FOREWORD

It is with pleasure and pride that I present this National HIV and AIDS Strategy and Action Plan 2010 – 2014, as a continuation and improvement of the previous National Strategy and Action Plan. This document contains a comprehensive set of strategies and prioritized activities and is in line with Indonesia's Mid-Term National Development Plan 2010 – 2014.

Prior to developing this document, a Mid-Term Review was conducted to evaluate the implementation of the National HIV and AIDS Action Plan 2007 – 2010. Important findings from this review, as well as the policy guidance from the Mid-Term National Development Plan 2010 – 2014 were used by representatives of both government and non-government groups to develop strategies and plans for future implementation. This document will serve as a reference for all actors involved in the implementation of a well focused, intensive, and comprehensive response to HIV and AIDS aiming to achieve the Millennium Development Goal Number 6 : "by 2015 to halt and begin to reverse the spread of HIV and AIDS". With hard work and commitment, we will prevent 1.2 million new HIV infections in Indonesia by the year 2025.

Nonetheless, as with other plans, however well they are made, targets will not be achieved without good leadership and governance. For this reason, I would like to remind us all that Presidential Regulation No. 75/ 2006 and Ministerial Regulation No. 20/ 2007 from Ministry of Home Affairs assign to the National AIDS Commission and AIDS Commissions at the provincial and district level respectively the responsibility to “lead, manage, regulate, monitor and evaluate the implementation of HIV and AIDS responses” at every level of government.

I thank the Drafting Team for their hard work and our national and international partners for providing comments, all of which have contributed greatly to the development of the National AIDS Strategy and Action Plan 2010 – 2014

May All Mighty God bless all of our efforts to save this nation from the worst ravages of the AIDS epidemic.

Coordinating Minister for People’s Welfare – Republic of Indonesia/
Chairperson of the National AIDS Commission

Agung Laksono

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ACRONYMS AND ABBREVIATIONS

ART or ARV	Antiretroviral Therapy or Antiretroviral
AusAID	Australia Agency for International Development
BAPPENAS	National Development Planning Agency
BCC	Behavior Change Communication
BPS	Central Statistics Bureau
BSS	Behavioral Surveillance Survey
CDC	Communicable Disease Centres
CST	Care, Support and Treatment
DAC	District AIDS Commission
FSW	Female Sex Workers
GF	Global Fund for AIDS, TB, and Malaria
HIV	Human Immune Deficiency Virus
IBBS MARP	Integrated Bio-Behavioral Surveillance in Most at Risk Populations
IEC	Information, Education, Communication
IDU	Injecting Drug Use/ User
IPF	Indonesia Partnership Fund for AIDS
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MMT	Methadone Maintenance Therapy
MoH	Ministry of Health
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NGO	Non-Government Organization
NSP	Needle/Syringe Program
OI	Opportunistic Infection
PAC	Provincial AIDS Commission
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV
PSM	Procurement Supply Management
STI	Sexually Transmitted Infections
SOP	Standard Operational Procedure
TB	Tuberculosis

UNAIDS	Joint United Nations Program on HIV and AIDS
UNGASS (AIDS)	United Nations General Assembly Special Session (AIDS)
USAID	US Agency for International Development
VCT	Voluntary Counseling and Testing
Waria	Indonesian term for transgender people

TERMINOLOGY

Geographic Focus: Priority areas were established in order to ensure that program implementation reach as many people of the key populations as possible. Three main criteria were used to select the geographic areas: (i) HIV transmission risk, (ii) HIV and AIDS disease burden, and (iii) the province's ability to implement an effective AIDS response. The risk of HIV transmission is measured by calculating the total number of people among key populations, particularly the number of injecting drug users and sex workers; while the disease burden is measured against the total number of PLHIV. The ability of the province to implement an effective response to AIDS is measured by institutional management capacity as well as capacity building for implementation of work at field level

Structural Intervention: Interventions related to physical structure/ environment, social condition of the society, economic, political and cultural condition, as well as the law and regulations to increase the efficiency of the response to HIV and AIDS. These interventions are directed towards establishing a wider and more conducive environment to ensure optimum response to and effectiveness of HIV program implementation. The interventions may include revising non-supportive policies; promotion/ creation of a social/ community order that is more supportive to issues related to HIV and AIDS, the key populations, condom use, and reduction of stigma and discrimination.

Civil Society: Groups of community members (aside from family relatives, friends, and co-workers) with similar interests who gather voluntarily to express their ideas and beliefs and to work for their achievement. The term "civil society" does not refer to either the private sector or to government. The United Nations has defined civil society as being made up of mass organization (such as agricultural, women, or retired workers organizations), labor unions, professional organizations; organizations of social activists, indigenous peoples, religious and other faith-based groups, academics and mutual support self-help groups. It is important for the civil society to take an active role in the response to HIV and AIDS.

Impact Mitigation: Impact mitigation is part of the effort to reduce the negative impact of the epidemic particularly for people infected and affected by HIV and who are often living lives which are disadvantaged both socially and economically. Certain social security mechanisms for disadvantaged people have already been established by the government, as well as numerous efforts carried out by non-government institutions. In this Strategy and Action Plan, impact mitigation is included because review of work under the former Action Plan found that there is still room for improvement in this area. By including Impact Mitigation in this Action Plan, related sectors, such as Ministry of Social Affairs, are reminded to carry out special programs to ensure access for those affected and infected by HIV and in need of improved social security, protection, and support.

Prevention of HIV infection resulting from Sexual Transmission: This comprehensive accelerated program was developed in 2008, following localized success of earlier programs and in response to observation of persistent high STI prevalence and low condom use over the years in Indonesia. There are four main components in this comprehensive program: behavior change communication, stakeholders' capacity building, supply management for condoms and lubricants, and STI treatment in community health centres, along with intensive monitoring of all components and evaluation of behavior change. While the main goal of this effort is to reach and influence female sex workers and their clients, the new aspect of this program as contrasted with former approaches is the addition of structural interventions and involvement/ mobilization of the whole community.

Key Population: Key populations determine the success of prevention and treatment for their own benefit as well as for other people. It is because of this, that it is important that people of key populations participate actively in the response to HIV and AIDS. Among key populations are people at elevated risk of infection: (1) People vulnerable to HIV infection, due to unprotected sex as well as those sharing contaminated injecting equipment; (2) People vulnerable to HIV infection due to their line of work and/ or their environment, such as migrant workers, refugees, and young people at risk; and (3) people who are living with HIV (PLHIV).

Action Plan: The systematic and comprehensive response to HIV and AIDS in this Action Plan will be carried out in areas with the highest HIV prevalence and highest number of people of key populations. Specific structured programs will be planned and carried out to reach, work with, and serve all key populations. The Action Plan involves many different stakeholders at all levels, both government and the community, in order to achieve behavior change that will reduce transmission of HIV infection, so that individuals, families and community at large can live full and productive lives and both contribute to and enjoy the benefits of development.

Universal Access: Refers to all objectives of universal access related to prevention, care and treatment. For Indonesia, Universal Access in the National Strategy and Action Plan 2010 – 2014 refers to the main goal of the HIV and AIDS response: to ensure that at least 80% of people of key populations have access to prevention, care, support and treatment services. They need access to prevention programs to obtain information on how to prevent HIV transmission, assess risk, access condoms and clean needles, access voluntary counseling and testing (VCT), as well as services for STI treatment and other HIV-related care, support and treatment. PLHIV, on the other hand, need access to ARV therapy, treatment for opportunistic infections, as well as access to meet other needs related to care and support. It is hoped that by improving access to effective prevention and treatment programs utilization of the services will increase and 60% of all key populations will practice safe behavior.

Coverage: The term coverage refers to the number of people of key populations reached in a given period of time by effective programs.

Direct Sex Worker: A person, male or female, selling sex as an occupation or main source of income. Direct Sex Workers may be either street based or based in a brothel or other fixed location.

Indirect Sex Worker: A person, male or female, working in the entertainment business, such as in bars, karaoke centres, beauty salons or massage parlors, who to increase their income also sell sex. It should be noted that not everyone working in these places sells sex.

Informed Consent: Agreement for an action to be carried out which is given by a person after they have received adequate information to make an informed decision.

High Risk Sex: Unprotected sexual intercourse which has the risk of infection with any sexually transmitted infection including the possibility of HIV infection. Sexual intercourse is considered high risk if performed without a condom if the partner's status is unknown, when one of the people engaging in the intercourse is HIV positive, or is in the HIV infection window period. Both reducing the number of sexual partners and consistent condom use (either male or female condoms) can reduce the risk of HIV infection.

EXECUTIVE SUMMARY

Introduction: This Strategy and Action Plan (2010-2014) was developed as a reference for all partners in the response to HIV and AIDS -- government, non-government, as well as international partners. At the national level, the Action Plan will be used as a tool to integrate HIV issues into national development plans, as well as serving as reference for government departments to develop more AIDS-related technical strategies. At the regional level, it serves to inform development of local AIDS Action Plans, which will serve, in turn, as the basis of local budget development. This document will also be used as an instrument to mobilize funds at the national and international levels.

The AIDS epidemic and response: In general, the epidemic in Indonesia is a concentrated epidemic. Integrated bio-behavioral surveillance on HIV and the behavior of key populations (2007) yielded the following HIV prevalence levels: 10.4% among Direct Sex Workers; 4.6% among Indirect Sex Workers; 24.4% among *Waria*; 0.8% among Clients of Female Sex Workers; 5.2% among MSM; and 52.4% among Injecting Drug Users. As contrasted with the rest of the country, in the provinces of Papua and West Papua (together known as Tanah Papua), there is a generalized epidemic with 2.4% HIV prevalence among the general population age 15-49 years[1]. In order to tailor the response to the epidemic it is important to monitor trends in HIV transmission in all settings. For example, overall nationally, transmission of HIV infection is rising among MSM.

