAC and with local AIDS Commissions at the provincial, district, and city levels.

1.1 Financial resources

Total spending for the HIV and AIDS response in Indonesia increased from USD 72,543,623 in 2011 to USD 87,002,697 in 2012. Of this, the international partners contributed 59% in 2011 and 58% in 2012.[98] Although this continues the trend of substantially increased domestic resources since 2006 (from 27% of the total budget in 2006 to 42% in 2012) it still falls short of the NASAP target of reaching 70% domestic funding by 2014. External contributions are focused more on prevention programming, while the Government is increasingly covering treatment and support.

Table 9. Trends in HIV and AIDS Expenditure in 2009-2012 (in USD)

Source	2009		2010		2011		2012	
	USD	%	USD	%	USD	%	USD	%
Public/central	21,318,844	35	27,779,28040	40	29,727,979	41	36,851,918	42
International	38,966,576	65	41,367,600	60	42,815,644	59	50,150,779	58
Total (current USD)	**60,285,420**	**100**	**69,146,880**	**100**	**72,543,623**	**100**	**87,002,697**	**100**
Total (constant PPP)	41,804,075	100	32,930,134	100	28,813,479	100	34,426,512	100

Source: National AIDS Spending Assessment 2011-2012

The Global Fund remains the largest source of funds, contributing 64.1% in 2011 and 49.6% in 2012 of all HIV and AIDS spending by international partners. The Government of Australia remains another major contributor, covering 20.5% of international expenditures in 2011 and 32.9% in 2012.[99] Other significant international sources include the US Government, the UN agencies, the Government of the Netherlands and the World Bank.

a. Global Fund

The Global Fund provided a total of USD 27,428,479 (64.1% of all international funding) in 2011 and USD 24,858,113 (49.6%) in 2012.[100] Under the current grant arrangements, Global Fund support will end in 2015, although applications are being developed for further support until 2017. The Global Fund channels its support through four principal recipients (MoH, NAC, NU and PKBI), focusing on service delivery, health care and community systems building and strengthening, and M&E system strengthening.[101] The programme is working in 141 priority districts in 33 provinces with a specified division of labour between the four PRs.

b. Government of Australia

The Government of Australia is the second largest contributor after the Global Fund, and increased its contribution from USD 8,788,691 in 2011 (20.5% of international support) to USD 16,496,612 (32.9%) in 2012.[102] Support is focused on the response to the epidemic in Tanah Papua, harm reduction programming in Java, North Sumatra and Bali, prevention among key

populations in Bali and comprehensive HIV services in model prisons. Funds are channelled largely through HCPI, which works in collaboration with national implementers, including community health centres, as well as through CHAI, NAC, UNDP and others. HCPI support is scheduled to end in early 2016.[103]

c. US Government

The US Government increased its funding both by volume (from USD 3.7 million to USD 5.7 million) and in terms of overall share (from 8.7% to 11.4%) between 2011 and 2012.[104] Support prioritises CSO capacity building and the prevention of sexual transmission, including condom promotion and support for the 'test and treat' approach.

d. UN system

Support from UN agencies for the response is coordinated at the policy level by the UN Country Team and at the technical level by the Joint UN Team on AIDS (UNJT), which is convened by the UNAIDS Country Coordinator. Support is financed through the budgets of individual agencies, allocations from the Unified Budget, Results and Accountability Framework (UNBRAF), and resources mobilised locally from bilateral and other sources.[105] The UN plays an important role in providing technical support, particularly to the NAC and government Ministries, and in leveraging funding from other sources.[106] It also provides technical assistance and support for Global Fund proposal development and grant implementation.

The Joint UN Support Programme and Work Plan for 2012-2015 focuses on support for the implementation of the NASAP 2010-2014 and the achievement of the UNGASS global targets in Indonesia. Each of the Programme's 13 Joint Outcomes and associated activities are implemented by one or several co-sponsors, coordinated either by one of the co-sponsors and/or the UNAIDS Secretariat. UN system support for the period 2011-2012 amounted to USD 5.6 million.[107]

1.2 Indonesian Partnership Fund (IPF)

The IPF was supported by an initial grant of USD 47 million from the UK government (DFID) for 2005-2007, and was subsequently extended with a further USD 4.6 million from DFID, USD 2.6 million from the Australian government and USD 1 million through USAID. IPF funding has been used to expand coverage of the HIV and AIDS response, to support CSOs, to provide management support to the NAC and provincial and district AIDS Commissions, and to support external resource mobilization. DFID support for the IPF has been phased out and was largely replaced by funding from the Global Fund.[108]

2. Actions needed to ensure achievement of targets

There is a clear need for continued support if Indonesia is to meet its NASAP targets. The increase in domestic funding to 42% in 2012 is largely accounted for by the MoH's expanded coverage of the ART programme. However, the NAC estimates that the total funding gap for the acceleration of the response could exceed USD 400 million over the period 2013-2015. With an estimated USD 155 million in domestic resources expected to be available for HIV testing and access to ARV for 2013-2015, this leaves a funding gap of more than USD 100 million for scaling up HIV testing and access to ARV alone by 2015. This does not include the funding needed to intensify prevention.

Despite the considerable amounts of funding that have been made available in recent years, particularly from the Global Fund, concern has been expressed that a lack of technical support has left the country unable to maximise the potential gains that could have been derived.[109] In mid-2013 a review of the technical support and capacity building requirements of the partners implementing the Global Fund HIV grant in Indonesia identified key challenges and made recommendations to address the gaps.[110]

Priority technical support and capacity building areas included strengthening field quality and rigour (more accurate mapping of key populations, improving planning, intensity and quality of outreach, strengthening field monitoring, etc.), local leadership and coordination, supportive supervision and M&E. Slightly less urgent, but equally important were strengthening both financial management and procurement & supply management systems. Community systems strengthening and the STI and ART programmes were also seen as being in need of attention. Legal and policy frameworks, including regulations that constrain CSOs' access to public funding, also need to be addressed.

While the assessment covered only the Global Fund-supported programmes and activities, these challenges have been broadly identified in other externally supported programmes, and could represent key areas for continued support by international partners. However, the landscape for future international support remains unclear. Applications are currently being developed for further Global Fund until 2017, while options for a new programme of support from the Australian government, potentially over ten years from 2016 to 2026, are being explored.[111]

VII. Monitoring and evaluation environment

1. Overview

Indonesia's national HIV M&E system is coordinated by the NAC. Currently, 33 provinces and 172 districts are using the national M&E guidelines to report progress against national indicators. The data, collected from health facilities, related line ministries and local NGOs, are collated by the NAC M&E team, which consists of four full-time professional M&E staff at the NAC Secretariat, as well as programme staff in each of the reporting provinces and districts who have M&E responsibilities. M&E planning, coordination and data sharing is effected through the M&E Working Group, which includes representatives of government sectors, civil society, international partners, key affected populations and PLHIV.

M&E mechanisms and policies are set out in the National Monitoring and Evaluation Plan 2010-2014, a complementary document of the National Strategy and Action Plan for HIV and AIDS (NASAP 2010-2014), which has its legal basis in Decree of the Minister of Social Welfare No.8/2010.

In line with the Plan, several M&E components have been enhanced in the last three years,[112] including: 1) A clear mandate for the NAC to coordinate the M&E of the HIV response in Indonesia; 2) regular IBBS, mapping of key populations and hotspots, HIV projections using mathematical modelling and Investment Case Analysis; 3) evaluation and research; 4) systematic collection of programme data, chiefly from the 4 GF PRs and HCPI, and routine reporting of data from district to provincial and national levels; 5) M&E partnerships and coordination (linkage with development partners such as USAID, Australian Aid, international NGOs, UN agencies, the Global Fund and the technical working group); 6) installation of a full team of qualified M&E officers at the NAC Secretariat, and in the health sector at both national and sub-national levels; 7) M&E system harmonization among the GF PRs, including the integration of HIV into the Health Information System; 8) a national costed M&E plan for the national level and M&E guidelines for the sub-national level; 9) monitoring of AIDS spending; and 10) evidence-based planning and advocacy at the national level.

The 3rd Joint Assessment of the National HIV M&E System[113] was carried out in December 2013, based on the 12 components of the M&E System Strengthening (MESS) tool developed by the Global Fund, UNAIDS and other partners. The assessment was carried out at the key national level organisations that are coordinating or implementing the response, namely the NAC, MoH, NU and PKBI (all Global Fund PRs), and the Ministry of Law and Human Rights (MoLHR). It also covered three provincial AIDS Commissions and three hospitals to represent the health facility level.

The assessment revealed that progress been made over the last two years in operationalizing the national HIV M&E system: there is a national M&E plan; more routine data are being captured, and there is greater recognition of HIV M&E and its importance. However, significant weaknesses remain, with those at the national level tending to be magnified at the provincial and health facility levels.

The review findings can be grouped into three broad categories:

- Enabling Environment (people, partnerships and planning)
- Data and Information (collection, capturing and verification of data)
- Use in Decision Making (the understanding of how to promote the use of feedback in decisions, rather than simple up and out reporting).

- **Enabling Environment**

  M&E staffing at both national and sub-national levels is inadequate, with some staff having limited skills. At sub-national level there are no staff focusing solely on M&E. Additional technical assistance is needed to provide capacity building and assist with data collection and analysis, conducting evaluation, and data management.

  While the NAC and MoH have plans for M&E training, there is no schedule for its provision. Elsewhere, training is limited, partly due to a lack of funding, and there are no clear mechanisms for evaluating staff capacity or performance, making it difficult to assess capacity building needs.

  At the national level, M&E Working Group meetings take place routinely, and there is cooperation between stakeholders and partners. However, there is a lack of coordination between the national, provincial and district levels, even within organisations, and limited M&E working group activity at the provincial level also contributes to the lack of coordination when reporting data.

  At the national level, there is an integrated M&E plan linked to the development of the national HIV and AIDS database, but M&E plans within key institutions or sectors either have significant gaps or are non-existent. At the provincial level, participatory M&E planning processes are included in strategic plans but there is a need for improving the collection of minimum and accurate data. There are no M&E plans at the health facility level, thus staff are only involved in recording and reporting according to the guidelines.

- **Data and Information**

  The NAC and the provinces conduct rapid behavioural surveys as well as HIV surveillance and mapping jointly; however, data from these surveys have not been aggregated. The MOH has plans to conduct routine web-based (HIV & AIDS Information System/SIHA) data reporting in 33 provinces. SIHA is being phased in gradually in certain locations and by certain services, and there is a need for training on its use. Health facilities funded by HCPI use Excel spreadsheets to validate data in Jakarta and seven other provinces while SIHA is being developed.

  All key national level organisations have HIV databases and most health facilities have reporting guidelines and a schedule for data collection and the aggregation and submission of reports, but overall there is lack of focus on data quality, and there are no guidelines on conducting data quality audits. While supervision visits are conducted at all levels, there is limited guidance on how to conduct them, and feedback from both visits and routine data reporting is limited.

There is insufficient financial support for HIV-related research and evaluation that covers all programme areas, and limited use, at any level, of the results of research and evaluations that are conducted to inform policy planning and future research.

At the regional level, Indonesia contributes to the Asia Data Hub (www.aidsdatahub.org).

- **Use in Decision Making**
  Data analysis and dissemination at the national level is limited. At the provincial level, there are no guidelines for data analysis or dissemination, and accordingly little use of strategic information in programme planning, apart from the data collected by HCPI partners for the annual client behaviour survey.[114]

  At all levels, there has been limited progress in utilising M&E data to roll out advocacy efforts. Furthermore, at the health facility level, there are generally insufficient staff (coupled with minimal support from management) to focus on advocacy.

2. Planned actions

As reported in the Mid-term Review of the National AIDS Strategy and Action Plan 2010-2014, the results of this assessment will inform the development of the M&E plan for the 2015-2019 period. They indicate the need for a stronger emphasis on, and support for partnerships, routine data verification, and using data in decision making at all levels. The key recommendations of the assessment were to:

- Improve coordination between National and Provincial AIDS Commissions, particularly on the development of M&E plans and M&E activities;
- Improve M&E capacity at the national, provincial and health facility levels, by identifying M&E staff capacity needs and providing regular training, with refresher training and mentoring;
- Provide resources and training in SIHA and the use of data validation spreadsheets while SIHA is being developed;
- Strengthen, systematize and conduct routine procedures for data quality at least every quarter, building capacity and skills for this at all levels;
- Use data from monitoring, surveys and research to promote and enhance HIV advocacy and communication efforts;
- Strengthen the focus and use of HIV surveys, surveillance, evaluations and research that are based on programme and M&E needs so as to directly inform programme staff and stakeholders on where and how improvements are needed.

As noted in the Mid Term Review, the challenge will be to ensure that the development of M&E at all levels corresponds with the NASAP 2015-2019 strategies, which will be more results-oriented.

Annex 1. National Commitments and Policy Instrument (NCPI)

Appendix 3. National Commitments and Policy Instrument (NCPI) 2014

COUNTRY: **INDONESIA**

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: **Dr. Kemal N. Siregar**

Postal address: **Wisma Sirca 2nd Floor. Jl. Johar No. 18 Menteng Jakarta Pusat, 10340**

Tel: **+62- 21-3905918**

Fax: **+62- 21-3905918**

E-mail:**kemal.siregar@aidsindonesia.or.id**

Date of submission: **30 March 2014**

Instructions

The following instrument measures progress in the development and implementation of national HIV policies, strategies and laws. It is an integral part of the core indicators and is to be completed and submitted as part of the 2014 Country Progress Report.

This is the sixth version of the NCPI and the second revised version since the tool changed the name to National Commitments and Policy Instrument (NCPI), instead of the earlier National Composite and Policy Index (NCPI). The NCPI has since 2012 been updated where necessary to reflect new HIV programmatic guidance and includes the questions regarding HIV integration that were included in the Special 2013 GARPR questionnaire (can be found in Part AI). The majority of questions are identical to the previous rounds of reporting to allow for trend analyses. Countries are strongly advised to conduct a trend analysis and include a description of progress made in (a) policy, strategy and law development and (b) implementation of these in support of the country's HIV response. Comments on the agreements or discrepancies between overlapping questions in Parts A and B should also be included as well as a trend analysis on the key NCPI data, where available[1].

I. STRUCTURE OF THE QUESTIONNAIRE

The NCPI is divided into two parts.

Part A to be administered to government officials.

Part A covers:

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

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

Part B covers:

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

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

For questions that pertain to key populations at higher risk for HIV (heretofore referred to as "key populations") and other vulnerable populations, the following definition is applied: Key populations are defined as most at risk for HIV within a defined epidemiological context, that have significantly higher levels of risk of acquiring and transmitting HIV, and with higher rates of mortality and/or morbidity; access or uptake of relevant services is often significantly lower than the rest of the population. Depending on the disease and the country context, some population groups may require explicit attention (for example, people who inject drugs, sex workers, men who have sex with men, transgender people and people living with HIV). Other populations that may be vulnerable to HIV are women and girls, clients of sex workers, prisoners, refugees, migrants or internally displaced populations, adolescents, and young people, vulnerable children and orphans, people with disabilities, ethnic minorities, people in low-income groups, people living in rural or geographically isolated settings or other group(s) specific to the country context.

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

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

II. PROPOSED STEPS FOR DATA GATHERING AND DATA VALIDATION

The NCPI is ideally completed in the last 3 months before submission (i.e. between January 2014 and March 2014 for the 2014 reporting round). As a variety of stakeholders need to be consulted, it is important to allow adequate time for the data gathering and data consolidation process.

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

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

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

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

3. Obtain data

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

Each section should include completion of the following tasks:

(i). Desk review of relevant documents.

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

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

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

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

4. Validate, analyse and interpret data

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

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

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

5. Enter and submit data

Submit the final NCPI data before 31 March 2014, using the dedicated software provided on the Global AIDS Progress reporting website (www.unaids.org/AIDSReporting). If this is not possible, an electronic version of the completed questionnaire should be submitted as an appendix to the Country Progress Report before 15 March 2014 to allow time for the manual entry of data in Geneva.

National Commitments and Policy Instrument (NCPI)
Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:
In filling out the NCPI form, participants were divided into two groups, Government (Part A) and Non-Government (Part B). Each group was guided by two facilitators who were members of the group. Group A was subdivided into 2 sub-groups while Group B was only one group. The choice of sub-groups was based on the members expertise and interest. In sub-groups, each question was discussed. Once discussions were completed, the sub-group results were then discussed in a large group, and the group agreed on a final position.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
Discussions were open with each sub-group member free to give their opinion without pressure. If no agreement was reached within sub-groups with a wide variation in opinions, these differences were noted, although participants appreciated a joint decision about questions.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
Some data and information still require confirmation, for example data about orphans. But in general the participants agreed with the final outcomes of the meetings.

NCPI Respondents

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

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

Organization	Names/Positions	Respondents to Part A [indicate which parts each respondent was queried on]					
		A.I	A.II	A.III	A.IV	A.V	A.VI
NAC	Dheni Fidiyahfika	√	√	√			
Ministry of Transportation	Jalaluddin	√	√	√			
Indonesian National Police	Hj. Saminen, SH	√	√	√			
Ministry of Woman Empowerment and Child Protection	Skriptandoho	√	√	√			
Ministry of Internal Affairs	Najib	√	√	√			
NAC	Setyo W	√	√	√			
Ministry of Woman Empowerment and Child Protection	Wiwik Kristiyanti	√	√	√			
Ministry of Woman Empowerment and Child Protection	Dessy Oktaria	√	√	√			
Ministry of Social Affairs	Dian Setiawan	√	√	√			
Ministry of Communication and Information	Tahsinul Manaf	√	√	√			
Ministry of Communication and Information	Aditya R				√	√	
Ministry of Health	Fatcha Nuraliyah				√	√	
NAC	Suriadi Gunawan				√	√	
NAC	Yayu Mukaromah				√	√	
National Narcotics Board	Amrita Dwi				√	√	
UNAIDS	Lely Wahyuniar						√
Ministry of Health	Victoria Indrawati						√
NAC	Nenden Siti Aminah						√
NAC	Rudi Hartono						√

Ministry of Health	Awi Muliadi W.						√
Ministry of Woman Empowerment and Child Protection	Anisah						√

Add details for all respondents.

NCPI - PART B

[to be administered to civil society organizations, bilateral agencies, and UN organi-zations]

Organization	**Names/Positions**	**Respondents to Part B** [indicate which parts each respondent was queried on]				
		B.I	B.II	B.III	B.IV	B.V
FHI360	Yunita Wahyuningrum	√	√	√	√	√
FHI360	Fiferi Murni	√	√	√	√	√
UNESCO	Grace Halim	√	√	√	√	√
Independent Youth Alliance	Prameswari Puspa Dewi	√	√	√	√	√
Independent Youth Alliance	Faiqoh	√	√	√	√	√
IAC	Aditya Wardhana	√	√	√	√	√
GWL-Ina	Harry Prabowo	√	√	√	√	√
UNODC	Ade Aulia	√	√	√	√	√
NAC	Irawati	√	√	√	√	√

Add details for all respondents.

National Commitments and Policy Instrument (NCPI)

Part A

[to be administered by government officials]

I. STRATEGIC PLAN

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

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

Yes √	No

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

Most recent is 2010 – 2014

- 2010 - 2014 = Strategies and action plans are combined in one document, the *SRAN* or NASAP (National Strategy and Action Plan) for HIV and AIDS in Indonesia.
- 2007 – 2010 = Strategies and action plans separately in 2 (two) documents, the Strategic Plan for HIV/AIDS in Indonesia and the National Action Plan for HIV/AIDS in Indonesia.
- 2003 - 2007 Strategic Plan = HIV/AIDS in Indonesia.
- 2000 - 2003 = No policy as the Coordinating Ministry of People's Welfare was disbanded.
- 1994 - 1999 = Strategic Plan for HIV/AIDS in Indonesia.

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

IF NO or NOT APPLICABLE, briefly explain why.

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

Indonesia National AIDS Commission

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

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

Indonesia National AIDS Commission

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

SECTORS	Included in Strategy		Earmarked Budget	
Education	**Yes √**	No	**Yes √**	No
Health	**Yes √**	No	**Yes √**	No
Labour	**Yes √**	No	**Yes √**	No
Military/Police	**Yes √**	No	**Yes √**	No
Social Welfare[2]	**Yes √**	No	**Yes √**	No
Transportation	**Yes √**	No	**Yes √**	No
Women	**Yes √**	No	**Yes √**	No
Young People	**Yes √**	No	**Yes √**	No
Information	**Yes √**	No	**Yes √**	No
	Yes	No	Yes	No

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

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

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS		
Discordant couples	**Yes √**	No
Elderly persons	**Yes √**	No
Men who have sex with men	**Yes √**	No
Migrants/mobile populations (truck driver, sailor, worker)	**Yes √**	No
Orphans and other vulnerable children[3]	**Yes √**	No
People with disabilities	**Yes √**	No
People who inject drugs	**Yes √**	No
Sex workers	**Yes √**	No

Transgender people	**Yes √**	No
Women and girls	**Yes √**	No
Young women/young men	**Yes √**	No
Other specific vulnerable subpopulations[4]	**Yes √**	No
SETTINGS		
Prisons	**Yes √**	No
Schools	**Yes √**	No
Workplace	**Yes √**	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	**Yes √**	No
Gender empowerment and/or gender equality	**Yes √**	No
HIV and poverty	**Yes √**	No
Human rights protection	**Yes √**	No
Involvement of people living with HIV	**Yes √**	No

IF NO, explain how key populations were identified?

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

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

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

Yes √	No

1.6. Does the multisectoral strategy include an operational plan?

Yes √	No

1.7. Does the multisectoral strategy or operational plan include:

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

1.8. Has the country ensured "full involvement and participation" of civil society[5] in the develop-ment of the multisectoral strategy?

Active Involvement √	Moderate Involvement	No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:
For the preparation of the NASAP 2010 – 2014, civil society representatives were involved from the design stage up to the finalization of the document, so the various needs of civil society are reflected in the programs set forth in the NASAP.

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

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

Yes √	No	N/A

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

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

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

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS			
Common Country Assessment/UN Development Assistance Framework	**Yes √**	No	N/A
National Development Plan	**Yes √**	No	N/A
Poverty Reduction Strategy	**Yes √**	No	N/A
National Social Protection Strategic Plan	**Yes √**	No	N/A
Sector-wide approach	**Yes √**	No	N/A
Other *[write in]*: **health sector operational plan, local plans**	**Yes √**	No	N/A

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

HIV-RELATED AREA INCLUDED IN PLAN(S)			
Elimination of punitive laws	**Yes √**	No	N/A
HIV impact alleviation (including palliative care for adults and children)	**Yes √**	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	**Yes √**	No	N/A
Reduction of income inequalities as they relate to HIV prevention/treatment, care and/or support	**Yes √**	No	N/A
Reduction of stigma and discrimination	**Yes √**	No	N/A
Treatment, care, and support (including social protection or other schemes)	**Yes √**	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	**Yes √**	No	N/A
Other *[write in]*:	Yes	No	N/A

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

Yes √	No	N/A

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

LOW					HIGH
0	1	2	3	**4√**	5

4. **Does the country have a plan to strengthen health systems?**

Yes √
Overall for the strengthening health system we already conduct: 1. Implementation of the National Health Insurance scheme (*BPJS Kesehatan*) began at the beginning of 2014. The scheme covers treatment (OI and STI) for HIV patients. 2. Developing the NASAP involving the stakeholder (government, civil society and international partners) 3. Developing the National M&E Plan

5. **Are health facilities providing HIV services integrated with other health services?**

Area	**Many**	**Few**	**None**
a) HIV counselling & testing with sexual & reproductive health	√		
b) HIV counselling & testing and tuberculosis	√		
c) HIV counselling & testing and general outpatient care		√	
d) HIV counselling & testing and chronic non-communicable diseases			√
e) ART and tuberculosis	√		
f) ART and general outpatient care		√	
g) ART and chronic non-communicable diseases			√
h) PMTCT with antenatal care/maternal & child health	√		
i) Other comments on HIV integration:			

6. **Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?**

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

Since 2011, what have been key achievements in this area:
1. Ministry of Home Affairs Instruction no.444.24/2259/SJ 2013: Institutional Strengthening and Community Empowerment on the AIDS Response at Provincial and District Level. 2. Ministry of Health Decree no.51/2013: Prevention of Mother-to-Child HIV Transmission. Increased allocation of domestic funds (state budget and regional budgets) 3. Ministry of Health Decree no.21/2013: AIDS Response 4. Other related policies (129 policies as of 2013)

What challenges remain in this area:
1. Domestic funding for AIDS is neither adequate nor sufficiently equitable, especially at the district level. 2. Monitoring of policy implementation.

II. POLITICAL SUPPORT AND LEADERSHIP

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

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

A. Government ministers

Yes √	No

B. Other high officials at sub-national level

Yes √	No

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

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

Yes √	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
1. On World AIDS Day 2011, the Vice President officially launched the event and gave a speech in Jakarta, capital city of Indonesia. 2. The Minister of Manpower and Transmigration was the Chair of the World AIDS Day 2011 committee. 3. The Minister of Women's Empowerment and Child Protection was the Chair of the World AIDS Day 2012 committee. 4. Coordinating Minister of People's Welfare as speaker in ICAAP XI 2013 Bangkok

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

Yes √	No

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

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	**Yes √**	No
Have active government leadership and participation?	**Yes √**	No
Have an official chair person?	**Yes √**	No
IF YES, *what is his/her name and position title?* ***Dr.HR. Agung Laksono/Chief of NAC***		
Have a defined membership?	**Yes √**	No
IF YES, *how many members?****39 members***		
Include civil society representatives?	**Yes √**	No
IF YES, *how many?****5 (PKNI, OPSI, GWL, IPPI, IAKMI, Spiritia)***		
Include people living with HIV?	**Yes √**	No

*IF YES, how many?**1 (IPPI)***		
Include the private sector?***2 (IBCA, Kadin)***	**Yes√**	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	**Yes√**	No

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

Yes√	No	N/A

IF YES, briefly describe the main achievements:
1. Coordination meeting of the Cabinet/Ministers, led by the Coordinating Minister for People's Welfare 2. A meeting of the Implementation Team every three months 3. There are regular reporting mechanisms for each sector, covering the program and related activities on AIDS prevention. 4. National AIDS Conference every 4 years

What challenges remain in this area:
Financial support from the state budget is still low (43%). The officials representing each sector at coordination meetings often change, affecting the continuity of the program of the Ministry/Agency. Lack of socialization of important issues related to HIV/AIDS

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

14%

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

Capacity-building	**Yes√**	No
Coordination with other implementing partners	**Yes√**	No

Information on priority needs	**Yes√**	No
Procurement and distribution of medications or other supplies	**Yes√**	No
Technical guidance	**Yes√**	No
Other [write in below]:	Yes	No

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

Yes√	No

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

Yes√	No

IF YES, name and describe how the policies/laws were amended
Law no 22/1997, converted into Law No.35/2009 on Narcotics Minister of Health Decree No 416/Menkes/Per/II/2011, converted into Minister of Health Decree No 29/2012 on Health Service Fees for Members of Askes (health insurance scheme for people in formal employment)

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?

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

Since 2011, what have been key achievements in this area:

1. Commitment Letter of 5 Ministries on Comprehensive Knowledge on HIV among 15-24 year-olds.
2. Ministry of Home Affairs Instruction no.444.24/2259/SJ 2013: Institution Strengthening and Community Empowerment on the AIDS Response at Provincial and District Levels
3. VCT @work by the Ministry of Manpower and Transmigration
4. Policy letter of the Ministry of Public Works No. 13/se/m/2012 and Decree No.3/2013 on AIDS Response in Construction Sites

What challenges remain in this area:
Monitoring national policy implementation at provincial/district level.

III. HUMAN RIGHTS

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

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

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

Yes √	No

IF YES to Question 1.1. or 1.2., briefly describe the content of the laws:

1. Law no. 7/1984 on the Ratification of CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women) 2. Law no. 39/1999 on Human Rights; 3. Law no. 5/1998 on the Ratification of the Convention against Torture and Degrading Treatment or Punishment that is Cruel, Inhumane or Degrading (CAT); 4. Circular Letter of the Supreme Court No 3/2011 concerning the Placement of Victims of Substance Abuse in Rehabilitation Institutions; 5. MoU Between Ministry of Law and Human Right, The Supreme Court, The Attorney General, Indonesian Police, National Narcotics Board, Ministry of Health, Ministry of Social Affairs, witnessed by the Vice President on 11 March 2014, mentions that imprisonment is only imposed for drug manufacturers and dealers 6. Regulation on Gender Responsive Budget Planning, Presidential Decree No. 9/2000, Government Regulation No. 8/2008 7. Child Protection Act No. 23/2002 8. Elimination of Domestic Violence Act No. 23/2004 9. Law No. 21/2007 on Eradication of Criminal Acts of Human Trafficking.
Briefly explain what mechanisms are in place to ensure these laws are implemented:
1. Establishment of National Human Rights Commission as a watchdog of human rights implementation in Indonesia; 2. Establishment of the Ad Hoc Court as a judicial body on human rights violations; 3. Establishment of the National Commission for Child Protection; 4. Establishment of the National Commission on Violence Against Women, National Commission for the Elderly, etc.