Presidential Regulation No 75/ 2006 indicated the scaling up of Indonesia's response to AIDS. The regulation expanded and diversified the membership of the National AIDS Commission to include civil society. The Presidential Regulation designates the Coordinating Minister for People's Welfare as chair of the National AIDS Commission under and directly responsible to the President and stipulates that the AIDS Commission is to have a full time secretary. In 2006, National AIDS Commission began strengthening AIDS Commissions in 100 priority districts/cities. In 2007 this effort was expanded to cover all of Indonesia's 33 provinces.

Policy development also facilitated the development of more prevention, care, support and treatment services. Although program coverage has increased, there is still a big gap between existing coverage and achievement of universal access targets. With increasing support from both National and local budgets as well as from international partners, for example Global Fund Round 8 (2009 - 2014), universal access targets will be achieved, although not until sometime after 2010.

Challenges remain in some programs, as seen in the small increase in condom use among people of key populations from 2002 to 2007. On the other hand progress is seen related to equipment sharing among injecting drug users: fewer injecting drug users are sharing injecting equipment in 2007 than in 2004. Likewise, the impact of ARV Therapy is significant and positive with AIDS related deaths declining from 46% in 2006 to 17% in 2008.

The ratio of domestic funding to external funding for the response to AIDS shows strengthening of domestic support rising from 22% in 2004 to 51% in 2008. In 2006, the total HIV and AIDS budget was IDR 105 billion. By 2008 it had reached IDR 542 billion.

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[1] **Central Bureau of Statistics & Ministry of Health,** Risk Behavior and HIV Prevalence in Tanah Papua (data collection 2006, publication 2007), Jakarta.

Some of the challenges faced are: inadequate program coverage and effectiveness to assure achievement of universal access; uncertainty related to program sustainability; weak health and community service systems; the need to improve good governance in all sectors; as well as the need to establish more a conducive environment for effective implementation of the full range of HIV and AIDS programs and services.

The Strategy of the Response to HIV and AIDS: It is the strategy to: prevent and reduce the risk of HIV transmission; to improve the quality of life of PLHIV; and to reduce the social and economic impact of HIV and AIDS among individuals, families, and the community at large thus enabling and ensuring their full participation as valuable, productive members of society. It is the plan of the Strategy that by 2014 eighty percent (80%) of key populations will be reached through effective programs and 60% of them will engage in safe behavior. To achieve that target, the following strategies will be followed:

- Expand and scale-up the coverage of all prevention efforts.
- Expand and scale-up availability of care, support and treatment services, as well as impact mitigation.
- Strengthen partnerships as well as health service and community systems.
- Increase coordination among stakeholders and effective use of resources at all levels.
- Improve and expand utilization of structural interventions.
- Implement evidence-informed program planning, priority setting, and implementation.

Action Plan Framework (areas of work and geographic focus): The program framework is structured around 4 areas 1) prevention; 2) care, support and treatment; 3) impact mitigation programs; and 4) promotion of establishment of conducive environments for program implementation.

Geographic Focus: Based on a process which included calculating the risk of transmission of HIV, HIV and AIDS burden, and the condition/ quality of the present AIDS response -- 137 districts or 31% of all districts in Indonesia's 33 provinces were selected. With the current geographic focus, it is expected that activities will reach 94% of injecting drug users (205,860 people); 92% of female sex workers (203,000 people); and 85% PLHIV (164,000 people).

Implementation of Action Plan: Implementation of the Action Plan will be promoted through strong leadership mechanisms, coordination, partnership, active involvement of community groups, as well as resource mobilization and it will follow principles of good governance.

Resource needs and mobilization: Resource calculations have been made related to human and financial resources. Human resources for the response to HIV and AIDS include field staff (peer educators, outreach workers, program supervisors, and program managers); personnel at service sites (counselors, specialists, general practitioners, laboratory technicians, nurses, administrative staff, nutritionists, midwives, and case managers); and management personnel at the district level (program managers, monitoring and evaluation staff, finance administrators, and secretaries). Staff needs have been calculated. Human resource mobilization will be conducted and will include recruitment, information and skills building, and provision of technical assistance.

Funding needed to carry out the 2010-2014 Action Plan is estimated to be IDR 10.3 trillion, or US$ 1.1 billion. The funds will be used among the four main work areas mentioned above: 1) prevention (57%); 2) care, support and treatment (28%); 3) impact mitigation (2%); 4) establishment of conducive environments (13%). Activities will be focused on

effective program implementation in the 137 districts/ cities where 80% of the key populations are located.

Monitoring and evaluation: There are three main indicators which will be used in monitoring the AIDS response: coverage, effectiveness and sustainability.

Coverage: It is expected that by the end of 2014 program coverage will reach at least 80% of all key populations. Eighty percent of prison inmates and injecting drug users will already be reached by 2011. Eighty percent of female sex workers will be reached by 2012 and 80% of MSM and clients of sex workers by 2014.

Effectiveness: By 2014, it is hoped 60% of people among the key populations will be using condoms consistently, 60% of injecting drug users will not be sharing injecting equipment and 60% of PLHIV needing ARV will receive regular ARV treatment.

Sustainability: It is hope that by the end of 2014 adequate funding will be available for the response to HIV and AIDS with 70% coming from domestic sources. Availability of program funding is a key indicator of program sustainability.

Conclusion: This National AIDS Strategy and Action Plan (2010-2014) has been produced in the context of an established and on-going planning cycle. Implementation of the Action Plan will be reviewed periodically through mid-term and annual reviews. Findings from these reviews will be used to improve the program and the content of plan.

Chapter 1: Introduction

1.1. Background

Responding to the escalating number of new HIV infections reported since the year 2000, Presidential Regulation No. 75/2006 was issued to intensify the AIDS response in Indonesia.

The AIDS epidemic in Indonesia is one of the fastest growing in Asia[2]. The Ministry of Health estimates that without increased efforts to expand and strengthen prevention, treatment, care and support services across the country, Indonesia will have almost twice the number of people living with HIV and AIDS in 2014 as compared to 2008, rising from an estimated 227,700 to 501,400.

Mounting an effective and comprehensive HIV and AIDS response in Indonesia requires a combination of efforts -- strategic approaches, tackling of structural factors as well as mobilization of a wide range of partners in government, civil society, and the private sector. The geographic and socio-economic challenges are many in this country. Indonesia, the world's fourth most populous nation, is spread over 17,000 islands. It is governed in a decentralized system divided into 33 provinces which are again divided into a total of 500 districts. HIV infection has now been reported more than 200 districts and in all 33 provinces. As the AIDS epidemic is a global challenge and one of the most complicated issues of our time, successfully controlling HIV and AIDS in Indonesia will benefit not only Indonesia but will also be a contribution to the global response to the epidemic.

The 2010-2014 National AIDS Strategy and Action Plan is a continuation of the National Strategy and Action Plan for HIV and AIDS in Indonesia 2007-2010 and was developed based on this background. It will serve as a reference document for all partners in the national response -- national government, regional governments, civil society, private sector, all implementing partners, and communities -- to develop their respective HIV and AIDS strategies and Action Plans. At the national level, the Action Plan will be used as the basic for mainstreaming HIV into national planning documents. These, in turn, will be basic reference for government departments in developing their respective strategies responding to AIDS, as well as for local governments (provincial and district) in developing their Action Plans and budgets. This document will also provide reference for broader resource mobilization at all levels.

1.2. Rationale

Since 2007, when the previous Strategy and Action Plan were issued, there have been many developments in Indonesia's response to HIV and AIDS. Aside from developments in the response, new data have also become available. Findings of the Integrated Bio Behavioral Surveillance in Tanah Papua confirmed that HIV prevalence among general population aged 15 - 49 in had reached 2.4%[3]. IBBS among Most at Risk Populations in 2007 showed that STI prevalence in Indonesia is high, while condom use remains low[4]. National AIDS Commission

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[2] **UNAIDS** (2008). Report of global AIDS epidemic 2008.

[3] **Central Bureau of Statistics & Ministry of Health,** *Risk Behavior and HIV Prevalence in Tanah Papua* (data collection 2006, publication 2007), Jakarta.

[4] **Ministry of Health & Central Bureau of Statistics,** *Integrated Biological and Behavior Surveillance (IBBS) Most at Risk Population in Indonesia* 2007, Jakarta.

monitoring data also shows increased program coverage, although not all targets are achieved yet. These findings, along with program data from implementing partners in the National response are sufficient to evaluate the progress of program implementation against the growth of the AIDS epidemic in Indonesia. A national mid-term review of the 2007-2010 National Strategy and Action Plan was carried out in 2009.

At the same time, in 2009 there were various important developments in government -- a national general election took place which led to formation of a new cabinet including a new Coordinating Minister for People's Welfare as Chair of the National AIDS Commission and development of Indonesia's national mid-term development plan (2010-2014) These changes necessitated acceleration of the process for formulation of a new National AIDS Strategy and Action Plan 2010-2014 even though reporting on mid-term evaluation of the previous National Strategy and Action Plan was not yet complete. The result of these factors was that the final year of National Action Plan (2007-2010) became first year of the new Strategy and Action Plan (2010-2014).