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

2. Does the country have laws, regulations or policies that present obstacles[6] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes √	No

***IF YES,* for which key populations and vulnerable groups?**		
People living with HIV	Yes	**No √**
Elderly persons	Yes	**No √**
Men who have sex with men	**Yes √**	No
Migrants/mobile populations	Yes	**No √**
Orphans and other vulnerable children	Yes	**No √**
People with disabilities	Yes	**No √**
People who inject drugs	Yes	**No √**
Prison inmates	Yes	**No √**
Sex workers	**Yes √**	No
Transgender people	**Yes √**	No

Women and girls	Yes	No √
Young women/young men	**Yes** √	No
Other specific vulnerable populations[7] [write in below]:	Yes	No

Briefly describe the content of these laws, regulations or policies:
Law No. 44/2008 on Social Welfare, Article 4 paragraph 1, refers to male to sex as a deviant form of intercourse. Sub-national regulations refer to brothel areas as an immoral activity.

Briefly comment on how they pose barriers:
• Laws and regulations which contain stigma mentioned above, cause a negative perception for the stakeholders related to planning and budgeting. This is one cause of the lack of domestic funding support for the HIV program. • Discrimination can also affect the provision of services for HIV treatment in the health sector.

IV. PREVENTION

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

Yes √	No

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

Information about access to services and protection for women and children, pornography (Ministry of Women's Empowerment); child protection, pornography, trafficking, drugs and HIV (Ministry of Information and Communication), pre/post-test counselling in VCT and increasing access to ARV through rehabilitation in cooperation with Drug Dependency Hospital (National Narcotics Board)

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

Yes √	No

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

Yes √	No

2.1.

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

2.2. Does the strategy include

a) age-appropriate sexual and reproductive health elements?

Yes √	No

b) gender-sensitive sexual and reproductive health elements?

Yes √	No

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

Yes √	No

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

Yes √	No

Briefly describe the content of this policy or strategy:
Indonesia has mapped sub-populations and promotes information, education, communication and health interventions for the sub-populations that have been mapped. There are a few provinces with integrated basic information on HIV/AIDS in the curriculum, including boarding schools, such as Papua and East Java. There is a national strategic plan and IEC strategy for the young high-risk population. The IEC strategy includes testimonies, social media, etc.

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

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

	IDU[8]	MSM[9]	Sex workers	Customers of Sex Workers	Prison inmates	Other populations[10] *[write in]*
Condom promotion	√	√	√	√	√	HRM, young people
Drug substitution therapy	√				√	
HIV testing and counselling	√	√	√	√	√	HRM, young people
Needle & syringe exchange	√				√	
Reproductive health, including sexually transmitted infections prevention and treatment	√	√	√	√	√	HRM, young people
Stigma and discrimination reduction	√	√	√	√	√	
Targeted information on risk reduction and HIV education	√	√	√	√	√	HRM, young people
Vulnerability reduction (e.g. income generation)	√		√		√	

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?

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

Since 2011, what have been key achievements in this area:
1. NASAP 2010 – 2014 2. Establishment of working groups in NAC and other sectors, such as working groups on Research, Young People, Gender, Papua and M&E 3. Agreement between 5 Ministries on Comprehensive Knowledge of Young People aged 15 – 24 years 4. ARV for Prevention strategy (Strategic Use of ARV - SUFA) 5. Continuum of Care (LKB)

What challenges remain in this area:

1. Implementation of condoms as prevention
2. Cross-sectoral coordination
3. Optimization of report and documentation use
4. Commitment of national and sub-national stakeholders
5. Limited domestic funding allocation
6. Implementation of the 5 Ministries agreement
7. Limited information dissemination on HIV counselling and testing

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

Yes √	No

IF YES, how were these specific needs determined?
There is National Strategic Plan and IEC for young people at high risk. Indonesia has conducted KIE on HIV among the sub-populations which have been mapped. The IEC strategy is implemented through testimonials, social media etc. There is cooperation with working groups to identify program needs and arrange specific plans, for example in the workplace working group.

IF YES, what are these specific needs?
Giving IEC to: 1. Young people, to increase basic knowledge about HIV 2. Workers at ports, terminals, truck stops, airports and centres of industry 3. Prison inmates 4. Vulnerable groups such as street children, beggars and the homeless

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	**4√**	N/A
Condom promotion	1	**2√**	3	4	N/A
Economic support e.g. cash transfers	1	2	**3 √**	4	N/A
Harm reduction for people who inject drugs	1	2	**3√**	4	N/A
HIV prevention for out-of-school young people	1	**2√**	3	4	N/A
HIV prevention in the workplace	1	2	**3√**	4	N/A
HIV testing and counseling	1	2	**3√**	4	N/A
IEC[11] on risk reduction	1	2	**3√**	4	N/A
IEC on stigma and discrimination reduction	1	2	**3√**	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	**3√**	4	N/A

Prevention for people living with HIV[12]	1	**2√**	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and	1	**2√**	3	4	N/A
Risk reduction for intimate partners of key populations	1	**2√**	3	4	N/A
Risk reduction for men who have sex with men	1	**2√**	3	4	N/A
Risk reduction for sex workers	1	2	**3√**	4	N/A
Reduction of Gender based violence	1	2	**3 √**	4	N/A
School-based HIV education for young people	1	2	**3√**	4	N/A
Treatment as prevention	1	**2√**	3	4	N/A
Universal precautions in health care settings	1	2	3	**4√**	N/A
Other*[write in]*:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2013?

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

V. TREATMENT, CARE AND SUPPORT

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

Yes√	No

If YES, Briefly identify the elements and what has been prioritized:
1. Ministry of Health decree on free ARV 2. Integration of HIV prevention, treatment, care and support 3. Strategic Use of ARV (SUFA) 4. Expansion of HIV counselling and testing

Briefly identify how HIV treatment, care and support services are being scaled-up?
1. Referral Hospitals for PLHIV: 380 Hospitals 2. Increase in Satellites of Health Centres and Hospitals: 114 3. VCT clinics: 899 (including in prisons) 4. SOP for comprehensive and integrative services

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

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

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

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

Yes√	No

Please clarify which social and economic support is provided[13]:
1. Empowerment of PLHIV through development of productive economic activities 2. Social assistance through aid to PLHIV for basic needs fulfillment 3. Shelter for PLHIV in Sukabumi

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

Yes√	No

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

Yes √	No	N/A

IF YES, for which commodities?

1. ARV
2. Condoms
3. Treatment for OI and STI
4. Methadone

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?

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

Since 2011, what have been key achievements in this area:
1. Free ARV 2. Supply and distribution of condoms 3. Drugs are always available 4. Target for counselling and testing for people over 15 years of age is 600,000; achievement is 1,025,000 5. ARV distribution system uses the Inventory Order Management System

What challenges remain in this area:
1. Donor dependency. Ratio of domestic to donor funding is 2:3 2. Stigma and discrimination 3. Variation in adherence levels; in the first year it is 95% but in the following year decreases to 60-70%

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

Yes√	No	N/A

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

Yes√	No

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

Yes√	No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

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

Since 2011, what have been key achievements in this area:

Ministry of Social Welfare provides support for economic needs and impact mitigation for children and families living with HIV and AIDS

What challenges remain in this area:
1. Variation in geographical and social conditions 2. Variation in Government policy due to decentralized authority

VI. MONITORING AND EVALUATION

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

Yes √	In Progress	No

Briefly describe any challenges in development or implementation:
• Integration has taken place, although it is still limited to 4 primary partners on HIV/AIDS (Ministry of Health, NAC, NU, IPPA). Integration still needed with other partners, including Government ministries and national and international NGOs as well as local government. For example, the Directorate General of Prisons already implements systematic reporting of HIV activities in prisons but this is still not fully integrated in the national data system • Refinement of HIV/AIDS information system still needed • Data flow: data is not routinely reported from the region to the center due to decentralization • Human resources, finance and facilities are limited both in quantity and quality. For example, the results of the M&E Assessment indicate that M&E staff at national level receive limited training which does not fully meet the capacity building needs of the staff members. Furthermore, there is no mechanism to evaluate staff capacity or performance, making it even more difficult to assess capacity building needs • Cross-sectoral coordination at the regional level on M&E is still weak • M&E guidelines have not been updated in accordance with the requirements and latest developments

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

2010

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

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

Briefly describe what the issues are:
Harmonization of recording and reporting has been done, including indicators, yet problems are still found in the implementation of such due to differences in understanding of existing indicators or variables. For example: as an indicator of coverage, NAC uses the number of KAP who received KIE, while PKBI/NU use the number of KAP who received a comprehensive package of interventions (including referral to health services)

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	**Yes √**	No
IF YES, does it address:		
Behavioural surveys	**Yes √**	No
Evaluation/research studies	**Yes √**	No
HIV Drug resistance surveillance	**Yes √**	No
HIV surveillance	**Yes √**	No
Routine programme monitoring	**Yes √**	No
A data analysis strategy	**Yes √**	No
A data dissemination and use strategy	**Yes √**	No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)	**Yes √**	No
Guidelines on tools for data collection	**Yes √**	No

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

Yes √	In Progress	No

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

5%

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

Yes √	In Progress	No

Briefly describe any obstacles:

Limited resources (human resources, financial resources and support facilities) for managing national monitoring and evaluation activities to improve the quality of implementation of the national M&E system.

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

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

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

POSITION [write in position titles in spaces below]	**Fulltime**	**Part time**	**Since when?**
NAC			
Permanent Staff [Add as many as needed]	**5**		
Assistant Deputy for M&E	1		2013
M&E regional I coordinators (NAD, Sumatera Utara, Bengkulu, Bengka Belitung, Jambi, Lampung, Sumatera Selatan, Banten, DKI Jakarta, Jawa Barat, Sulawesi Tengah)	1		2009
M&E regional II coordinators (Sumatera Barat, Riau, Kepulauan Riau, Jawa Tengah, Kalimantan Barat, Kalimantan Tengah, Kalimantan Selatan, Kalimantan Timur, Sulawesi Selatan, Sulawesi Utara, Gorontalo)	1		2006
M&E regional III coordinators (DIY, NTB, NTT, Maluku, Bali, Jatim, Papua, Papua Barat, Maluku Utara, Sulawesi Tenggara)	1		2011
M&E coordinators of Sectors and PMTS	1		2013
	Fulltime	**Part time**	**Since when?**
Ministry Of Health			
Permanent Staff [Add as many as needed]	**14**		
M&E Staff for ART	1		2013
M&E Staff for VCT	2		2013
AIDS Surveillance	1		2012
M&E Staff for PMTCT, STI, LASS, PTRM	2		2005
M&E Coordinator	1		2005
Assistant M&E Coordinator	1		2007
Head of M&E Section	1		2002
Technical Staff for M&E	5		2002

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

Yes √	No

Briefly describe the data-sharing mechanisms:
Implementing partner districts/cities submit reports periodically (once a month) to the district/city AIDS Commission, where they are compiled and sent to the Provincial AIDS Commission and then sent to National AIDS Commission. All reports are reviewed and incorporated into national reports. The Ministry of Health receives reports from the health services every month through the HIV/AIDS Information System (SIHA) application as well as manually written reports (hard copies). These are compiled every three months at the national level and made into quarterly progress reports on HIV/AIDS cases. Each national partner integrates reports periodically through online systems which have been developed (dashboard for 4 main partners).
What are the major challenges in this area:
• Reports are not complete (there are provinces that do not report; some provinces report regularly but do not fill in the complete data) • Frequent changes of recording and reporting officer, lack of budgetary support to carry out monitoring and evaluation activities • Lack of commitment of the staff in some services

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

Yes √	No

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

Yes √	No

IF YES, briefly describe the national database and who manages it.
The HIV/AIDS Information System (SIHA) is the national database since December 2012 (www.siha.depkes.go.id). It is managed by the AIDS Sub-Directorate of the Ministry of Health and the Media Centre. With GF support through NAC, SIHA has integrated the databases of 4 main partners, namely the Ministry of Health, NAC, IPPA and NU (http://siha.depkes.go.id/integrasi). The national database is limited to data coverage of key partners. Improvements are still needed to ensure that all the important data of all partners can be included in the national database (eg: data from prisons, Ministry of Transportation, Indonesian armed forces, police, etc.). Each partner also maintains a database related to the programs they are implementing.

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

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

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

6.2. Is there a functional Health Information System[14]?

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

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

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

7.2. Is HIV programme coverage being monitored?

Yes √	No

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

Yes √	No

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

Yes √	No

IF YES, for which population groups?
Sex workers, MSM, Transgender, PWID

Briefly explain how this information is used:
• Development of a national strategy for HIV & AIDS prevention • Development of sector policies on HIV & AIDS prevention • Advocacy on the prevention of HIV & AIDS • Global reporting • Resource mobilization • Planning academic or operational research

(c) Is coverage monitored by geographical area?

Yes √	No

IF YES, at which geographical levels (provincial, district, other)?
Provincial and district

Briefly explain how this information is used:
Programme planning and correction, reporting, data input for HIV modelling, advocacy input.

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

Yes √	No

9. How are M&E data used?

For programme improvement?	Yes √	No
In developing/revising the national HIV response?	Yes √	No
For resource allocation?	Yes √	No

Other *[write in]*: • Development of national strategy for HIV & AIDS prevention • Development of policy on HIV & AIDS prevention • Advocacy on the HIV & AIDS prevention program • National and global reporting • Resource mobilization • Planning of academic and operational research		

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
Data from all sources (program reporting, surveillance, research) are used for the development of the HIV & AIDS control strategy and increasing funding allocations Data on HIV & AIDS cases published by MoH every quarter are providing information about the HIV & AIDS epidemic at province and district level Challenges: Improvement in data quality Data use for policy decision making is still limited in some provinces and districts

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

At national level?	**Yes √**	No
IF YES, what was the number trained: • TOT of M&E (MoH), 7-12 October 2013, 33 participants • NASA training (HCPI and NAC), 23-26 April 2013, 29 participants • Training on Direct Estimation (HCPI), 31 October – 1 November 201, 23 participants • Training on Rapid Surveys of PWID, FSW and MSM (NAC), 27 – 31 October 2013, 48 participants • Training on Sero Surveys (MoH), 27 – 31 October 2013 • TOT Sentinel surveillance 26 Nov -1 December 2013, 27 participants		
At subnational level?	Yes	No
IF YES, what was the number trained		
At service delivery level including civil society?	Yes	No
IF YES, how many?		

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

Yes √	No

IF YES, describe what types of activities
Workshops, seminars, national congress and national meetings.

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?

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

Since 2011, what have been key achievements in this area:

- Implementation of HIV AIDS Information System (SIHA)
- Development of integrated database of main implementing partners (MoH, NAC, IPPA, NU)
- Mapping of Key Affected Populations at district level 2012
- IBBS 2013
- Rapid Survey 2012, 2013
- Mid-Term Review of NASAP 2010-2014
- NASA 2011-2012
- Sero-Surveillance 2013
- Data Cohort Analysis of ART 2012, 2013
- Mathematic Modelling of HIV program
- Investment Case Analysis
- M&E Assessment 2013
- Revision of guidelines and technical guides on M&E:
    - M&E guidelines
    - Mapping guidelines
    - Technical Guide for sentinel surveillance
- HIV Drug Resistance
    - Monitoring survey
    - Threshold survey
    - Early warning indicators

What challenges remain in this area:

- Harmonization/synchronizing of the indicators from each implementing partner
- Low commitment on submitting reports
- Measuring the direct impact of program intervention

National Commitments and Policy Instrument (NCPI)

Part B

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

I. CIVIL SOCIETY[15] INVOLVEMENT

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

LOW					HIGH
0	1	2	3√	4	5

Comments and examples:
Note: Civil society is defined as: individuals, organizations/groups of individuals, that are part of the government (not civil servants or not working for the government). 1) Representatives from KAP communities are involved in meetings, whether strategic, consultative or technical; an exemplary involvement is how civil society assisted MoH with ARV logistics to improve their response to complaints of stock outs or other problems related to the logistics of ARV at subnational/community levels. Coordination with MoH and NAC has been good and/or improving. But the coordination with other NAC members/other ministries has been challenging. 2) Despite a greater role at national level, at subnational level, there is still lack of greater involvement of communities. They are limited to mere technical consultation, while strategic policy discussions do not involve local representatives from communities.

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

LOW					HIGH
0	1	2	3√	4	5

Comments and examples:
The National Strategy and Action Plan 2010-2014 and the current Mid-Term Review involved representatives from all MARP networks. Most discussions concerning policies and programmes do involve communities, but those at a more detailed level on budgeting usually do not involve communities.

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

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	4√	5

b. The national HIV budget?

LOW					HIGH
0	1	2√	3	4	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3√	4	5

Comments and examples:
1) National strategic plans involve civil society 2) Budgeting from foreign aid mostly has some level of involvement from civil society (e.g. IPF, GF) but this is not the case for domestic budgeting 3) Most NGOs report to their donors, and do not always report to local/government agencies. This impairs any feedback on the improvement of current programmes, therefore maintaining "business as usual" and the possibility of programme duplication among international agencies. There is a need for a transparent report-dissemination process. Examples of such processes are the GF or IPF with meetings attended by stakeholders from government and non-government. Other donor reporting systems are still segregated and need to be coordinated in a transparent manner.

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

a. Developing the national M&E plan?

LOW		HIGH

0	1√	2	3	4	5

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

LOW					HIGH
0	1√	2	3	4	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1√	2	3	4	5

Comments and examples:
1) Despite involvement in M&E working groups, problems in the field are not well accommodated. 2) Most members of KAP groups still lack ability to use primary data for their programmes and rely on international donors or other national agencies for assistance to analyse data. 3) Findings from fieldwork are not utilized as feedback for the improvement of current programmatic approaches. One clear example of this is the PWID situation in Indonesia. Field reports show that there are no longer many active PWID yet NGOs are still pushed to find new PWID as they are forced to meet targets set at the beginning of a project. 4) There is also no clarity on which data to use: estimates? Mapping? Rapid surveys? 5) A positive point is that NGOs are using more evidence-based data in their proposals, reports and advocacy briefs.

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

LOW					HIGH
0	1	2	3	4√	5

Comments and examples:

1) Diversity is well represented from KAPs (all are represented except for positive people due to internal issues; there is still a network of positive support groups) and faith-based organizations: NU is a GF PR, and at the subnational level, the church in Papua has been actively involved in AIDS programmes.
2) Some faith-based groups, such as NU, do not utilize their social capital, i.e. their networks of local organizations; for example, NU's large network of religious organizations makes it the largest Moslem entity in Indonesia but it is underused in the context of the AIDS response. Instead, the program is implemented by a small group of people within the organization.

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

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	1	2√	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	2√	3	4	5

Comments and examples:

1. Due to the global financial crisis we are seeing less project funds available for NGOs.
2. More local NGOs are forced to close down due to a lack of financial support.
3. There is also a tendency from donors to overwork (underpay) NGOs in order to reach certain targets. There is a need to distinguish between activism and professionalism. NGOs activism should not be exploited for reaching project targets.

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

Prevention for key-populations				
People living with HIV	<25%	25-50%	51–75%	**>75% √**
Men who have sex with men	<25%	25-50%	51–75%	**>75% √**
People who inject drugs	<25%	25-50%	**51–75% √**	>75%
Sex workers	<25%	25-50%	51–75%	**>75% √**
Transgender people	<25%	25-50%	51–75%	**>75% √**
Palliative care	**< 25% √**	25-50%	51-75%	> 75%
Testing and Counselling	<25%	**25-50% √**	51–75%	>75%

Know your Rights/Legal services	<25%	25-50%	**51–75% √**	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	**>75% √**
Clinical services (ART/OI)*	**< 25% √**	25-50%	51–75%	>75%
Home-based care	<25%	**25-50% √**	51–75%	>75%
Programmes for OVC**	**< 25% √**	25-50%	51–75%	>75%

* ART = Antiretroviral Therapy; OI=Opportunistic infections

** OVC = Orphans and other vulnerable children

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?

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

Since 2011, what have been key achievements in this area:
1. Increasing participation of KAP networks in GF meetings: TWG, CCM 2. Increasing participation in consultative meetings by government, INGOs

What challenges remain in this area:
1. Reduced resources for enabling community participation 2. Mechanisms for the representation of civil society might still be questionable: why a certain NGO is involved, why the other is not...

II. POLITICAL SUPPORT AND LEADERSHIP

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

Yes√	No

IF YES, describe some examples of when and how this has happened:
National Strategy and Action Plan, Mid Term Review facilitated by NAC, meetings with MoH, GF: CCM, TWG

III. HUMAN RIGHTS

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

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

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

Yes√	No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Law No.39/1999 on Human Rights: this law guarantees basic human rights for Indonesian people

Briefly explain what mechanisms are in place to ensure that these laws are implemented:

A National Commission on Human Rights has been established since then, with certain procedures for submitting complaints when one's human rights have been violated. A number of legal aid services are available to facilitate the legal procedures if needed.

Briefly comment on the degree to which they are currently implemented:
1. For most minority groups the process is long and does not always have positive results. For HIV-related groups, there are no major cases as precedents, as most are not accessing this service. 2. Discrimination in the workplace is still prevalent and information dissemination and knowledge are lacking among stakeholders.

2. Does the country have laws, regulations or policies that present obstacles[16] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopula-tions?

Yes√	No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS AND VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	**No√**
Men who have sex with men	**Yes√**	No
Migrants/mobile populations	Yes	**No √**
Orphans and other vulnerable children	Yes	**No √**
People with disabilities	Yes	**No √**
People who inject drugs	**Yes√**	No
Prison inmates	**Yes√**	No
Sex workers	**Yes√**	No
Transgender people	**Yes√**	No
Women and girls	Yes	**No√**
Young women/young men	**Yes√**	No
Other specific vulnerable populations[17] *[write in]*:	Yes	No

Briefly describe the content of these laws, regulations or policies:
1. Sex work: The Indonesian Criminal Code criminalizes the facilitation of acts of obscenity by others as a livelihood, trading in women, vagrancy, and living on the earnings of a female sex worker. At the sub-national level a range of local laws, regional regulations and by-laws may be applied to sex workers and the sex industry. Sex workers may be ordered by public order police (Satpol PP) to attend 'social rehabilitation' centres. 2. People who use drugs: Indonesia has two laws which regulate matters on narcotics and psychotropic substances: Law No. 35 of 2009 regarding Narcotics and Law No. 5 of 1997 regarding Psychotropic Substances. Despite the 2009 Narcotics Law introducing a new objective that guarantees the provision of medical and social rehabilitation for people who use drugs, it also retains the criminalization of drug use. Both the Narcotics Law and Psychotropic Substances Law contain severe penalties for drug offences. 3. Men who have sex with men: Several local level regulations linked to sex work specifically mention and thus prohibit homosexual acts and sodomy. In addition, Law No. 44 of 2008 regarding Pornography provides a broad definition of pornography which prohibits people to "produce, make, multiply, copy, disseminate, broadcast, import, export, offer, sale, rent, or provide pornography which explicitly contains sexual intercourse including abnormal intercourse." Abnormal intercourse is specifically defined with reference to lesbian and homosexual intercourse.

Briefly comment on how they pose barriers:
There is no adequate and comprehensive national HIV law which specifically or explicitly protects people living with HIV from discrimination (for example, in health care settings, or education). The lack of adequate laws providing human rights protection for people living with HIV/AIDS may hinder HIV responses in Indonesia. Laws, policies, and practices that criminalize consensual sex between adult men and/or punish homosexual identity bring more harm than good for HIV responses. Like sex workers, transgender people and MSM often face harassment, arbitrary arrest and detention, and police violence. All of this contributes to increased marginalization and already entrenched stigmatization, increased exposure to HIV and disproportionately rare use of HIV prevention, treatment, care and support programs. Even when there is no explicit reference to sodomy or homosexual acts/identity, the authorities may inflict abuse under the aegis of 'public morality' or 'public decency'. When transgender people and MSM are subject to repressive actions from the authorities, it will discourage them from accessing HIV programs. This is worsened when health providers are reluctant to offer services as they worry that they will be charged with abetting a crime. Rather than punishing consenting adults involved in same-sex activities, the Government should offer such people access to effective HIV health services.

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

Yes√	No

Briefly describe the content of the policy, law or regulation and the populations included.
Indonesia enacted the Law on Elimination of Domestic Violence in 2004 (Law number 23 of 2004). This Law grounds the elimination of domestic violence on a principle of "gender justice and equality," and one of the objectives of the Law is "to prevent all forms of violence in household." Article 5 of the Law prohibits domestic violence in the form of physical, mental, sexual violence, and abandonment. Although the Law provides legal grounds for women who are victims of domestic violence, the patriarchal culture in most of Indonesian society holds women back from reporting. Society tends to demand that women keep silent if they become victims of domestic violence. However, the emphasis is on married couples, while there is no specific law on violence against women in general. In these cases, criminal laws on physical violence, or human rights laws are used. Protection for children is legally for those under the age of 18. This still leaves young people above 18 vulnerable and unprotected against violence.

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

Yes√	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
Yes, in the National Strategy and Action Plan of the AIDS Response, National Strategy for Women, Young People and Children Examples noted in the documents: program implementation exemplifies an awareness of and compliance with both the spirit and letter of the law thus promoting justice based on principles of human rights while respecting norms and values of the community. However, enforcement cannot be said to be optimal.

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

Yes	No√

IF YES, briefly describe this mechanism:

1. There is no specific mechanism for PLHIV.
2. There is a mechanism for human rights discrimination through the National Commission on Human Rights but no specific desk for HIV/AIDS or KAPs.
3. There are informal mechanisms for reporting and recording human rights violations against KAPs and PLHIV but these mostly implemented sporadically (not routinely) by certain NGOs, for example by Arus Pelangi to support LGBT. These mechanisms are ad hoc.
4. There is no clear channel for the submission of these reports from civil society to the Government system for enforcement and further follow up.

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

	Provided free-of-charge to all people in the country		**Provided free-of-charge to some people in thecountry**		**Provided, but only at a cost**	
Antiretroviral treatment	**Yes√**	No	Yes	No	Yes	No
HIV prevention services[18]	Yes	No	**Yes√**	No	Yes	No
HIV-related care and support interventions	Yes	No	Yes	No	**Yes√**	No

If applicable, which populations have been identified as priority, and for which services?
Indonesia's social protection system (JKN), which was launched in 2014, basically provides universal healthcare, yet there are some issues that affect KAPs and PLHIV: 1. JKN does not insure drug users/drug and alcohol-dependent people; 2. Issues with identity for waria/transgender (waria are identified as men, and their appearance is sometimes different from that on their ID card; 3. JKN only covers OIs while AIDS-specific drugs are still provided under MoH programmatic funds, therefore sustainability is not ensured.

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

Yes√	No

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

Yes√	No

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

Yes	**No√**

IF YES, Briefly describe the content of this policy/strategy and the populations included:

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

Yes	No

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

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

Yes√	No

IF YES, briefly describe the content of the policy or law:
1) The Ministry of Manpower and Transmigration Decree No.68/2004 and the DG for Workforce Monitoring and Education in the Workplace No.20/PPK/2005 ensure that there is no mandatory testing for migrant workers (exceptions can be found in military settings). 2) There is a setback for foreign teachers in Indonesia, with a ruling that they have to be drug free and HIV free (PERMENDIKNAS No.66/2009)

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

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

Yes√	No

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

Yes	**No√**

IF YES on any of the above questions, describe some examples:
There are national commissions for Human Rights and Women and Children's Protection. These have considered and worked together with HIV-related stakeholders and communities. The Ombudsman has not!

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

a. Programmes to educate, raise awareness among people living with HIV and key popula-tions concerning their rights (in the context of HIV)[19]?

Yes√	No

b. Programmes for members of the judiciary and law enforcement[20] on HIV and human rights issues that may come up in the context of their work?

Yes√	No

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

a. Legal aid systems for HIV casework

Yes	**No√**

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

Yes√	No

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

Yes√	No

IF YES, what types of programmes?		
Programmes for health care workers	**Yes√**	No

Programmes for the media	**Yes√**	No
Programmes in the work place	**Yes√**	No
Other *[write in]*:	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?