1.3. Development of Indonesia's National AIDS Strategy and Action Plan 2010-2014

The process of developing the new National Strategy and Action Plan ran from March to September 2009 as follows:

March: A meeting of the Planning and Budgeting Forum of BAPPENAS (National Planning Board) discussed the integration of the response to HIV and AIDS into Indonesia's National Mid Term Developmental Plan for 2010 – 2014. The meeting also suggested development of a new National Strategy and Action Plan for HIV and AIDS with the same time frame as the National Mid-Term Developmental Plan 2010 – 2014. Since then, the Technical Team for Planning and Budgeting of the National AIDS Commission has conducted numerous meetings.

May: The technical team began by collecting data from implementing partners (working on response to HIV) and carried out the Mid-Term Review of the implementation of National Action Plan 2007 – 2010 (MTR), the findings of which were used as the basis for development of the National Strategy and Action Plan for 2010 – 2014.

July The Secretary of the National AIDS Commission presented the main policies of the National Strategy and Action Plan 2010-2014 to a meeting of the BAPPENAS Planning and Budgeting Forum.

August Initial findings from Mid-Term Review were presented in August 2009 to stakeholders who volunteered to be members of the drafting team for the 2010-2014 National Strategy and Action Plan. The team proceeded to assemble the materials and develop policies and framework for the new Strategy and Action Plan.

September The first draft was completed by early September and circulated for comments and input from government and civil society stakeholders, as well as from international development partners. Subsequently, the final draft of National Strategy 2010 – 2014 also received input from international peer reviewers before presentation to and authorization by the Chairman of

National AIDS Commission\ Coordinating Minister for People's Welfare.

Responsibility for development and writing of the National Strategy and Action Plan rested with the Secretary of the National AIDS Commission. Two teams worked with the Secretary on this task: a Steering Committee and a Drafting Team. The Steering Committee was chaired by NAC Secretary assisted by two Vice Chairs: the Deputy Minister of People's Welfare (office of the Coordinating Minister of People's Welfare) and the Director General of Communicable Diseases Control & Environmental Health (Ministry of Health). Members of the Steering Committee include representatives from the National Development Planning Agency (BAPPENAS); the Ministries of Religious Affairs; Law and Human Rights; Tourism and Culture; National Education; Manpower and Transmigration; Transportation; Youth and Sport; Social Affairs; the State Ministry of Women Empowerment; State Ministry of Research and Technology; the Police Force of Republic of Indonesia; the Institute of Development of Technology (BPPT), the National Narcotics Board; the Indonesian Chamber of Commerce; the Cabinet Secretary; and the National Network of PLHIV (JOTHI);

Members of the drafting team, 50% of whom were from government and 50% from civil society, were drawn from the secretariat of the National AIDS Commission; AIDS Activists; the National Development Planning Agency (BAPPENAS); the Ministry of Health; the National Network of PLHIV (JOTHI); Spiritia; the National Networks of Women with HIV (IPPI); HIV Cooperation Program for Indonesia (HCPI); Family Health International (FHI); Yayasan Pelita Ilmu (YPI); the Provincial AIDS Commission of Jakarta; the Ministry of Law and Human Rights; the Ministry of Social Affairs; UNAIDS; Indonesian Community Care for AIDS (MPAI) and the National Network for Gay-Waria-MSM (GWL INA).

Chapter 2: The Epidemic and the Response to HIV and AIDS

2.1. The AIDS epidemic globally and in Indonesia

2.1.1. Global Epidemic Status

Globally, since the first case of AIDS was identified in 1981, an estimated 60 million people have been infected with HIV and 25 million have died because of AIDS. Currently, there are about 35 million people living with HIV. It is estimated that 7,400 new HIV infections occur each day. In 2007, there were 2.7 million new HIV infections and 2 million people died of AIDS-related causes[5].

At the end of 2007 an estimated 4.9 million people had been infected with HIV in Asia. Of this total, 440,000 were people with new HIV infections, 300,000 had already died. Although modes of HIV transmission vary across Asia, the epidemic is generally driven by (i) sexual intercourse with an HIV infected partner and without the use of a condom (ii) sharing of contaminated needles/ syringes.

2.1.2. Status of the Epidemic in Indonesia

Since the first case of AIDS was reported in Indonesia in Bali (1987), the number of cases increased steadily reaching a total of 225 in 2000. Since then reported cases of AIDS have increased rapidly driven by injecting drug use. By 2006, 8,194 AIDS cases had been reported. By the end of June 2009 that total had climbed to 17,699 with 15,608 of them (88%) people of productive age (15 - 49 years).

Since the year 2000, HIV prevalence has been consistently over 5% in several key populations such as injecting drug users, sex workers, transgenders (*waria)*, and MSM leading to classification of the epidemic in Indonesia as a concentrated epidemic. Specifically, Integrated Bio Behavioral Surveillance on HIV (IBBS) carried out by the Ministry of Health and the Central Bureau of Statistics in 2007 among key populations, found HIV prevalence as follows: Direct Sex Workers 10.4%; Indirect Sex Workers 4.6%; *Waria* 24.4 %; Clients of Sex Workers 0.8%[6]; MSM 5.2%; and Injecting Drug Users 52.4%.

In the two provinces of Papua and West Papua, the epidemic, driven almost completely by unsafe sexual intercourse, is categorized as a low-level generalized epidemic with HIV prevalence of 2.4% among 15-49 year-olds in the general population[7].

In 2006 it was estimated that there were 193,000 adults living with HIV in Indonesia, 21% of whom were women. By 2009 the estimated number of PLHIV increased to 333,200, 25% of whom were women. These figures show a feminization of the AIDS epidemic in Indonesia.

As described above, the distribution and variation of HIV infection across Indonesia is seen in the map below:

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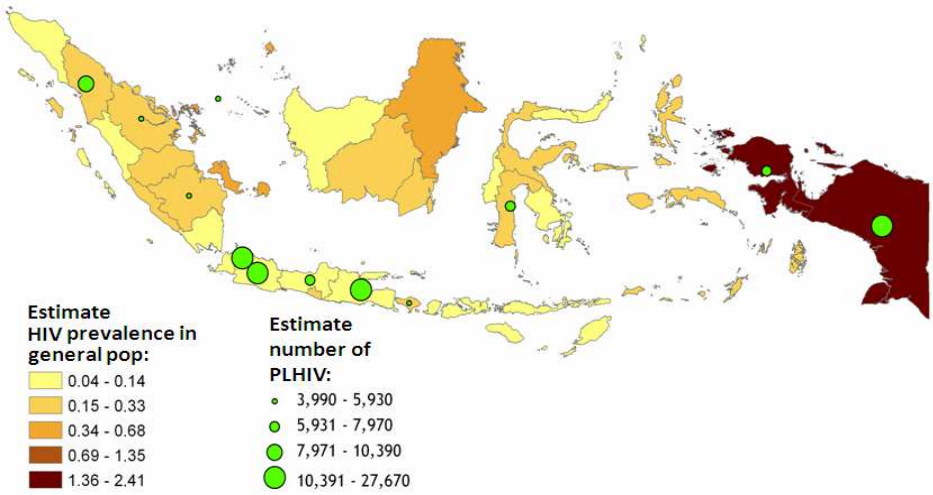
[5] **UNAIDS**, Report on the Global AIDS Epidemic, 2008.

[6] Data from survey conducted in 6 cities among clients of sex workers including truck drivers, ship crews, longshoremen and motor taxi drivers with prevalence ranging between 0.2% to 1.8%

[7] **Central Bureau of Statistics & Ministry of Health,** Risk Behavior and HIV Prevalence in Tanah Papua (data collection 2006, publication 2007), Jakarta.

Picture 2.1: Map of AIDS epidemic in Indonesia

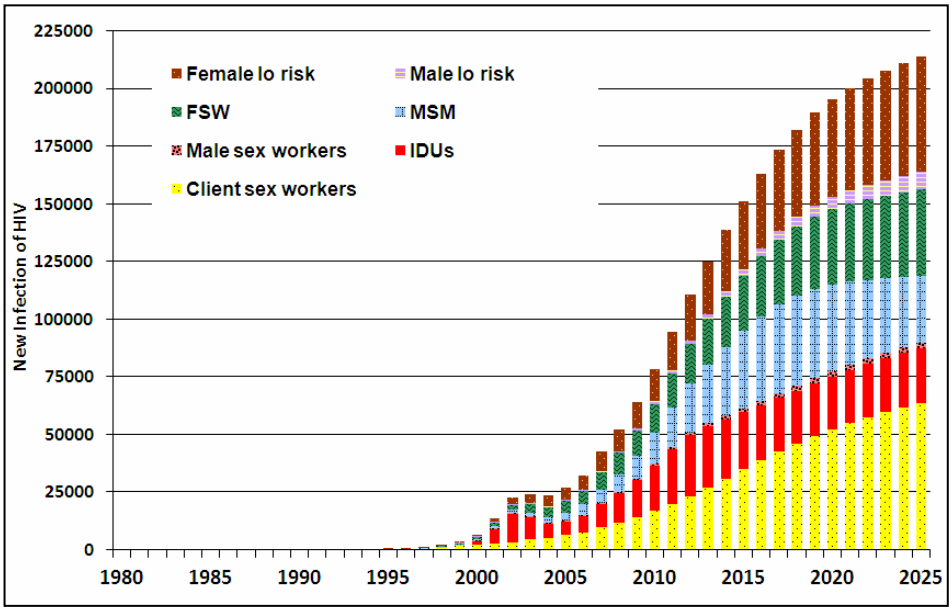


The map above shows variations in estimated HIV prevalence across Indonesia. With the exception of Tanah Papua, the AIDS epidemic in Indonesia is concentrated among people in the key populations, with a prevalence > 5%. In the two provinces of Papua and West Papua, on the other hand, the epidemic has prevalence ranging between 1.36% and 2.41% in the general population[8].