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

Since 2011, what have been key achievements in this area:
1) Series of MoH Decrees in 2012-2013 that increase access to free treatment 2) MoH Decrees to integrate HIV into the national health system 3) MoH Decrees to integrate HIV into the social protection scheme 4) National Commission on Human Rights' efforts are mostly concentrated on LGBT issues; yet other KAPs affected by HIV are not facilitated by the Commission

What challenges remain in this area:
The current National Social Protection scheme for Health (JKN) is impairing access to treatment for drug users. Although it does not specifically mention any excluded groups it does clearly state that JKN does not support treatment related to self-inflicted diseases, drugs and alcohol. This impairs the rights of PWID to social health protection.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?

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

Since 2011, what have been key achievements in this area:

There is no change because there has been no significant policy reform enabling greater human rights protection and access to public services for PLHIV and KAPs.

What challenges remain in this area:
Lack of motivation by the Government to enforce human rights protection for KAPs, including monitoring and recording/reporting of violations

IV. PREVENTION

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

Yes√	No

IF YES, how were these specific needs determined?
There various methods to analyse the needs: SCP (Rapid Behavioural Survey), IBBS, NGOs or community or subnational level mapping, Investment Case analysis

IF YES, what are these specific needs?
1) Strategic Use of ARV (SUFA) - increasing access to ARV/CST for prevention 2) Continuum of Care system, integrating the HIV programme into the national health system to increase access for KAPs (bringing access closer to those in need)

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access to...**				
	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**	**N/A**
Blood safety	1	**2√**	3	4	N/A
Condom promotion	1	2	**3√**	4	N/A
Harm reduction for people who inject drugs	1	2	**3√**	4	N/A
HIV prevention for out-of-school young people	1	**2√**	3	4	N/A
HIV prevention in the workplace	1	**2√**	3	4	N/A
HIV testing and counseling	1	2	**3√**	4	N/A
IEC[21] on risk reduction	1	**2√**	3	4	N/A
IEC on stigma and discrimination reduction	1	**2√**	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	**2√**	3	4	N/A

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

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?

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

Since 2011, what have been key achievements in this area:
1) PMTS (Prevention of sexual transmission program): STI module, Stigma and discrimination module 2) Youth: national strategy for young people 3) Access to CST is increasing especially through the Social Protection Scheme (JKN)

What challenges remain in this area:
1) Harm Reduction: advocacy for law enforcement forces, involvement of the police force so far has been through the medical sector (Pusdokes) but not Law Enforcement (Bareskrim) 2) The closing down of brothels across the country 3) Promotion of condoms for young people has been challenging (need to analyse policies inhibiting these efforts) – population laws do not provide access to contraception (condoms) for unmarried couples 4) Social protection (JKN) and how it impairs access for drug users. Impairs (as noted above)

V. TREATMENT, CARE AND SUPPORT

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

Yes√	No

IF YES, Briefly identify the elements and what has been prioritized:
The prioritized elements include: early testing and initiation; psychosocial support; integration of OI treatment through the social protection scheme; scaling up has been a priority through LKB (CoC, or continuum of care) and SUFA (Strategic Use of ARV)

Briefly identify how HIV treatment, care and support services are being scaled-up?
1. Access to ART has increased, bringing access closer to communities through the CoC approach (LKB) and SUFA by MoH. 2. Social protection scheme covers some components of PLHIV treatment needs, as advised by the Health Minister Regulation (Permenkes) No.21/2013.

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

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

Post-delivery ART provision to women	1	**2√**	3	4	N/A

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

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

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

Since 2011, what have been key achievements in this area:
With the legal support of the Health Ministerial Regulation (Permenkes) No.21/2013, the national insurance scheme covers some elements of HIV-related treatment.

What challenges remain in this area:

Access for drug users through the national insurance scheme is impaired as mentioned above.

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

Yes√	No

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

Yes√	No

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

Yes	**No√**

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

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

Since 2011, what have been key achievements in this area:
Defining here is HIV treatment related to mitigation, including OVCs. The Ministry of Social Affairs provides support for children affected by HIV, in particular at subnational levels where the AIDS epidemic is prevalent, for example in Papua, yet these programmes are mostly either sporadic and/or case-based.

What challenges remain in this area:

Support is not building sustainable systems; for example, when donors leave, PLHIV who already enjoying psychosocial support are left unattended. This is despite efforts by the Government to increase access to CST services through CoC (project approaches are more charitable than programmatic)

Annex 2. Domestic and International AIDS Spending

Target 6. Reach a significant level of annual global expenditure in low and middle-income countries

6.1. Domestic and international AIDS spending by source and spending categories

The Government of Indonesia, along with international partners has been working hard in suppressing the spread of AIDS in the country through various programs, despite considerable challenges continue to persist. The program response to HIV in Indonesia has been co-financed by the Government of Indonesia (GOI) and direct and indirect financial support by the international partners. The National AIDS Spending Assesment (NASA), which was designed for tracking resources of the responses to the HIV epidemic in the country, has delivered strategic information for the management of the national response to AIDS as well as in policy making processes since 2006.
NASA reported the expenditure of year 2011-2012 from both international and public sources. There was a slight increase in the total expenditures for HIV and AIDS program in Indonesia in 2012 compared to 2011. AIDS expenditures from international partners source of fund was still larger compared to Government source of fund. In 2011, international partners contributed 59% of the total spending for HIV and AIDS, and the remaining 41% was dedicated by the Government. In 2012, the Government contribution increased to 42% while international partners fund was 58%.

The trend of national HIV and AIDS expenditure in 2009-2012 indicated an increasing total spending though slightly fluctuating after adjusting with PPP. The NASA also revealed that the increased spending was due to the increased Government spending from USD 21 million in 2009 to USD 37 million in 2012. However, international partners contribution was also increased and continue to play an important role in the program implementation, reaching to USD 43.8 million in 2011 and USD 50.1 million in 2012.

Table 1. Trend HIV and AIDS Expenditure in 2009-2012 (in USD)

Source	2009		2010		2011		2012	
	USD	%	USD	%	USD	%	USD	%
public /pusat	21.318.844	35%	27.779.280	40%	29.727.979	41%	36.851.918	42%
Internasional	38.966.576	65%	41.367.600	60%	42.815.644	59%	50.150.779	58%
total (current USD)	**60.285.420**	**100%**	**69.146.880**	**100%**	**72.543.623**	**100%**	**87.002.697**	**100%**
total (constant PPP)	**41.804.075**	**100%**	**32.930.134**	**100%**	**28.813.479**	100%	**34.426.512**	100%

The Government contribution was mainly from central government source of fund (more than 70%). Subnational data shown increased local government contribution (data from 14 provinces). The HIV and AIDS expenditures contributed by the central government through central budget increased from

USD 22,206,430 in 2011 to USD 28,199,758 in 2012. The Ministry of Health was the main contributor. In 2011, the Ministry of Health spent 76% of all Government funds for AIDS related program and was increasing around 83%) in 2012. Most of MOH fund was devoted to drugs procurement, reaching around 89%, more than 11% for OI drugs procurement, and the remaining 6% was spent for program management and prevention activities.

The Global Fund is the largest funding source, covering 64.06% in 2011 and 49.57% in 2012 of all HIV & AIDS spending from international partners, including multilateral and bilateral partners.

Table 2. HIV and AIDS expenditures contributed by International Partners, 2011-2012

No	INTERNATIONAL SOURCE	TOTAL 2011		TOTAL 2012	
		USD	%	USD	%
A	**MULTILATERAL**	**30,239,464**		**27,734,502**	
	GLOBAL FUND	27,428,479	64.06%	24,858,113	49.57%
	UN AGENCIES	2,764,342	6.46%	2,821,289	5.63%
	WORLD BANK	46,643	0.11%	55,100	0.11%
B	**BILATERAL**	**12,576,180**		**22,416,277**	
	GOVERNMENT OF AUSTRALIA	8,788,691	20.53%	16,496,612	32.89%
	GOVERNMENT OF USA	3,736,517	8.73%	5,728,045	11.42%
	GOVERNMENT OF THE NETHERLANDS	50,972	0.12%	191,620	0.38%
TOTAL		**42,815,644**	**100%**	**50,150,779**	**100%**

Global Fund transfered its funding to four (4) primary recepients (PR): MOH, NAC, Nahdatul Ulama and PKBI. The highest amount was received by MOH. Each PR is responsible for activities at subnational level (141 districts/municipalities and 33 provinces). The GF support will be ended by the year 2015, while various program activities substantially depend on GF. The Government of Australia is the second largest funding source and through AusAID, donating more than USD 8 million in 2011 and increased to more than USD 16 million in 2012. Fifty of the funds were disbursed through GRM/HCPI to support program activities in collaboration with national implementers. The remaining funds were donated through CHAI, NAC, UNDP and other implementers.

Meanwhile in 2011, the US Government through USAID supported USD 3.7 million and increased in 2012 to USD 5.7 million, the Government of the Netherlands supported Unicef in 2011 and 2012.

AIDS Spending Category (2011-2012)

Spending for HIV/AIDS showed that Government was focusing more on support and treatment, while external partners contribution was more focusing on prevention program.

Table 3. HIV and AIDS Expenditures by Source and Spending Category in 2011-2012

ASC	CATEGORY	2011 (USD)				2012 (USD)			
		FA.01 Government	%	FA.03 International Partners	%	FA.01 Government	%	FA.03 International Partners	%
ASC 01	Prevention	5.888.726	28.88	14.498.148	71.12	6,881,439	28.67	17.119.022	71.33
ASC 02	Care, Support and Treatment	16.470.533	89.39	1.954.684	10.61	23,268,992	74.62	7.912.546	25.38
ASC 03	Orphans and Vulnerable	17.151	100			19,791	72.63	7.458	27.37
ASC 04	Program Management and Administration	3.719.884	19.20	15,650,465	80.80	3,375,269	21	12.697.951	79
ASC 05	Incentives for Human Resources	1.545.311	16.09	8.059.063	83.91	1,252,748	11.77	9.392.122	88.23
ASC 06	Social Protection and Services, excluding protection for orphans and vulnerable	1.072.345	90.78	108,878	9.22	1,127,268	99.47	6.000	0.53
ASC 07	Enabling Environment	631.977	23.18	2.094.476	76.82	843,867	32.43	1.758.046	67.57
ASC 08	Researches excluding Operational Research	382.052	45.92	449.931	54.08	82,543	6.16	1.257.633	93.84
	TOTAL	**29,727,979**		**42.815.645**		**36,851,918**		**50.150.779**	

Providers for Program Implementation (2011-2012)

There were two main providers to implement the program as reported in NASA 2011-2012: public sector providers and private sector providers. Public sector providers included central and provincial/district governement owned organizations such as ministeries/national board and provincial/districh health and non health organiations. More than 82% of program intervention in 2011 and around 71% in 2012 were implemented by public sector providers. The assessment result depicted that donor has been working with private sector povider including international and national CSO and NGOs to persue the program inplementation in the country.

Table 4. HIV and AIDS Spending by Provider2011-2012

Provider	2011		2012	
	USD	%	USD	%
Public Sector Provider	59,753,073	82.37	61,416,667	70.59
Private Sector Provider	12,790,550	17.63	25,586,031	29.41%
Total	**72,543,623**		**87,002,697**	

Spending by Beneficiary in 2011-2012

Spending by beneficiary shows how the HIV and AIDS Expenditures benefitting the people, especially the targeted/intended beneficiaries sucah as People Living with HIV, MARP, other key population, general population, etc. NASA reported that the highest proportion of the spending in 2011 was dedicated for the non target intervention, PLHIV and MARP (33%, 26% and 24% respectively). In 2012 the expenditures was devoted mainly for PLHIV, MARP and non targted population (34%, 27% and 24% respectively).

Table 5. HIV and AIDS Spending by Beneficiaries in 2011-2012

Beneficiary	2011		2012	
	USD	%	USD	%
PLHIV	18,811,838	25.93	29,470,740	33.87
MARP	17,379,143	23.96	23,692,860	27.23
Other key population	2,744,656	3.78	1,626,325	1.87
Specific "accessible" population	5.857.475	8.07	8,639,351	9.93
General Population	2.366.704	3.26	1,854768,	2.13
Non-targeted intervention	24,020,626	33.11	20,661,336	23.75
Specific targeted population n.e.c	1.363.514	1.87	1,057,316	1.22
TOTAL	72,543,623	100	87,002,697	100