2.1.3. AIDS Epidemic in the Future

Trend analysis of the development of the AIDS epidemic in Indonesia provides a clear picture of the present pattern of infection and projected course of the epidemic in future.

Picture 2.2: HIV Trends in Indonesia



This modeling is based on demographic, behavioral, and epidemiological data of the respective populations to illustrate the distribution of infection.

[8] **Central Bureau of Statistics & Ministry of Health,** Risk Behavior and HIV Prevalence in Tanah Papua (data collection 2006, publication 2007), Jakarta.

Based on these projections it is expected that**:**

- HIV prevalence will increase from 0.22% (2008) to 0.37% (2014) among people aged 15-49.
- New HIV infections will increase among women leading to a rise in infections among children.
- There will be significant increase in the number of new HIV infections among MSM.
- Special attention is needed to the potential for an increase in HIV infections among sexual partners (intimate partners) of people of key populations.
- The number of PLHIV will rise from 371,800 (2010) to 541,700 (2014).
- The need for ART will increase from 50,400 (2010) to 86,800 (2014)[9]. This increase will be larger still if the CD4 criteria for prescription of ART rises, for example from a CD4 count of 200 to 350.

2.2. The Response to HIV and AIDS

2.2.1. The Evolution of the Response to AIDS in Indonesia

In 1987, the Ministry of Health established a National AIDS Committee, which was chaired by the Director General of Communicable Diseases Control and Environmental Health. In 1994, Presidential Decree No. 36/1994 was issued establishing AIDS Commissions at the national, provincial, and district level. The National AIDS Commission, Chaired by the Coordinating Minister of People's Welfare, produced a National AIDS Strategy and 5 year work plan covering the years 1994 to 1998. Based on this plan a number of international development partners supported Indonesia's response to HIV and AIDS. Thereafter a number of ministries issued instructions related to HIV prevention and control. For example the Minister of Education issued regulation 9/U/1997 on prevention of HIV and AIDS through education which was followed by regulation 303/U/1997 providing instructions for implementation of reg 9/U/1997.

In 2001, Indonesia signed the "Declaration of Commitment on AIDS" of the UN General Assembly Special Session on AIDS (UNGASS). In 2004, to scale-up the response to HIV and AIDS in Indonesia, the Sentani Commitment was signed by several ministers, governors and other senior officials -- Coordinating Minister for People's Welfare, Minister of Health, Minister of Home Affairs, Minister of Social Affairs, and Minister of Religious Affairs), the Chair of the National Family Planning Coordinating Body, the Chair of Commission IX of Parliament, and 6 governors/ representatives of Provincial Governments: Riau, Jakarta, West Java, East Java Bali and Papua, the six provinces then known to be most seriously affected by the growing epidemic. In 2003, the Ministry of Health developed a health sector Strategic Plan to guide the response to AIDS in the Health Sector. Other government sectors also began to develop AIDS-related policies and programs, as well. The Minister of Manpower and Transmigration issued a decree in 2004 to promote implementation of HIV and AIDS programs in workplace. The Ministry of Social Affairs and National Family Planning Coordinating Body each established an HIV and AIDS response unit.

In 2003, in response to rapid HIV transmission among injecting drug users, the Coordinating Minister for People's Welfare in his capacity as Chair of NAC and the Chief of the Indonesian Police Force in his capacity as Chair of National Narcotics Board signed a joint Memorandum

[9] Source for data on both PLHIV and ARV is **Ministry of Health.** Mathematic Model of AIDS epidemic in Indonesia, 2008-2014.

of Understanding related to drug uses. In 2003, to coordinate Indonesia's response to AIDS, the Coordinating Minister of People's Welfare developed the National AIDS Strategy for 2003–2007.

In 2006 Presidential Decree No. 75/2006 indicated a strengthening of Indonesia's response to HIV and AIDS. This Decree expanded and diversified the National AIDS Commission membership to include professionals and civil society including PLHIV. The Decree stated that the National AIDS Commission is chaired by the Coordinating Minister of People's Welfare, that the Commission reported directly to the President, and included full time, professional secretary. Strengthening of AIDS Commission Secretariats in 100 priority districts/ cities began in 2006, followed shortly thereafter by strengthening of AIDS Commission Secretariats in all of Indonesia's 33 provinces.

In 2007, at the end of the 2003-2007 Strategy and Work Plan, a new Strategy and National Action Plan was released for the period 2007-2010. In the same year (2007) three additional important policies were put in place: 1) the Coordinating Minister of People's Welfare issued Regulation No 2/2007 on harm reduction among injecting drug users; 2) the Minister of Home Affairs issued Regulation No 20/2007 on the establishment of AIDS Commissions and empowerment of local communities; 3) and the Ministry of Justice and Human Rights issued their policy on the response to HIV and AIDS in prisons. In 2008, the Ministry of Home Affairs issued guidelines on local level budgeting for the response to HIV and AIDS.

In 2009, the National AIDS Commission issued a guideline on effective, comprehensive programming to prevent sexual transmission of HIV infection. Various relevant regulations and policies were also issued at the provincial and district level for scaling up of prevention, care, support and treatment services as well as providing enabling environments for delivery of such services. The development of these supportive policies promoted the development of a range of important services related to prevention, care, support, and treatment.

2.2.2. Development of Program Coverage and Effectiveness

a. Development of Program Coverage

1) Harm Reduction Programs for Prevention of Infection through Injecting Equipment

People who inject drugs are encourage to participate in sterile needles/ syringes exchange programs (NSP) in order to reduce the risk of HIV infection. The NSP are available in both community settings and community health centres. This program has expanded from 17 sites in 2005 to 182 sites in 2008 (113 in community health centres and 69 run by NGOs). IBBS 2007 findings showed that more injecting drug users preferred needle/ syringe programs provided by NGOs, than those provided by the community health centres[10]. To improve access to NSP for people using injecting drugs it is important that service in community health centres is strengthened. By the end of 2008 forty-nine thousand (49,000) injecting drug users had utilized NSP services equaling 67% of the 2008 coverage target.

[10] **Ministry of Health & Central Bureau of Statistics,** Integrated Biological and Behavior Surveillance (IBBS) Most at Risk Population in Indonesia 2007, Jakarta.

2) Methadone Substitution Therapy Program

Methadone substitution therapy breaks the dependency of injecting drug users and behaviors associated with that dependency thus reducing HIV transmission resulting from the sharing of unsterile needles/ syringes. At the end of 2008, 46 methadone substitution therapy service sites were available: 27 in community health centres, 15 hospitals, and 4 prisons. By the end of 2008 a total of 2,711 people were using methadone substitution therapy. This was only 12% of the annual target (21,790 people) for that year.

3) Prison-based Program

Scaling up of prison-based HIV and AIDS programs has been underway since 2007. Policies supporting these programs include: National Strategy to Respond to HIV and AIDS and Drug Abuse in Prison and Detention Centres; Master Plan for System Strengthening and Provision of Clinical Services Related to HIV and AIDS in Prisons and Detention Centres; Technical Guideline for prison-based HIV and AIDS Care, Support and Treatment; SOP for Methadone Service in Prisons and Detention Centres; Circular Letter from Directorate General of Prisons on Monitoring and Evaluation of the response to HIV and AIDS in Prisons and Detention Centres.

In 2010, the Ministry of Law and Human Rights set a target of 96 prisons to implement comprehensive HIV and AIDS prevention programs. As of July 2009 15 prisons had the comprehensive program underway. 4,285 inmates had used VCT services. Four prisons also have methadone services which by the end of 2008 had been used by 1,079 inmates. Fifty three prisons collaborate with referral hospitals to provide inmates with services for ART, TB and opportunistic infections (OI). Prison based programs are implemented in collaboration with NGOs. There are currently 26 NGOs in 15 provinces that implement prison-based programs, including outreach activities for inmates.

Limits of funding and human resources for prison-based HIV and AIDS programs remain the main obstacles to implementation and expansion of the program. Support of Global Fund Round 8 will help to expand work to 82 prisons in 12 provinces. The program will include capacity building as well as collaboration with community organizations to improve provision to prisoners of services for prevention, treatment, care and support, counseling, and testing.

4) Prevention of Sexual Transmission Program

Prevention of HIV infection through sexual contact is carried out through condom promotion and provision of STI treatment services. In 2008, there were 245 service units available in community health centres, private clinics, corporate clinics, and community clinics. As of June 2008 condom promotion activities in various locations had reached 27,180 female sex workers; 403,030 clients of sex workers; 27,810 *waria*; 63,980 MSM and 50,420 injecting drug users[11]. DKT data of 2008 reported 15,000 condom outlets were operational and 20 million condoms had been distributed both for free and through commercial outlets. With funding support from GF Round 8, the National AIDS Commission is expanding number of locations using the structural interventions to HIV prevention (including condom outlets) from 12 (2009) to 36 locations (2014).

[11] **NAC**. Coverage Data, June 2008.

Prevention of HIV transmission through sexual contact is also promoted in the context of life skills education provided to adolescents in school settings and outside. Activities of this sort are particularly important in the provinces of Papua and West Papua where the AIDS epidemic is generalized. Initially focused in junior high schools (2004-2009), the education departments of Papua and West Papua are mainstreaming a more comprehensive, educational response to HIV and AIDS running for the four years 2010-2014. Activities will integrate HIV related information, education, and referral services to a broader range of both young people and educators across the two provinces.

5) Prevention of Mother to Child Transmission (PMTCT)

Indications are that transmission of HIV is likely to increase as the number of HIV positive women continues to increase. Although data on vertical transmission of HIV infection from mother to child is limited, the number of HIV positive women who are pregnant is increasing. It is projected that the number of women who need PMTCT support and services will increase from 5,730 (2010) to 8,170 (2014).

PMTCT has been implemented on a limited scale since 2007, particularly in areas with high HIV prevalence. By 2008, 30 PMTCT service units were already in place, integrated with existing Antenatal Care. Data from 2007 and through 2008 indicates that out of 5,167 pregnant women tested for HIV, 1,306 (25%) were HIV positive. However, of that number only 165 women (12.6%) received ARV prophylaxis. Several community organizations have also implemented PMTCT activities to increase coverage and utilization of PMTCT.

6) Voluntary Counseling and Testing

A crucial part of any HIV prevention effort is provision of HIV voluntary counseling and testing (VCT). It is hoped that all people of key populations and their partners will be tested so they know their HIV status. By the end of 2008, there were 547 VCT sites across Indonesia, provided by the both government (383 locations) and non government organizations (164 units by provided by private sector as well as community groups). In areas where HIV prevention programs and services are provided and well run, progressively more people are making use of VCT services. From 2004 to 2007, utilization of VCT by key populations has increased: 27% to 41% among Female Sex Workers; 6% to 10% among Clients of Sex Workers; from 47% to 64% among *waria*; from 19% to 37% among MSM; and from 18% to 41% among Injecting Drug Users[12].

7) Care, Support, and Treatment Program

In 2009, care, support, and treatment services were provided by 154 referral hospitals across Indonesia. It is estimated that a total of 27,770 PLHIV need ARV (10% of total estimated number of PLHIV). In June 2009, 12,493 PLHIV were receiving free ARV treatment (45% of those in need of ARV). The biggest impact of ARV utilization is the reduction in number of mortality among PLHIV, in Indonesia from 46% in 2006 to 17% in 2008.

The main opportunistic infections (OI) among PLHIVs are TB (41%), followed by chronic diarrhea (21%), and candidiasis (21%). These are the OIs that have been known to cause death among people with AIDS. Data for mortality among the prison population is as

[12] **Ministry of Health & Central Bureau of Statistics,** Integrated Biological and Behavior Surveillance (IBBS) Most at Risk Population in Indonesia 2007, Jakarta.

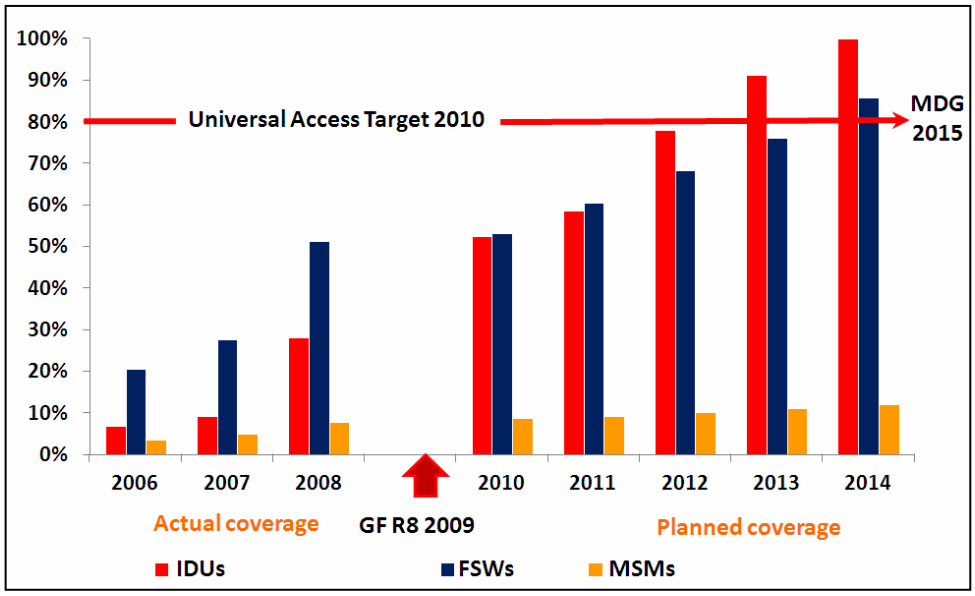
follows: 22.68 % are AIDS related deaths, 18.37% were caused by TB, while 6.19% were caused by Hepatitis[13].

8) Program coverage of key populations

Although program coverage has increased since 2006, there is still a big gap to achieve universal access targets.

Picture 3 illustrates the increase of program coverage from 2006 to 2008 and the coverage targets of the 2010-2014 period using funding from domestic sources and from GF Round 8. Even with these resources, there is still a big gap in MSM coverage due to fund limitations.

Picture 2.3 : Universal Access Targets for 2010 Compared to Coverage Achieved (2006-2008) and Coverage Planned (2010-2014)



Based on evaluation of implementation of specific earlier programs, several issues have been identified which need to be included in future work -- more collaboration is needed between government and civil society to reach people of key populations; involvement of community and civil society groups in program implementation needs to be increased.

b. Program Effectiveness

1) Prevention of Transmission through Injecting Equipment (Harm Reduction)

Harm reduction programs encourage injecting drug users to adopt healthy behavior, both pertaining to HIV infection and utilization of prevention and treatment services. Findings in the 2007 IBBS among most at risk populations show significant positive changes in behavior among injecting drug users including increased condom use, increased utilization of sterile injecting equipment and a significant decrease (5%-52%) in sharing of injecting equipment. Positive results were particularly noticeable in 4 cities: Surabaya, Jakarta, Medan, and Bandung.

Several factors contributed to this achievement : adoption of appropriate policies; creation of conducive environments which decriminalized injecting drug use; active involvement of

[13] **Ministry of Law and Human Rights**, Directorate General of Correctional Facilities, 2008.

injecting drug users in program design, implementation, and management; accessibility of health service units; and capacity building for drug users to increase awareness and to ensure their involvement in prevention programs. Comprehensive harm reduction programs have been implemented in many areas in Indonesia, particularly in areas with a large number of injecting drug users. In the future, prevention of HIV transmission through injecting equipment will continue to be expanded following the example of activity found to be effective.

2) Prevention of HIV through Sexual Transmission Program

Sexual transmission of HIV can be prevented effectively with the ABC approach (**A**bstinence, **B**e faithful, and **C**ondom use). Since 2002, condom use among key populations has not increased significantly. For example, condom use among female sex workers increased by only 2% every year, there is no increase of condom use among clients of sex workers, and condom use among *waria* and MSM has decreased. It is clear, that a more effective prevention program and Behavior Change Communication strategy is needed. The 2007 IBBS among most at risk populations found that consistent condom use among key populations was as follows: 35% among female sex workers; 40% among transgenders, 20% among MSM; 15% among clients of female sex workers; 30% among injecting drug users. There has been an encouraging and significant increase in condom use among injecting drug users, from 17% in 2004 to 30% in 2007.

Prevention of infection through use of condoms is not yet effective among female sex workers, clients of sex workers, *waria*, and MSM. There are various obstacles to be addressed: financial support from government related to condom supplies has been unpredictable; lack of adequate supporting policy in some areas; continuing rejection of condom for this purpose among some segments of the public; and still promotion of condom use on a broad scale.

3) Care and Treatment

Care and treatment programs are not yet effective enough: there are too many limitations in availability of service with the result that access for key populations including PLHIV is also too limited. Weaknesses in the logistics and supply systems related to ART also limit effectiveness of treatment programs. Greater leadership commitment is needed, as well as improved collaboration, coordination, and HIV-related skill training to overcome these challenges.

2.2.3. Progress toward Sustainability

Progress toward sustainability is reflected in the regulatory environment, institutional capacity and budget allocations.

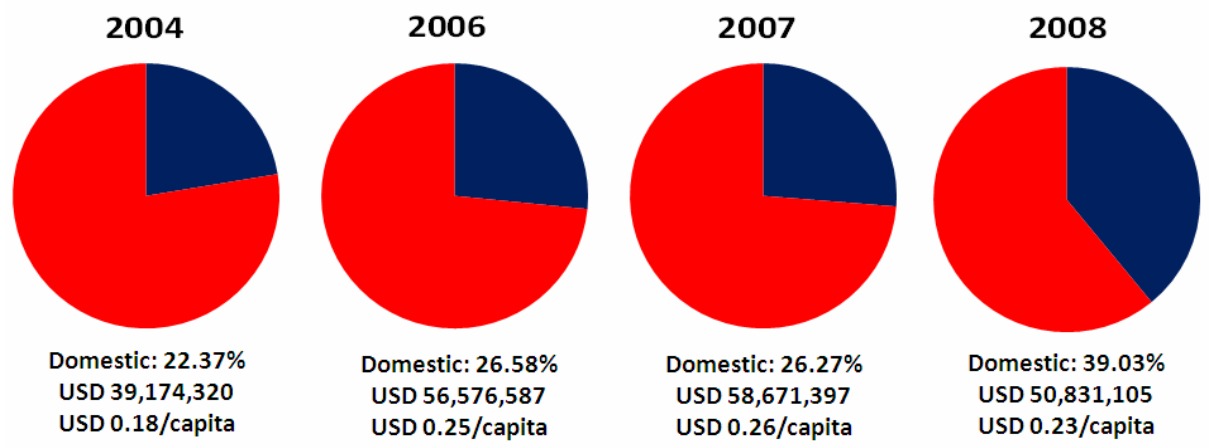
From the institutional perspective provincial and district AIDS Commissions are already active in all 33 provinces of Indonesia and 171 districts. All provincial AIDS Commissions are supported by decrees from their respective Governors. In 26 provinces the Provincial AIDS Commission have their own office space and in 29 they organize routine meetings with related government departments and other partners.