Annex 3. National AIDS Spending Assessment (NASA) Matrix

ANNEXES

TOTAL HIV EXPENDITURE 2011

AIDS SPENDING CATEGORIES	**TOTAL ($)**	**SUMBER PEMBIAYAAN (SOURCE)**											
		PEMERINTAH (PUBLIC)			**INTERNATIONAL**								
		Public (Sub Total)	**Central/ Nasional**	**Sub Nasional**	**International (Sub Total)**	**Sub Total Multilateral**	**Multilateral**			**Sub Total Bilateral**	**Bilateral**		
							GLOBAL FUND	**WORLD BANK**	**UN AGENCIES**		**AUSAID**	**USAID**	**HIVOS**
Total spent in 2011 ($):	**2.543.623**	**29.727.979**	**22.206.430**	**7.521.549**	**42.815.644**	**30.239.464**	**27.428.479**	**46.643**	**2.764.342**	**12.576.180**	**8.788.691**	**3.736.517**	**50.972**
1. Prevention (sub-total)	**0.386.874**	**5.888.726**	**2.785.411**	**3.103.315**	**14.498.148**	**10.064.418**	**7.985.920**	**-**	**2.078.499**	**4.433.729**	**3.681.503**	**52.226**	**-**
1.01 Communication for social and behavioural change	.737.573	1.591.268	1.130.439	460.828	3.146.305	2.258.893	2.206.612		52.281	887.413	653.668	233.744	
1.02 Community mobilization	1.023.797	563.348	297.734	265.614	460.449	43.287	-		43.287	417.162	417.162	-	
1.03 Voluntary counselling and testing (VCT)	2.967.179	24.576	-	24.576	2.942.604	2.942.604	2.942.604		-	-		-	
1.04 Risk-reduction for vulnerable and accessible populations	205.742	205.742	-	205.742	-	-	-		-	-		-	
1.05. Prevention - Youth in school	1.830.523	262.815	60.335	202.480	1.567.708	1.567.708	-		1.567.708	-		-	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
1.06 Prevention - Youth out-of-school	196.630	50.246	-	50.246	146.384	146.384	-		146.384	-		-	
1.07 Prevention of HIV transmission aimed at people living with HIV	746.750	437.975	345.629	92.347	308.775	308.775	261.783		46.992	-		-	
1.08 Prevention programmes for sex workers and their clients	552.914	153.820	114.025	39.795	399.094	24.958	-		24.958	374.136	364.755	9.381	
1.09 Programmes for men who have sex with men	60.944	625	-	625	60.320	-	-		-	60.320	46.420	13.899	
1.10 Harm-reduction programmes for injecting drug users	2.098.593	258.961	109.301	149.660	1.839.632	376.480	324.246		52.234	1.463.152	1.447.192	15.960	
1.11 Prevention programmes in the workplace	459.014	454.014	371.662	82.353	5.000	5.000	-		5.000	-		-	
1.12 Condom social marketing	1.081.623	1.425	-	1.425	1.080.198	788.441	786.151		2.290	291.757		291.757	
1.13 Public and commercial sector male condom provision	122.425	122.425	122.425	-	-	-	-		-	-		-	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
1.14 Public and commercial sector female condom provision	233.861	233.861	233.861	-	-	-	-		-	-		-	
1.15 Microbicides	-	-	-	-	-	-	-		-	-		-	
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	2.260.704	43.873	-	43.873	2.216.830	1.464.524	1.464.524		-	752.306	752.306	-	
1.17 Prevention of mother-to-child transmission	78.072	49.417	-	49.417	28.655	28.655	-		28.655	-		-	
1.18 Male Circumsicion	4.722	4.722	-	4.722	-	-	-		-	-		-	
1.19 Blood safety	-	-	-	-	-	-	-		-	-		-	
1.20 Safe medical injections	-	-	-	-	-	-	-		-	-		-	
1.21 Universal precautions	-	-	-	-	-	-	-		-	-		-	
1.22 Post-exposure prophylaxis	1.847	1.847	-	1.847	-	-	-		-	-		-	
1.98 Prevention activities not disaggregated by	296.195	-	-	-	296.195	108.710	-		108.710	187.485		187.485	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
intervention													
1.99 Prevention activities not elsewhere classified	1.427.765	1.427.765	-	1.427.765	-	-	-		-	-		-	
2. Care and Treatment (sub-total)	**18.425.218**	**16.470.533**	**15.616.728**	**853.805**	**1.954.684**	**1.015.357**	**1.015.357**	**-**	**-**	**939.328**	**939.328**	**-**	**-**
2.01 Outpatient care	1.022.862	7.505	-	7.505	1.015.357	1.015.357	1.015.357	-	-	-	-	-	-
2.01.01 Provider-initiated testing and counselling	17.973	17.973	-	17.973	-	-	-		-	-		-	
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	1.761.139	1.755.481	1.744.035	11.446	5.658	5.658	5.658		-	-		-	
2.01.03 Antiretroviral therapy	14.907.178	13.900.199	13.872.693	27.506	1.006.979	1.006.979	1.006.979		-	-		-	
2.01.04 Nutritional support associated to ARV therapy	42.756	42.756	-	42.756	-	-	-		-	-		-	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
2.01.05 Specific HIV-related laboratory monitoring	282	282	-	282	-	-	-		-	-		-	
2.01.06 Dental programmes for PLHIV	-	-	-	-	-	-	-		-	-		-	
2.01.07 Psychological treatment and support services	104.333	104.333	-	104.333	-	-	-		-	-		-	
2.01.08 Outpatient palliative care	-	-	-	-	-	-	-		-	-		-	
2.01.09 Home-based care	171	171	-	171	-	-	-		-	-		-	
2.01.10 Traditional medicine and informal care and treatment services	-	-	-	-	-	-	-		-	-		-	
2.01.98 Outpatient care services not disaggregated by intervention	-	-	-	-	-	-	-		-	-		-	
2.01.99 Outpatient Care services not	2.719	-	-	-	2.719	2.719	2.719		-	-		-	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
elsewhere classified													
2.02 In-patient care	594.713	2.272	-	2.272	-	-	-	-	-	-	-	-	-
2.02.01 Inpatient treatment of opportunistic infections (OI)	594.713	594.713	-	594.713	-	-	-		-	-		-	
2.02.02 Inpatient palliative care	-	-	-	-	-	-	-		-	-		-	
2.02.98 Inpatient care services not disaggregated by intervention	-	-	-	-	-	-	-		-	-		-	
2.02.99 In-patient services not elsewhere classified	-	-	-	-	-	-	-		-	-		-	
2.03 Patient transport and emergency rescue	-	-	-	-	-	-	-		-	-			
2.98 Care and treatment services not disaggregated by intervention	-	-	-	-	-	-	-		-	-			
2.99 Care and treatment	984.176	44.848	-	44.848	939.328	-	-		-	939.328	939.328		

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
services not-elsewhere classified													
3. Orphans and Vulnerable Children (sub-total)	**17.151**	**17.151**	**-**	**17.151**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
3.01 OVC Education	-	-	-	-	-	-	-		-	-		-	
3.02 OVC Basic health care	-	-	-	-	-	-	-		-	-		-	
3.03 OVC Family/home support	-	-	-	-	-	-	-		-	-		-	
3.04 OVC Community support	16.011	16.011	-	16.011	-	-	-		-	-		-	
3.05 OVC Social services and Administrative costs	1.140	1.140	-	1.140	-	-	-		-	-		-	
3.06 OVC Institutional Care	-	-	-	-	-	-	-		-	-		-	
3.98 OVC services not disaggregated by intervention	-	-	-	-	-	-	-		-	-		-	
3.99 OVC services not-	-	-	-	-	-	-	-		-	-		-	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
elsewhere classified													
4. Program Management and Administration Strengthening (sub-total)	**19.370.348**	**3.719.884**	**1.349.423**	**2.370.461**	**15.650.464**	**11.627.645**	**11.406.938**	**46.643**	**174.064**	**4.022.819**	**2.340.324**	**1.671.506**	**10.990**
4.01 Planning, coordination and programme management	4.133.471	1.807.371	848.552	958.819	2.326.100	768.428	747.174		21.254	1.557.672	1.549.298	4.834	3.540
4.02 Administration and transaction costs associated with managing and disbursing funds	2.087.245	214.491	127.384	87.107	1.872.754	1.785.805	1.735.316		50.490	86.949		84.249	2.700
4.03 Monitoring and evaluation	7.761.014	284.251	44.222	240.029	7.476.762	6.726.872	6.693.633		33.239	749.891	338.443	411.448	
4.04 Operations research	127.513	127.513	51.897	75.616	-	-	-		-	-		-	
4.05 Serological-surveillance (Serosurveillance)	2.170.700	130.773	14.306	116.467	2.039.927	1.535.964	1.489.321	46.643	-	503.963		503.963	
4.06 HIV drug-resistance surveillance	-	-	-	-	-	-	-		-	-		-	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
4.07 Drug supply systems	106.489	106.489	-	106.489	-	-	-		-	-		-	
4.08 Information technology	85.512	85.512	26.576	58.936	-	-	-		-	-		-	
4.09 Patient tracking	64.074	58.738	42.929	15.808	5.336	5.336	5.336		-	-		-	
4.10 Upgrading and construction of infrastructure	276.814	269.583	-	269.583	7.230	2.480	2.480		-	4.750		-	4.750
4.11 Mandatory HIV testing (not VCT)	-	-	-	-	-	-	-		-	-		-	
4.98 Program Management and Administration Strengthening not disaggregated by type	1.472.364	193.557	193.557	-	1.278.807	562.492	493.411		69.081	716.315	49.303	667.012	
4.99 Program Management and Administration Strengthening not-elsewhere classified	1.085.152	441.605	-	441.605	643.547	240.267	240.267		-	403.280	403.280	-	
5. Human resources (sub-total)	**9.604.374**	**1.545.311**	**770.678**	**774.633**	**8.059.063**	**6.288.346**	**6.208.073**	**-**	**80.273**	**1.770.717**	**426.265**	**1.312.786**	**31.667**

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
5.01 Monetary incentives for human resources	2.977.819	544.499	108.413	436.086	2.433.320	2.409.970	2.409.970		-	23.350		-	23.350
5.02 Formative education to build-up an HIV workforce	11.917	11.917	-	11.917	-	-	-		-	-		-	
5.03 Training	5.578.930	978.233	662.265	315.968	4.600.697	2.853.330	2.778.188		75.142	1.747.367	426.265	1.312.786	8.317
5.98 Incentives for Human Resources not specified by kind	1.022.766	-	-	-	1.022.766	1.022.766	1.019.915		2.851	-		-	
5.99 Incentives for Human Resources not elsewhere classified	12.942	10.661	-	10.661	2.281	2.281	-		2.281	-		-	
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**1.181.223**	**1.072.345**	**969.213**	**103.132**	**108.878**	**108.878**	**82.378**	**-**	**26.500**	**-**	**-**	**-**	**-**
6.01 Social protection through monetary	1.078.954	1.069.954	969.213	100.741	9.000	9.000	-		9.000	-		-	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
benefits													
6.02 Social protection through in-kind benefits	-	-	-	-	-	-	-		-	-		-	
6.03 Social protection through provision of social services	2.391	2.391	-	2.391	-	-	-		-	-		-	
6.04 HIV-specific income generation projects	-	-	-	-	-	-	-		-	-		-	
6.98 Social protection services and social services not disaggregated by type	82.378	-	-	-	82.378	82.378	82.378		-	-		-	
6.99 Social protection services and social services not elsewhere classified	17.500	-	-	-	17.500	17.500	-		17.500	-		-	
7. Enabling Environment (sub-total)	**2.726.453**	**631.977**	**368.947**	**263.030**	**2.094.476**	**868.297**	**729.813**	**-**	**138.484**	**1.226.179**	**1.217.864**	**-**	**8.315**

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
7.01 Advocacy	1.242.146	502.251	260.172	242.079	739.895	59.928	-		59.928	679.967	671.652	-	8.315
7.02 Human rights programmes	32.980	-	-	-	32.980	32.980	-		32.980	-	-	-	
7.03 AIDS-specific institutional development	514.561	1.824	-	1.824	512.737	28.077	-		28.077	484.661	484.661	-	
7.04 AIDS-specific programmes focused on women	88.724	27.173	22.979	4.194	61.551	-	-		-	61.551	61.551	-	
7.05 Programmes to reduce Gender Based Violence	13.683	13.683	-	13.683	-	-	-		-	-		-	
7.98 Enabling Environment and Community Development not disaggregated by type	833.110	85.797	85.797	-	747.313	747.313	729.813		17.500	-		-	
7.99 Enabling Environment and Community Development not elsewhere classified	1.249	1.249	-	1.249	-	-	-		-	-		-	

AIDS SPENDING CATEGORIES	TOTAL ($)	SUMBER PEMBIAYAAN (SOURCE)											
		PEMERINTAH (PUBLIC)			INTERNATIONAL								
		Public (Sub Total)	Central/ Nasional	Sub Nasional	International (Sub Total)	Sub Total Multilateral	Multilateral			Sub Total Bilateral	Bilateral		
							GLOBAL FUND	WORLD BANK	UN AGENCIES		AUSAID	USAID	HIVOS
8. Research (sub-total)	**831.982**	**382.051**	**346.029**	**36.022**	**449.931**	**266.523**	**-**	**-**	**266.523**	**183.408**	**183.408**	**-**	**-**
8.01 Biomedical research	-	-	-	-	-	-	-		-	-		-	
8.02 Clinical research	-	-	-	-	-	-	-		-	-		-	
8.03 Epidemiological research	155.174	7.316	-	7.316	147.858	147.858	-		147.858	-		-	
8.04 Social science research	573.739	285.332	272.196	13.136	288.408	105.000	-		105.000	183.408	183.408	-	
8.05 Vaccine-related research	-	-	-	-	-	-	-		-	-		-	
8.98 Research not disaggregated by type	13.665	-	-	-	13.665	13.665	-		13.665	-		-	
8.99 Research not elsewhere classified	89.403	89.403	73.833	15.570	-	-	-		-	-		-	

TOTAL HIV EXPENDITURE 2012

AIDS SPENDING CATEGORIES	**TOTAL ($)**	**SUMBER PEMBIAYAAN (SOURCE)**											
		PEMERINTAH (PUBLIC)			**INTERNATIONAL**								
		Public (Sub Total)	**Central/ Nasional**	**Sub Nasional**	**International (Sub Total)**	**Sub Total Multilateral**	**Multilateral**			**Sub Total Bilateral**	**Bilateral**		
							GLOBAL FUND	**WORLD BANK**	**UN AGENCIES**		**AUSAID**	**USAID**	**HIVOS**
Total spent in 2012 ($):	**87.002.697**	**36.851.918**	**28.199.758**	**8.652.159**	**50.150.779**	**27.734.502**	**24.858.113**	**55.100**	**2.821.289**	**22.416.277**	**16.496.612**	**5.728.045**	**191.619**
1. Prevention (sub-total)	**24.000.461**	**6.881.439**	**2.787.613**	**4.093.826**	**17.119.022**	**6.593.225**	**4.349.391**	**-**	**2.243.834**	**10.525.798**	**8.730.061**	**1.795.737**	**-**
1.01 Communication for social and behavioural change	5.310.769	1.713.085	1.113.932	599.153	3.597.684	3.361.633	3.346.576		15.057	236.051		236.051	
1.02 Community mobilization	850.739	313.211	14.190	299.021	537.528	-	-		-	537.528		537.528	
1.03 Voluntary counselling and testing (VCT)	77.884	77.884	165	77.719	-	-	-		-	-		-	
1.04 Risk-reduction for vulnerable and accessible populations	173.201	160.701	14.358	146.343	12.500	12.500	-		12.500	-		-	
1.05. Prevention - Youth in school	2.002.189	226.189	42.867	183.322	1.776.000	1.776.000	-		1.776.000	-		-	
1.06 Prevention - Youth out-of-school	195.648	36.320	-	36.320	159.327	159.327	-		159.327	-		-	
1.07 Prevention of HIV	996.203	331.987	300.434	31.553	664.216	475.504	432.036		43.468	188.712		188.712	

transmission aimed at people living with HIV													
1.08 Prevention programmes for sex workers and their clients	224.041	96.267	71.032	25.235	127.774	34.597	-		34.597	93.177		93.177	
1.09 Programmes for men who have sex with men	401.120	1.228	-	1.228	399.892	-	-		-	399.892		399.892	
1.10 Harm-reduction programmes for injecting drug users	361.836	336.418	215.674	120.744	25.418	25.418	-		25.418	-		-	
1.11 Prevention programmes in the workplace	1.181.612	1.030.603	900.570	130.033	151.009	18.271	15.771		2.500	132.738		132.738	
1.12 Condom social marketing	689.369	51.678	-	51.678	637.691	637.691	555.008		82.683	-		-	
1.13 Public and commercial sector male condom provision	115.972	115.972	114.390	1.582	-	-	-		-	-		-	
1.14 Public and commercial sector female condom provision	-	-	-	-	-	-	-		-	-		-	
1.15 Microbicides	-	-	-	-	-	-	-		-	-		-	
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	107.131	90.931	-	90.931	16.200	16.200	-		16.200	-		-	
1.17 Prevention of mother-to-	123.095	114.095	-	114.095	9.000	9.000	-		9.000	-		-	

child transmission													
1.18 Male Circumsicion	4.421	4.421	-	4.421	-	-	-		-	-		-	
1.19 Blood safety	3.729	3.729	-	3.729	-	-	-		-	-		-	
1.20 Safe medical injections	-	-	-	-	-	-	-		-	-		-	
1.21 Universal precautions	-	-	-	-	-	-	-		-	-		-	
1.22 Post-exposure prophylaxis	2.727	2.727	-	2.727	-	-	-		-	-		-	
1.98 Prevention activities not disaggregated by intervention	9.004.784	-	-	-	9.004.784	67.084	-		67.084	8.937.700	8.730.061	207.639	
1.99 Prevention activities not elsewhere classified	2.173.992	2.173.992	-	2.173.992	-	-	-		-	-		-	
2. Care and Treatment (sub-total)	31.181.538	**23.268.992**	**22.392.634**	**876.359**	**7.912.546**	**4.261.140**	**4.261.140**	**-**	**-**	**3.651.406**	**3.651.406**	**-**	**-**
2.01 Outpatient care	4.270.272	9.132	-	9.132	4.261.140	4.261.140	4.261.140	-	-	-	-	-	-
2.01.01 Provider-initiated testing and counselling	38.524	38.524	-	38.524	-	-	-		-	-		-	
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment	2.072.861	2.072.861	1.767.806	305.055	-	-	-		-	-		-	
2.01.03 Antiretroviral therapy	24.767.073	20.660.360	20.624.827	35.532	4.106.713	4.106.713	4.106.713		-	-		-	