Despite funding short falls for program implementation in 2007-2009, there has been steady increase in availability of domestic budget for response to HIV and AIDS. Overall funding for the response in Indonesia comes from domestic sources, bilateral assistance (USAID, AusAID), Global Fund, and other development partners. Domestic government funding is

allocated through the national budget (APBN) and through local budgets at both provincial and district levels (APBD).

As seen in the diagram below, the proportion of domestic funding for the response to AIDS continues to increase as compared to funding from foreign donors:

Picture 2. 4. Financial Resources: Increase in Domestic Funding for AIDS



As seen above, there has been steady increase in domestic funding of AIDS programming compared to external funding, rising from 22% to 51% between 2004 and 2008. In 2006, Rp 105 billion was allocated. In 2008 the budget allocation increased to Rp 542 billion.

2.3. Challenges

The response to AIDS in Indonesia is entering a new phase. The rapidly changing socio-economic situation influences efforts to expand the response at all levels. Some emerging issues include:

1. At present, as a result of limited funding for program implementation, coverage is still inadequate to achieve Universal Access in all areas. This is true for prevention among various key populations (MSM, *waria*, injecting drug users, clients of female sex workers, migrant workers, and their respective intimate partners), as well as prevention of mother to child transmission as well as care, support, and treatment for PLHIV needing service, and for impact mitigation.
2. To ensure behavioral change, a minimum of 8 outreach contacts is needed each year per person. This requires more resources, both human and financial, before programs can meet these outreach standards and be implemented effectively.
3. For many reasons, consistent condom use is still low. A major factor is the absence of a conducive environment in some settings because of continuing opposition from some religious organizations and community groups. It is also difficult to reach and work effectively with male clients of sex workers

4. Program sustainability is uncertain.
   Resources, both human and financial, are not yet sufficiently reliable to ensure program sustainability. There are significant challenges in assuring availability of the resources needed to meet program targets at national, provincial, and district level. External support is unpredictable. Because of these concerns the National Strategy and Action Plan direct that attention be given to increased planning and mobilization of domestic resources.

5. Health service systems and community systems are weak.
   There is uneven capacity in health care and community systems. Health care systems need strengthening to effectively respond to HIV and AIDS -- for prevention, diagnosis, care and treatment, blood safety and full compliance with the practice of universal precautions. Likewise, community systems need to be strengthened. NGOs and other civil society partners need to increase their capacity for active participation in response to HIV and AIDS including work toward achievement of program targets especially in work with key population groups including people living with HIV.

6 The practice of good governance still needs Strengthening to ensure effective coordination among stakeholders, policy harmonization, effective and accountable management, sharing and utilization of strategic information, as well as more transparent program implementation, monitoring and evaluation.

5. More positive, enabling environments are needed for successful implementation of the comprehensive, inclusive response to HIV and AIDS by both government and civil society eliminating stigma and discrimination, gender inequities and violation of basic human rights.

Chapter 3: Strategies for Responding to HIV and AIDS

3.1. Direction of National Policy

Improvement in the quality of the lives and productivity of the Indonesian people is currently seriously threatened. This is shown by the high rate of HIV transmission. AIDS has been reported in all provinces across Indonesia, specifically in 214 districts/ cities with the real possibility that unless there are serious and effective interventions the number of infections will continue to increase. The AIDS epidemic is multidimensional having reached a concentrated level, with HIV prevalence is over 5% among several key population groups (female sex workers, injecting drug users, inmates, MSM). In the provinces of Papua and West Papua, on the other hand, the epidemic has already reached the general population with surveillance showing prevalence of 2.4% among the general population aged 15-49. An increase in the seriousness of the epidemic will clearly increase the social and economic burden carried by the people of Indonesia.

To address the epidemic effectively, the response needs to be more intensive, and comprehensive as well as better integrated and coordinated to strengthen coverage, effectiveness, and sustainability. The fundamental aim of national policy is to : I) Increase the coverage of prevention 2) increase availability of care, support and treatment; 3) reduce negative impact from the epidemic by improving access to social mitigation, as needed; 4) strengthen partnership, as well as health systems and community systems as related to HIV; 5) improve coordination and mobilization of financial resources; 6) increase application of structural interventions; 7) use an evidence-informed approach in planning, priority setting, and program implementation.

This strategy requires active involvement from both government and community (including those infected and affected by HIV) to ensure good program implementation, particularly for prevention, treatment, impact mitigation, and maintenance of conducive environments.

The health sector is very important in providing care, support and treatment for those infected, as well as providing necessary services related to prevention.

Prevention of drug abuse is closely related to the prevention of transmission through injection and has an important role to play in Indonesia's response to HIV and AIDS.

The defense and security sector has an important role in the response to HIV and AIDS in provision of adequate information and services to protect their own people whose work may place then at risk of HIV infection

Law enforcement systems are particularly important in supporting HIV prevention education as well as assuring access to necessary care, support, and treatment for those in prisons and detention centres.

Departments that oversee the labor force, transportation, public works and mining also have an important role strengthening the effectiveness of prevention efforts, protecting workers from risk of infection which might result of work-related high mobility or employment in environments which expose workers to high-risk of infection.

Departments responsible for education, youth, religion and family need to protect their members of their families from the risk of infection, promote education about HIV and AIDS, and work to reduce stigma and discrimination.

As appropriate to their respective mandates, departments and offices concerned with people’s welfare, home affairs, women empowerment, finance, developmental planning

and research play vital roles in advocating for and promoting the conducive environments needed for an effective response to the epidemic.

In addition to fulfilling their technical mandate as reflected in their tasks and duties, each sector is also responsible for protecting their employees and their families from HIV infection through awareness raising, prevention education and provision of service and/ or referrals, as needed.

The tourism sector should protect all people working in and enjoying services of the tourism industry, particularly those in settings which have the potential to contribute to spread of HIV infection.

National and global commitments related to HIV, including Millennium Development Goal 6[14] will be fulfilled if 80% of the most-at-risk population is reached by effective programs and at least 60% of the same population practice safe behavior. In this way they, themselves and others will be protected from HIV infection. Thus, it is hoped that, step by step the epidemic will be brought under control as new infections decline.

3.2. Principles and Background of Policies

In developing the strategies and programs for this Strategy and Action Plan, consideration has been given to laws, policies, and structural factors that influence and shape the evolving AIDS response in Indonesia. The main guiding principles are:

1. The HIV and AIDS response must consider religious and cultural values, societal norms, and be respectful of human pride and dignity, as well as giving due attention to justice and gender equality.
2. Responding to HIV and AIDS is a social and developmental issue; therefore action should be integrated into development programs at the national, provincial, and district level.
3. HIV and AIDS responses are carried out in a structured and integrated manner, involving all relevant stakeholders from government and civil society. Structural responses include promoting healthy life styles, prevention of disease, as well as care, support and treatment for people living with HIV and affected by AIDS.
4. The response to HIV and AIDS is carried out based on the principle of partnership between civil society, government, and international development partners.
5. In line with the principles of Greater Involvement of People Living with HIV or Affected by AIDS (GIPA)[15], people living with HIV and affected by AIDS have an active and meaningful role in HIV and AIDS response.
6. The aim of developing economic-productive support activity with and for PLHIV and people affected by HIV and AIDS is to empower them to maintain the quality of their lives with dignity and self respect.
7. Every effort will be made for laws and regulations to be supportive of and in accordance with the response to HIV and AIDS at all levels.

[14] to halt and begin to reverse the spread of HIV and AIDS. by 2015"

[15] Principles of GIPA included in final declaration of the Paris AIDS Summit, 1994.

3.3. Goal and Objectives

3.3.1. Goal

The goal of the National AIDS Strategy and Action Plan 2010-2014 is to prevent and reduce the transmission of HIV infection; improve the quality of life for people living with HIV; and to reduce the socio-economic impact of the AIDS epidemic on individuals, families, and society, while safeguarding Indonesia's productive and valuable human resources.

3.3.2. Objectives

1) Provide effective HIV prevention for all key populations and their partners, and to improve program effectiveness where needed;

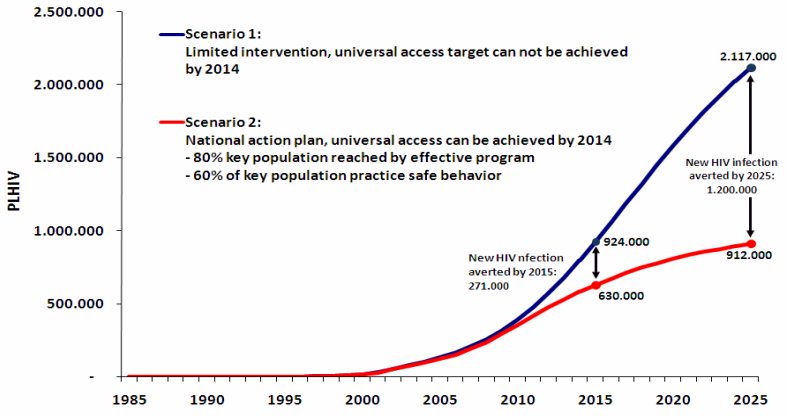
2) Provide quality care, support and treatment services that are accessible, affordable and client-friendly for all people living with HIV who need services;

3) Increase access to economic and social support for PLHIV, children and affected families who are living in hardship;

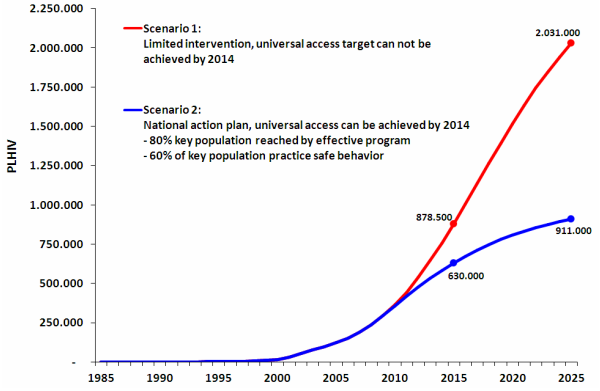
4) Create an enabling environment that promotes an effective response to HIV and AIDS at all levels, particularly one that empowers civil society to have a meaningful role and reduces stigma and discrimination towards people of key populations and all people living with HIV and affected by AIDS. This includes developing policies, program coordination, management, monitoring and evaluation, as well as monitoring of behavior and status of the epidemic and operational research.