2.01.04 Nutritional support associated to ARV therapy	42.537	42.537	-	42.537	-	-	-		-	-		-	
2.01.05 Specific HIV-related laboratory monitoring	158.942	4.515	-	4.515	154.427	154.427	154.427		-	-		-	
2.01.06 Dental programmes for PLHIV	-	-	-	-	-	-	-		-	-		-	
2.01.07 Psychological treatment and support services	86.299	86.299	-	86.299	-	-	-		-	-		-	
2.01.08 Outpatient palliative care	-	-	-	-	-	-	-		-	-		-	
2.01.09 Home-based care	375	375	-	375	-	-	-		-	-		-	
2.01.10 Traditional medicine and informal care and treatment services	384	384	-	384	-	-	-		-	-		-	
2.01.98 Outpatient care services not disaggregated by intervention	-	-	-	-	-	-	-		-	-		-	
2.01.99 Outpatient Care services not elsewhere classified	-	-	-	-	-	-	-		-	-		-	
2.02 In-patient care	227.665	3.920	-	3.920	-	-	-	-	-	-	-	-	-

2.02.01 Inpatient treatment of opportunistic infections (OI)	227.665	227.665	-	227.665	-	-	-		-	-		-	
2.02.02 Inpatient palliative care	-	-	-	-	-	-	-		-	-		-	
2.02.98 Inpatient care services not disaggregated by intervention	-	-	-	-	-	-	-		-	-		-	
2.02.99 In-patient services not elsewhere classified	-	-	-	-	-	-	-		-	-		-	
2.03 Patient transport and emergency rescue	-	-	-	-	-	-	-		-	-			
2.98 Care and treatment services not disaggregated by intervention	-	-	-	-	-	-	-		-	-			
2.99 Care and treatment services not-elsewhere classified	3.773.827	122.421	-	122.421	3.651.406	-	-		-	3.651.406	3.651.406		
3. Orphans and Vulnerable Children (sub-total)	**27.249**	**19.791**	**-**	**19.791**	**7.458**	**7.458**	**-**	**-**	**7.458**	**-**	**-**	**-**	**-**
3.01 OVC Education	2.131	-	-	-	2.131	2.131	-		2.131	-		-	
3.02 OVC Basic health care	-	-	-	-	-	-	-		-	-		-	
3.03 OVC Family/home support	-	-	-	-	-	-	-		-	-		-	

3.04 OVC Community support	19.791	19.791	-	19.791	-	-	-		-	-		-	
3.05 OVC Social services and Administrative costs	-	-	-	-	-	-	-		-	-		-	
3.06 OVC Institutional Care	5.327	-	-	-	5.327	5.327	-		5.327	-		-	
3.98 OVC services not disaggregated by intervention	-	-	-	-	-	-	-		-	-		-	
3.99 OVC services not-elsewhere classified	-	-	-	-	-	-	-		-	-		-	
4. Program Management and Administration Strengthening (sub-total)	**16.073.220**	**3.375.269**	**1.308.901**	**2.066.368**	**12.697.951**	**7.501.569**	**7.245.257**	**11.100**	**245.212**	**5.196.382**	**2.951.145**	**2.204.929**	**40.307**
4.01 Planning, coordination and programme management	2.522.348	1.480.461	322.424	1.158.036	1.041.888	693.284	602.143	5.100	86.041	348.604	121.829	212.438	14.337
4.02 Administration and transaction costs associated with managing and disbursing funds	987.762	372.546	340.933	31.613	615.216	592.324	523.517		68.807	22.892		1.672	21.220
4.03 Monitoring and evaluation	4.479.416	585.421	306.569	278.852	3.893.996	3.309.304	3.276.290		33.014	584.691	85.357	499.334	
4.04 Operations research	101.384	101.384	50.244	51.140	-	-	-		-	-		-	

4.05 Serological-surveillance (Serosurveillance)	770.323	151.744	15.763	135.982	618.579	6.970	970	6.000	-	611.609		611.609	
4.06 HIV drug-resistance surveillance	340	340	-	340	-	-	-		-	-		-	
4.07 Drug supply systems	7.499	7.499	-	7.499	-	-	-		-	-		-	
4.08 Information technology	232.726	123.350	45.175	78.175	109.376	109.376	109.376		-	-		-	
4.09 Patient tracking	234.149	28.030	-	28.030	206.119	206.119	206.119		-	-		-	
4.10 Upgrading and construction of infrastructure	467.698	21.109	-	21.109	446.589	441.839	441.839		-	4.750		-	4.750
4.11 Mandatory HIV testing (not VCT)	-	-	-	-	-	-	-		-	-		-	
4.98 Program Management and Administration Strengthening not disaggregated by type	3.348.176	256	256	-	3.347.921	928.663	871.313		57.350	2.419.258	1.539.382	879.876	
4.99 Program Management and Administration Strengthening not-elsewhere classified	2.921.398	503.130	227.538	275.593	2.418.268	1.213.691	1.213.691		-	1.204.577	1.204.577	-	
5. Human resources (sub-total)	**10.644.870**	**1.252.748**	**367.147**	**885.601**	**9.392.122**	7.405.065	7.363.284	-	**41.781**	1.987.058	194.000	1.671.282	121.776
5.01 Monetary incentives for human resources	6.656.053	539.662	788	538.874	6.116.391	6.011.036	6.011.036		-	105.355		-	105.355
5.02 Formative education to	34.281	34.281	-	34.281	-	-	-		-	-		-	

build-up an HIV workforce													
5.03 Training	3.742.539	662.938	366.359	296.579	3.079.601	1.391.898	1.352.248		39.650	1.687.703		1.671.282	16.421
5.98 Incentives for Human Resources not specified by kind	196.131	-	-	-	196.131	2.131	-		2.131	194.000	194.000	-	
5.99 Incentives for Human Resources not elsewhere classified	15.867	15.867	-	15.867	-	-	-		-	-		-	
6. Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)	**1.133.268**	**1.127.268**	**1.039.810**	**87.458**	**6.000**	6.000	-	-	**6.000**	-	-	-	-
6.01 Social protection through monetary benefits	1.072.885	1.066.885	984.465	82.421	6.000	6.000	-		6.000	-		-	
6.02 Social protection through in-kind benefits	639	639	-	639	-	-	-		-	-		-	
6.03 Social protection through provision of social services	3.120	3.120	-	3.120	-	-	-		-	-		-	
6.04 HIV-specific income generation projects	1.278	1.278	-	1.278	-	-	-		-	-		-	

6.98 Social protection services and social services not disaggregated by type	55.346	55.346	55.346	-	-	-	-		-	-		-	
6.99 Social protection services and social services not elsewhere classified	-	-	-	-	-	-	-		-	-		-	
7. Enabling Environment (sub-total)	**2.601.913**	**843.867**	**243.041**	**600.826**	**1.758.046**	1.728.510	1.519.506	-	**209.004**	29.536	-	-	29.536
7.01 Advocacy	768.365	677.614	164.839	512.775	90.751	70.919	-		70.919	19.832		-	19.832
7.02 Human rights programmes	97.232	51.352	51.352	-	45.880	36.176	-		36.176	9.704		-	9.704
7.03 AIDS-specific institutional development	28.468	3.468	-	3.468	25.000	25.000	-		25.000	-		-	
7.04 AIDS-specific programmes focused on women	97.893	83.091	26.850	56.241	14.802	14.802	14.802		-	-		-	
7.05 Programmes to reduce Gender Based Violence	3.196	-	-	-	3.196	3.196	-		3.196	-		-	
7.98 Enabling Environment and Community Development not disaggregated by type	1.578.417	-	-	-	1.578.417	1.578.417	1.504.704		73.713	-		-	

7.99 Enabling Environment and Community Development not elsewhere classified	28.342	28.342	-	28.342	-	-	-		-	-		-	
8. Research (sub-total)	**1.340.176**	**82.543**	**60.613**	**21.930**	**1.257.633**	231.535	119.535	44.000	**68.000**	1.026.098	970.000	56.098	-
8.01 Biomedical research	-	-	-	-	-	-	-		-	-		-	
8.02 Clinical research	-	-	-	-	-	-	-		-	-		-	
8.03 Epidemiological research	72.071	-	-	-	72.071	15.973	15.973		-	56.098		56.098	
8.04 Social science research	239.593	68.031	60.613	7.417	171.563	171.563	103.563		68.000	-		-	
8.05 Vaccine-related research	-	-	-	-	-	-	-		-	-		-	
8.98 Research not disaggregated by type	970.000	-	-	-	970.000	-	-		-	970.000	970.000	-	
8.99 Research not elsewhere classified	58.512	14.512	-	14.512	44.000	44.000	-	44.000	-	-		-	

Annex 4. List of GARP Indicators Reported by Indonesia, 2014

Target 1.Reduce sexual transmission of HIV by 50 per cent by 2015			
	Indicator	**GARPR 2013**	**GARPR 2014**
1.1	Young People: Knowledge about HIV Prevention*	**14.3%**	**N/A**
1.2	Sex Before the Age of 15	**0.28%**	**N/A**
1.3	Multiple sexual partners	**0.33%**	**N/A**
1.4	Condom Use During Higher-RiskSex	**-**	**N/A**
1.5	HIV Testing in the General Population	**N/A**	**N/A**
1.6	Percentage of young people aged 15–24 who are living with HIV	**N/A**	**N/A**
1.7	Sex Workers: Prevention programmes	**18.5%**	**N/A**
1.8	Sex Workers: Condom Use		**N/A**
1.9	Sex Workers: HIV Testing	**67.1%**	**N/A**
1.10	Sex Workers: HIV Prevalence	**9.0%**	**N/A**
1.11	Men who have sex with men: Prevention programmes	**23.4%**	**N/A**
1.12	Men who have sex with men: condom use	**60.0%**	**N/A**
1.13	Men who have sex with men: HIV Testing	**64.5%**	**N/A**
1.14	Men who have sex with men: HIV Prevalence	**8.5%**	**N/A**
1.16	HIV Testing in 15+ (from programme records)		
	Number of women and men aged 15 and older who received HIV testing and counselling in the past 12 months and know their results	**886,825**	**1,042,550**
	HIV+ out of number tested	**21,511**	**29,037**
	Number of pregnant women aged 15 and older who received testing and counselling in the past 12 months and received their results	**42,276**	**100,718**
1.16.1	Rapid test kit stock-outs		**N/A**
1.17.1	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis	**0.1%**	**0.5%**

1.17.2	Percentage of antenatal care attendees who were positive for syphilis	**6%**	**1%**
1.17.3	Percentage of antenatal care attendees positive for syphilis who received treatment	Not reported last year	**49.6%**
1.17.4	Percentage of sex workers with active syphilis	**7.9%**	**6.8%**
1.17.5	Percentage of men who have sex with men with active syphilis	**21.9%**	**19.9%**
1.17.6	Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 months	Data not requested in 2013	**8,348**
1.17.7	Number of reported congenital syphilis cases (live births and stillbirth) in the past 12 months		**N/A**
1.17.8	Number of men reported with gonorrhoea in the past 12 months		**5,930**
1.17.9	Number of men reported with urethral discharge in the past 12 months		**10,574**
1.17.10	Number of adults reported with genital ulcer disease in the past 12 months		**1,952**

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

	Indicator	GARPR 2013	GARPR 2014
2.1	People who inject drugs: Number of needles/IDU	**21**	**26**
2.2	People who inject drugs: Condom Use	**51.6%**	**N/A**
2.3	People who inject drugs: Safe Injecting Practices	**87.0%**	**N/A**
2.4	People who inject drugs: HIV Testing	**90.6%**	**N/A**
2.5	People who inject drugs: HIV Prevalence	**36.4%**	**N/A**
2.6b	People on opioid substitution therapy	**5,332**	**5,329**
2.7	NSP and OST sites	**83 OST** **194 NSP**	**87 OST** **215 NSP**

Indicators on Condom use, Safe injecting practices, HIV Testing and HIV Prevalence are not reported this year.