Effective implementation of the 4 specific objectives mentioned above will make possible the successful coverage of 80% of key populations and behavior change among 60% of them. As seen below (graphs 3.1, 3.2 and 3.3), implementation of the National Action Plan will decrease the number of adults and children living with HIV and AIDS in Indonesia, in 31 provinces (graph 3.2) and in the 2 provinces of Papua and West Papua (graph 3.3).

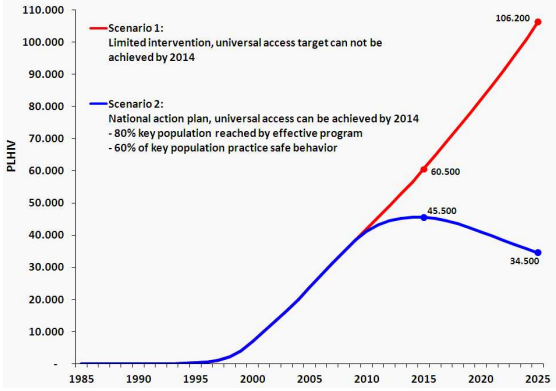
Graph 3.1. Projection of number of PLHIV in Indonesia: Scenario 1 and Scenario 2



Graph 3.2. Projection : PLHIV in 31 Provinces: Scen 1 and 2



Graph 3.3. Projection : PLHIV in Papua and West Papua Scen 1 and 2



3.3.3. Targets

If the Action Plan 2010-2014 is effectively carried out it is hoped that by 2015 294,000 new infections will have been avoided and if that level of effectiveness continues, 1,205,000 new infections will be avoided by 2025.

Indonesia has not yet achieved its Universal Access targets so efforts will be needed to accomplish them in the years to come. For this to happen, the following have been set as the targets of National Strategy and Action Plan 2010 -2014:

1) 80% of key populations are to be reached by comprehensive and effective prevention programs.

2) Behavioral change to prevent transmission of HIV infection will to be achieved including a) consistent and correct condom use in 60% of high risk sexual transactions and b) increase in use of sterile injection equipment to 60% of injecting drug users.

3) Comprehensive service will be available including assurance that all eligible PLHIV receive ARV treatment in a setting where they receive professional and humane, treatment, support, and care, provided without discrimination, and including provision of effective referrals as well as adequate guidance and case monitoring, as needed.

4) All HIV positive pregnant women and their children will receive ARV prophylaxis as appropriate.

5) Every person infected and/or affected by HIV, especially orphans and needy widows, will have access to and utilize social and economic support, as needed.

6) Enabling environments are established which empower civil society to have a meaningful role in the response to HIV and AIDS, and where stigma and discrimination towards PLHIV and people affected by HIV and AIDS are eradicated. Progress in this area will need to be measured by observing the degree to which the situation of positive people and other key populations has improved.

7) There are increases in government commitment to the national response and in budget allocations at all levels thus assuring an adequate, self reliant, and sustainable Indonesian response to HIV and AIDS.

To reach the necessary percentage of the key populations and achieve the universal access targets as listed above, Indonesia needs funding security and technical assistance so that programs can be accelerated and expanded in designated priority cities/ districts.

3.4. Strategies

The 2010-2014 National Strategy is a continuation of the 2007-2010 National Strategy. The new strategy was drawn up taking into account experience and results thus far. The new National Strategy and Action Plan aim to overcome obstacles previously encountered. They also make use of findings from the Mid-Term Review. The Strategy will be implemented in a coordinated manner by government and civil society, including community groups and peer support groups.

To achieve the targets and the scaling-up of prevention and treatment programs for key populations, the following strategies will be followed:

3.4.1. Scaling-up coverage of prevention

a. Prevention of HIV infection transmitted through use of contaminated needle/ syringe

Scaling-up of prevention efforts targeting injecting drug users and prison inmates will be conducted through comprehensive harm reduction activity including needle/ syringe exchange programs, methadone substitution therapy, referral to VCT services and health services for treatment of STIs, Hepatitis C and addiction recovery therapy.

b. Prevention of HIV through unsafe sexual contact

Scaling-up of prevention of sexual transmission of HIV infection will be carried out through promotion of condom use for all unsafe sexual contact and wide provision in easily accessible locations of treatment for sexually transmitted infections. These actions will contribute to slowing and ultimately reversing of the spread of HIV infection by reducing the number of unsafe sexual transactions and reducing STI prevalence, as well as reducing HIV prevalence among sex workers, clients of sex workers, injecting drug users, MSM, *waria*, PLHIV, and sex partners of key populations.

c. Development of comprehensive program for MSM

To increase MSM coverage which is still too low, a comprehensive program will be formulated and implemented with active participation of the MSM community.

d. Prevention of Mother to Child Transmission

Prevention of mother to child transmission (PMTCT) is need particularly in areas with high prevalence and areas where the epidemic is already generalized. The main objective of PMTCT is to increase significantly the number of pregnant women and their partners who test for HIV and to expand availability of PMTCT services by integrating them into existing mother and child health services.

3.4.2. Increase and expand care, support and treatment services

It is hope that increasing information about HIV and VCT within the community accompanied by expansion of VCT services and strengthening of collaboration between health care providers, NGOs and target groups will combine to increase utilization of service and result in achievement of the goal to provide HIV-related service including VCT to all who need them.

To meet the growing need for care and treatment related to HIV and AIDS (testing, ARV and treatment of opportunistic infections) the number and quality of health service facilities such as hospitals, community health centres, and other health care units will be gradually increased and quality of service improved during the period of this Action Plan.

At the same time, quality assurance related to care and treatment should be improved through (1) increasing the number and quality of health care providers to ensure professional, client-friendly services that meet the needs of PLHIV; (2) strengthening logistic support for essential medicines needed for HIV and AIDS related treatment; (3) strengthening the role of community-based health services to complement existing government health services

3.4.3. Reducing the negative impact of the epidemic, by improving access to and utilization of programs for impact mitigation

Provide opportunities for disadvantaged PLHIV and people affected by AIDS, orphans, single-parents, and widows to access income-generation, skills building, and other education programs to improve their self reliance and the quality of their lives.

3.4.4. Strengthening partnerships, health systems and community systems

Improving program performance requires collaboration between service providers and those needing and utilizing service. The roles and responsibilities of health and other sectors should also be clarified in order to provide better-coordinated service systems. To increase utilization of services, the services provided and their availability to meet the need of the community,

Health system strengthening is an important component in an effective HIV and AIDS response. This includes integration of HIV-related services to existing programs, for example the integration of services for STI treatment into existing reproductive health services; integration of PMTCT service into the Mother and Child Health programs; and provision of TB/ HIV service. Calculations for integration of management of HIV infection, VCT, and ARV therapy also need to be integrated into budgets for chronic disease management rather than having them as "stand alone" health services.

Other policies which will contribute to health system strengthening would be the inclusion of HIV and AIDS related services in Community Health Insurance schemes; strengthening human resource skill and motivation to provide high quality, patient-friendly service through training and incentive programs for health workers involved in HIV-related activity; strengthening of the health information system as well as infrastructure and logistic management to improve health outcomes; provision of support for PLHIV through community based care.

Community Systems Strengthening capacity building programs (for program implementation, management, and monitoring and evaluation) for all who are or should be involved in community based aspects of the response to HIV and AIDS. Resource mobilization for community based work is also crucial as well as full and active involvement of community groups including key populations and PLHIV in the overall response to the epidemic.

3.4.5. Increase coordination among stakeholders and resource mobilization at all levels

To produce the best outcomes, coordination among stakeholders including implementing partners should be increased at all levels.

Implementation of activity is to be guided by principles of good governance and supported by data and facts.

Scaling-up of the response to HIV and AIDS requires major funding which now comes from both domestic and foreign sources. Funding from foreign sources will be used for scaling-up of the response as well as strengthening of both health systems and community systems. Funding from domestic sources will focus on building sustainability of programs by integrating HIV and AIDS-related work in national and regional development plans and budgets (APBN and APBD, respectively. Mobilization of resources from the private sector and other community sources also need to increase.

3.4.6. Structural interventions

Structural interventions, including substantive involvement of key populations and the broader environment within which they live and work, are needed for all programs because experience shows program success depends both on the key populations themselves as well as creation of broader supportive environments for the response to AIDS. This approach includes decreasing stigma and discrimination, behavior change, and sustainability of program implementation. Achieving this requires political commitment, political support and on going attention of AIDS Commissions to the advocacy work which is part of their mandate.

This structural approach will be carried out including the following:

Increasing the active participation of community members (leaders and local residents) and other stakeholders for example the local AIDS Commission, a range of relevant government departments whose work can make positive contributions in responding to the epidemic -- particularly health, education, social, law, drug prevention, manpower, police force, empowerment of women, and family planning.

Systematic structural intervention will result in increasingly supportive local policy as well as encouraging active community roles in program implementation.

The term "structural intervention" includes attention to physical infrastructure, socio-cultural aspect of the community as well as policies that support coordination among government department which together will improve effectiveness of the implementation of the response to HIV and AIDS.