The IBBS among MARPs at the same sites will be conducted in 2014

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

	Indicator	GARPR 2013	GARPR 2014
3.1	Percentage of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission	**21.6%**	**27.0%**
3.1a	Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period	**-**	**N/A**
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	N/A	**7.3%**
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	**34.2%**	**34.3%**

3.4	Pregnant women who were tested for HIV and received their results	**42,276**	**100,718**
3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	N/A	N/A
3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	N/A	N/A
3.7	Percentage of infants born to HIV-infected women provided with ARV prophylaxis to reduce the risk of early mother-to-child-transmission in the first 6 weeks	N/A	**62%**
3.9	Percentage of infants born to HIV-infected women started on co-trimoxazole (CTX) prophylaxis within two months of birth	Not reported last year	**27%**
3.10	Distribution of feeding practices for infants born to HIV-infected women at DPT3 visit, Exclusive breastfeeding, Mixed feeding/other and Uncategorized/other	**-**	N/A
3.11	Number of pregnant women attending ANC at least once during the reporting period	**5,015,535**	**5,046,521**
	Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015		
	Indicator	**GARPR 2013**	**GARPR 2014**
4.1	ART coverage (adults and children)*, including number of eligible adults and children who are currently receiving antiretroviral therapy during the reporting period (2013)	**31,002** Current estimate of eligible PLHIV: **71,470** at CD4<200 based on 2008 modelling	**39,418** Current estimate of eligible PLHIV: **201,184** at CD4<350 based on 2012 modelling
4.2a	HIV Treatment: 12 months retention	**66.2%**	Data currently being validated with HIV services
4.2b	HIV Treatment: 24 months retention	**61.9%**	Data currently being validated with HIV services
4.2c	HIV Treatment: 60 months retention	**44.3%**	Data currently being validated with HIV services
4.3.a	Health facilities that offer antiretroviral therapy	**338 (284 public + 54 private)**	**446 (384 public+62 private)**
4.3b.	Health facilities that offer paediatric antiretroviral therapy	New indicator	**98 (85 public + 13 private)**
4.4	ARV stock-outs	**1%**	0%
	Number of adults and children enrolled in HIV care at the end of the reporting period	**16,332**	**141,360**
	Number of adults and children newly enrolled in HIV care during the reporting period	**-**	**23,017**

4.7	Percentage (%) Percentage of people on ART tested for viral load who have a suppressed viral load in the reporting period	-	N/A
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015			
	Indicator	**GARPR 2013**	**GARPR 2014**
5.1.	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	**4,209** Current estimation of total TB incidence among PLHIV 27,939 with 15% based on national 2012 Stop Global TB report and 2009 size estimation of KAPs	**4,602** Current estimation of total TB incidence among PLHIV 49,348 with 7.5% based on national 2013 Stop Global TB Report and 2012 size estimation of KAPs
5.2	Percentage of people living with HIV (PLHIV) newly enrolled in care who are detected having active TB disease		**22%**
5.3	Percentage of adults and children newly enrolled in HIV care (starting isoniazid preventive therapy (IPT)	N/A	N/A
5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	**92.2%**	**84%**
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries			
	Indicator	**2011**	**2012**
6.1	AIDS Spending - Domestic and international AIDS spending by categories and financing sources	**USD**	**USD**
	Total spending	**69,146,880**	**87,002,694**
	Public (domestic) sources	**27,779,280**	**36,851,918**
	International sources	**41,367,600**	**50,150,779**
Target 7: Eliminate gender inequalities			
	Indicator	**GARPR 2013**	**GARPR 2014**
7.1	Prevalence of Recent Intimate Partner Violence (IPV)	-	-
Target 8: Eliminate stigma and discrimination			
	Indicator	**GARPR 2013**	**GARPR 2014**
8.1	Discriminatory attitudes towards people living with HIV	-	-
Target 10: Strengthen HIV integration			
	Indicator	**GARPR 2013**	**GARPR 2014**
10.1	Orphans and non-orphans school attendance* (previously 7.3)	**87.2%**	N/A
10.2	Economic support for eligible households (previously 7.4)	**70%**	73.60%

Annex 5. List of Documents Consulted

'Barriers, Challenges & Good Practices in Delivering Antiretroviral Treatment'. HIV Working Group, Padjadjaran University, Bandung, 2013

'Concept Note for NASAP 2015-19 Development,' NAC (Draft, Nov. 2013)

'Estimates and Projections of HIV/AIDS in Indonesia,' MoH, (Draft, 2014)

'Hasil FGD DinKes Tangerang' *(Report on the Results of the FGD, Tangerang Health Office)*, Ministry of Health, NAC, 2014.

'IBBS 2011: Integrated Biological and Behavioural Survey,' MoH, 2011

'IBBS among Populations at Risk 2013,' MoH (Draft, Jan. 2014)

'Integrated Biological & Behavioural Surveillance (IBBS) in General Population in Tanah Papua, 2013,' MoH (Draft, Jan. 2014)

'Joint Assessment of National MSM and TG People Program, Indonesia' NAC, UNAIDS, WHO, UNICEF, AusAID, 2013

'Laporan Hasil FGD di Kota Pontianak' *(Report on the Results of the FGD in Pontianak City),* Ministry of Health, NAC, 2014.

'Making Lokalisasi Safer: A Review of Interventions in 5 Locations,' Steen, R./WHO (Draft, Nov. 2013)

'Mid-Term Review of the National AIDS Strategy and Action Plan 2010-2014: Preliminary Report.' NAC, 2013

'National AIDS Spending Assessment 2011-2012,' NAC, 2013

'Pemulihan Adiksi Berbasis Masyarakat; suatu pilihan terapi pemulihan adiksi bagi Pengguna Napza Suntik,' NAC (Draft, Mar. 2014)

'Republic of Indonesia Country Report on the Follow up to the Declaration of Commitment on HIV/AIDS (UNGASS), Reporting Period 2011-2011,' NAC, 2012

'Result Focused Technical Support and Capacity Building; Assessment & Coordinated and Integrated Plan,' NAC/Swasti (Draft, June 2013)

'Summary of discussions for NASAP Mid-Term Review,' NAC File Note, 2013

'Synthesis Report on Key Institutional and Coordination Challenges at District and Provincial Levels,' NAC (Draft, Sept. 2013)

'The 3rd Joint Assessment of the National HIV M&E System in Indonesia 2013,' NAC, 2014

'Young Key Affected Populations and their Access to HIV Services: A Formative Assessment in Nine Locations in Indonesia', Ministry of Health, UNICEF. 2013

'2011 UN General Assembly Political Declaration on HIV/AIDS: Mid-Term Review Report of the "Ten Targets" in Indonesia, NAC, 2013

'2012 Size Estimation of Key Affected Populations (KAPs),' MoH, 2013

[1] IBBS among the General Population in Tanah Papua 2013 (MoH, draft results)
[2] Estimates and Projections of HIV and AIDS in Indonesia, MoH (draft, 2014)
[3] Mid-term Review of the National AIDS Strategy and Action Plan 2010-2014 (NAC 2013)
[4] IBBS among Key Affected Populations 2011 (MoH 2011)
[5] Estimates and Projections of HIV and AIDS in Indonesia, MoH (draft, 2014)
[6] Ibid
[7] This population includes former sex workers; partners of clients, PWID and MSM; as well as partners of former clients, former PWID and former MSM.
[8] Mid-term Review of the National AIDS Strategy and Action Plan 2010-2014 (NAC 2013)
[9] IBBS among the General Population in Tanah Papua 2013 (MoH, draft results); Results of the IBBS 2006 in Tanah Papua (MoH/BPS 2007)
[10] Ibid
[11] MoH, referenced in MTR NASAP Mid-Term Review of the NASAP 2010-2014 (NAC 2013), and programme data.
[12] IBBS 2011 (MoH 2011)
[13] Concept Note for NASAP 2015-19 Development (NAC 2013)
[14] Estimates and Projection of HIV/AIDS in Indonesia Year 2011-2016 (MoH 2013)
[15] IBBS among the General Population in Tanah Papua 2013 (MoH, draft results)
[16] Mid-term Review of the NASAP 2010-2014 (NAC 2013)
[17] Estimates and Projections of HIV and AIDS in Indonesia, MoH (draft, 2014)
[18] Mid-term Review of the NASAP 2010-2014 (NAC 2013)
[19] IBBS among Key Affected Populations 2013 (MoH, draft results)
[20] Focus Group Discussions key stakeholders in Tangerang and Pontianak, January 2014. IBBS Team, Ministry of Health.
[21] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[22] Ibid
[23] Women who are infected through sex with an infected partner who typically engages in high risk behavior, and/or women who may have engaged in high risk behaviour in previous years.
[24] Estimates and Projections of HIV and AIDS in Indonesia, MoH (draft, 2014)
[25] IBBS among the General Population in Tanah Papua 2013 (MoH, draft results)
[26] IBBS among the General Population in Tanah Papua 2013 (MoH, draft results), Mid-term Review of the NASAP 2010-2014 (NAC 2013)
[27] Steen, R. Making Lokalisasi Safer: A review of interventions in 5 locations, WHO, 2013. See also Chapter 4 of this report.
[28] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[29] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[30] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[31] Joint Assessment of National MSM and TG People Program, Indonesia, (NAC, UNAIDS, WHO, UNICEF, AusAID, 2013).
[32] Ibid
[33] Ibid
[34] Program data, June 2013, in Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[35] Young Key Affected Populations and their Access to HIV Services: A Formative Assessment in Nine Locations in Indonesia, Ministry of Health, UNICEF.
[36] IBBS among Key Affected Populations 2013 (MoH, draft results)
[37] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[38] Focus Group Discussions key stakeholders in Tangerang and Pontianak, January 2014. IBBS Team, Ministry of Health.
[39] Ibid
[40] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[41] Focus Group Discussions key stakeholders in Tangerang and Pontianak, January 2014. IBBS Team, Ministry of Health.
[42] Ibid
[43] National Commitments and Policy Instrument 2014
[44] Ibid
[45] Barriers, Challenges & Good Practices in Delivering Antiretroviral Treatment. HIV Working Group, Padjadjaran University, Bandung, 2013.
[46] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[47] National Commitments and Policy Instrument 2014
[48] Barriers, Challenges & Good Practices in Delivering Antiretroviral Treatment. HIV Working Group, Padjadjaran University, Bandung, 2013
[49] Presidential Regulation No. 76/2012
[50] Comprehensive knowledge among prisoners was 12%: IBBS 2011 (MoH 2011).
[51] MoH Rapid Study on HIV comprehensive knowledge in 5 cities in 5 provinces 2011
[52] Steen, R. Making Lokalisasi Safer: A review of interventions in 5 locations, WHO, 2013.

[53] Specifically, Law 27/2009, which provides for drug users to be sentenced to state rehabilitation centres rather than narcotics detention centres.
[54] HIV Cooperation Program for Indonesia Annual Survey among Harm Reduction Program Participants in Seven Provinces (NAC, HCPI-AusAID, 2011)
[55] Focus Group Discussions with key stakeholders in Tangerang and Pontianak, January 2014. IBBS Team, Ministry of Health.
[56] Ibid
[57] Young Key Affected Populations and their Access to HIV Services: A Formative Assessment in Nine Locations in Indonesia, Ministry of Health, UNICEF
[58] Focus Group Discussions with key stakeholders in Tangerang and Pontianak, January 2014. IBBS Team, Ministry of Health
[59] Ibid.
[60] National Commitments and Policy Instrument 2014
[61] Ibid
[62] http://www.thejakartaglobe.com/news/surabaya-shut-dolly-mid-june/; http://www.thejakartapost.com/news/2014/06/10/red-light-district-raided-jembrana.html; http://www.republika.co.id/berita/nasional/daerah/14/06/15/n76taa-banjarbaru-siap-tiru-surabaya-tangani-prostitusi
[63] Pemulihan Adiksi Berbasis Masyarakat; suatu pilihan terapi pemulihan adiksi bagi Pengguna Napza Suntik, NAC (Draft, March 2014)
[64] Rojanapithatykorn W, Jana S, Steen R. Interventions with sex workers: from the 100% condom-use programme to community empowerment. In: Three Decades of HIV/AIDS in Asia. Narain JP (Ed). New Delhi: Sage publications; New Delhi, (2012), as quoted in Steen, R. Making Lokalisasi Safer: A review of interventions in 5 locations, WHO, 2013.
[65] Pencegahan HIV Melalui Transmisi Seksual
[66] Steen, R. Making Lokalisasi Safer: A review of interventions in 5 locations, WHO, 2013.
[67] National AIDS Spending Assessment 2011-2012
[68] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[69] National AIDS Spending Assessment 2011-2012
[70] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[71] Ibid
[72] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[73] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[74] Ibid
[75] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[76] Synthesis Report on Key Institutional and Coordination Challenges for Coordination of the HIV Response at the District and Provincial Levels in Indonesia (NAC 2013)
[77] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[78] Synthesis Report on Key Institutional and Coordination Challenges for Coordination of the HIV Response at the District and Provincial Levels in Indonesia (NAC 2013)
[79] Ibid
[80] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[81] Local office of the National Development Planning Agency (Bappenas)
[82] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[83] Ibid
[84] Ibid
[85] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[86] An IBBS conducted in different sites indicated a significant increase in HIV prevalence among PWID from 27% in 2009 to 39.5% in 2013.
[87] IBBS among Key Affected Populations 2013 (MoH, draft results)
[88] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[89] Ibid
[90] Estimates and Projections of HIV and AIDS in Indonesia, MoH (draft, 2014)
[91] Ibid
[92] Mid-Term Review Report of the 'Ten Targets' in Indonesia (NAC 2013)
[93] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[94] Ibid
[95] Mid-Term Review Report of the 'Ten Targets' in Indonesia (2013)
[96] Ibid
[97] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[98] National AIDS Spending Assessment 2011-2012
[99] Ibid
[100] Ibid

[101] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[102] National AIDS Spending Assessment 2011-2012
[103] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[104] NASA 2011-2012
[105] Joint United Nations Support Program and Work Plan for 2012-2015
[106] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[107] NASA 2011-2012
[108] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[109] Summary of discussions for NASAP Mid-Term Review (NAC File Note, 2013)
[110] Result focused Technical Support and Capacity Building. Assessment & a Coordinated and Integrated Plan: Phase II HIV Grant, Indonesia (NAC/Swasti 2013)
[111] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[112] Mid-Term Review of the NASAP 2010-2014 (NAC 2013)
[113] The 3rd Joint Assessment of the National HIV M&E System (NAC 2014)
[114] *Institutional Analysis of HIV Control Program in Indonesia.* For Indonesia National AIDS Commission and HIV Cooperation Program for Indonesia, Jakarta, 15 May 2013. Peter Heywood and Meiwita Budiharsana, as quoted in Mid-Term Review of the NASAP 2010-2014 (NAC 2013): PAC and DAC secretariats "use very little information or feedback in making annual program plans. This limits the performance of NAC/PAC/DAC Secretariat at all levels"