3.4.7. Evidence-Informed Planning, Prioritizing, and Program Implementation

In general, the AIDS epidemic in Indonesia is a concentrated epidemic though it varies greatly from one region to another. In the two provinces of Papua and Papua West it has spread the general public and the epidemic is classified as a low-level, generalized epidemic. The main modes of transmission of HIV infection are: (1) sexual transmission (particularly among sex workers, clients of sex workers and their partners, *waria*, and MSM), (2) sharing of contaminated injecting equipment, and (3) mother-to-child transmission.

In some parts of Indonesia, the epidemic is caused by transmission of infection through sharing of contaminated needles/ syringes among injecting drug users in the community and prison inmates. In other areas, the main mode of transmission is unprotected sex (sex workers, clients of sex workers, *waria*, MSM) and in the two provinces of Papua and West Papua the epidemic has spread into the general population.

Local application of this Strategy and Action Plan will take into account the differing epidemics, local situations, modes of transmission, socio-economic factors, as well as the nature and level of stigma and discrimination and any special community needs. These will include issues related to access to services for prevention and treatment as well as access to education, information and mitigation services.

Thus, priorities for Plan implementation will vary from place to place depending on the local situation. In areas with limited resources, programs will be prioritized to ensure that available resources are utilized effectively and complemented, as needed. Initial priority will be given to interventions which are known to be low cost but are effective and have high impact.

Chapter 4: Action Plan - Priority Areas and Geographic Focus

Indonesia's response to AIDS focuses on prevention programs for the populations which are most at risk and on strengthening of care, support and treatment services for people living with HIV (PLHIV). The response has been developed with the aim to achieve maximum effectiveness and high impact at low cost.

The main populations to be reached and served in prevention programs are: injecting drug users, sex workers, and men who have sex with men (MSM). Injecting drug users include those in prisons while female sex workers comprise both direct and indirect sex workers. Sub-populations that are linked to these are clients of sex workers, MSM, *waria*, and intimate partners of each key population group.

Projections show a significant increase in new HIV infections among MSM in the near future. This means that effective work with MSM will be important to reverse the rising trend of the of AIDS epidemic. Coverage and program targets will need to increase 3 to 8 times over before the transmission of HIV among MSM and their intimate partners can be contained.

To achieve Universal Access targets, the Action Plan covers the following focus areas:

1. Prevention: Behavior change among key populations to prevent transmission of HIV infection through contaminated injecting equipment and sexual transmission.
2. Care, support, and treatment : To be provided for all PLHIV including ARV treatment for those meeting the agreed upon criteria including CD4 count and basic health condition
3. Impact mitigation: Provision of social and economic support for PLHIV and those affected by HIV, as needed.
4. Establishment of a supportive environment: Attention will be given to reducing stigma and discrimination, increasing government commitment reflected in allocation of appropriate budgets as well as establishment of policies that support the response to HIV and AIDS.

4.1. Priority Areas

4.1.1. Prevention

The main focus for prevention is to expand and scale-up effective interventions to halt the rapid spread of HIV infection via sharing of contaminated needles/ syringes and via unprotected high-risk sexual intercourse.

The key populations to be reached are male and female injecting drug users, including those in prisons; indirect and direct sex workers; men who have sex with men; transgenders (*waria*) and sexual partners (intimate partners) of all among the key populations. Prevention programs will also reach out to young people (between 15-24 years old) who are vulnerable or at risk of HIV infection as well as to private and public sector employees, laborers, and migrant workers (who are recognized as potential clients of sex workers). In the two provinces of Papua and West Papua prevention programs will also reach out to the general population.

Of particular concern in the context of prevention is addressing the continuing high number of new HIV infection among men who have sex with men. Epidemiological trend analysis indicates that the number of new HIV infection among MSM will increase significantly in the

next few years. Program targets and outreach must be significantly raised (3 – 8 times), in order to control the spread of HIV both among the MSM population.

Priority interventions related to prevention will include:

a. Prevention of sexual transmission of HIV infection through structural intervention to increase condom use in every high risk sexual transaction.

b. In Papua and West Papua, prevention of sexual HIV transmission by increasing consistent condom use within the general population, while also providing life skills education/ safe sex education to young people both in school settings and outside in collaboration with religious organizations, community organizations, and community leaders.

c. Harm reduction programs with structural interventions in community and prison settings to prevent transmission of HIV infection resulting from the sharing of contaminated injecting equipment including treatment of drug addiction.

d. Prevention of mother to child transmission

Detailed description of these activities is in Attachment 2.

Aside from prevention programs listed above, other prevention activities such as promotion of the practice of Universal Precautions and blood safety will be carried out by the Ministry of Health while focused information campaigns through mass media will be conducted by NAC. Other government departments will carry out other prevention programs known to be effective as part of their respective core mandates.

4.1.2. Care, Support, and Treatment

In order to improve the quality of life and the health of people living with HIV as well as to slow progression from HIV to AIDS it is critical to ensure comprehensive and sustainable support for those who are HIV positive. For those whose CD 4 level meets the criteria for treatment, access to ARV therapy is essential. Meeting these needs will require development of optimal ARV procurement and distribution systems as well as a supportive environment that is gender-sensitive and free of stigma and discrimination towards people living with and seeking HIV-related treatment.

In order to achieve effective treatment and case management, community-based care programs for PLHIV and people affected by AIDS are needed which will provide psychological and social support from peer groups, family and communities. These efforts are needed alongside clinic-based interventions.

The main components of the care, support and treatment include:

a. Development of competent health service units and capacity strengthening, as needed across the country

b. Comprehensive programs for prevention and treatment of opportunistic infections and co-infections as well as periodic routine examinations and ARV treatment, as appropriate.

c. Provision of community-based care and support systems for PLHIV including provision of psychological, social, and economic support, in addition to the necessary health service support.

d. Training and education to empower PLHIV with information on treatment and treatment options so they can manage their own health effectively.

e. Activities to promote, support, and improve treatment adherence.

f. Increase in positive prevention by PLHIV.

4.1.3. Impact Mitigation

To reduce the negative socio-economic impact of HV and AIDS on PLHIV and their families, impact mitigation programs are provided for people who need and seek such support. Providing opportunities for education, health care, nutritional support and economic viability are the main components.

Impact mitigation is carried out in collaboration with Ministry of Social Affairs, Ministry of National Education, and with peer support groups. Criteria to determine the need for impact mitigation still need to be developed before appropriate activities can be identified and provided. This will include identifying coverage, funding needs, time period, and targets for the activities.

4.1.4. Conducive Environments

For the response to AIDS to be adequately led and coordinated across the 33 provinces of Indonesia, there must be adequate capacity for management including coordination at all levels. The AIDS Commissions at province and district level must be fully functional and have capacity to coordinate all stakeholders and partners from government and civil society effectively in their work on the response to HIV and AIDS. Likewise, many implementing partners need to improve their skill and capacity in line with their respective roles in responding to the epidemic. Capacity building is also necessary to ensure effective support for the building of conducive environments for implementation of the response to HIV and AIDS and for application of the principles of good governance, focusing on transparency and accountability.

Equally important is ensuring that policy gaps are addressed as they are identified and that policies are developed and implemented to support the comprehensive response to AIDS. Policy development is a key part of all structural interventions and must address the needs and involve a broad range of institutions and actors including civil society. Two crucial supporting activities are a) monitoring and evaluation and b) operational research to ensure availability of adequate information to assure effective program development.

4.2. Geographic Focusing

The National AIDS Strategy and Action Plan for 2010-2014 aims to scale-up priority interventions and services for key populations including people living with HIV and affected by AIDS. The identification of priority program sites where these activities will be carried out has been based on the following criteria:

1. **The risk of HIV transmission:** based on estimation of the size of key populations, particularly the number of IDUs (including prison inmates), sex workers and MSM.
2. **HIV and AIDS disease burden:** estimation of the number of people living with HIV.
3. **Existing response:** review of capacity building programs already conducted under GF Round 1 and Round 4, as well as the growth in capacity of local AIDS Commissions.

Based on these criteria, 137 districts were selected (31% of all districts in 33 provinces in Indonesia). Focusing on these districts, it is estimated that activity will reach 94% of

Injecting Drug Users (205,860 people); 92% of Female Sex Workers (203,300 people); and 85% of PLHIV (164,000 people). See annex 4 for the selected districts

Table 4.1.Priority Districts and Cities

No.	Provinsi		Kab.upaten/ Kota
1	NAD	1	Kota Banda Aceh
		2	Kab. Pidie
		3	Kab. Aceh Tenggara
		4	Kota Lokseumawe
2	Sumatera Utara	5	Kota Medan
		6	Kab. Deli Serdang
		7	Kab. Labuhan Batu
		8	Kab. Simalungun
3	Riau	9	Kota Pekanbaru
		10	Kab. Indragiri Hilir
		11	Kab. Bengkalis
		12	Kota Dumai
		13	Kab. Rokan Hilir
		14	Kab. Pelalawan
		15	Kab. Kampar
4	Kepulauan Riau	16	Kota Batam
		17	Kab. Karimun
		18	Kota Tanjung Pinang
5	Sumatera Barat	19	Kota Padang
		20	Kota Bukittinggi
		21	Kota Sawah Lunto
6	Jambi	22	Kota Jambi
		23	Kab. Tanjung Jabung Timur
		24	Kab. Bungo
		25	Kab. Kerinci
7	Bengkulu	26	Kota Bengkulu
		27	Kab. Rejang Lebong
		28	Kab. Bengkulu Utara
8	Sumatera Selatan	29	Kota Palembang
		30	Kab. Ogan Komering Ilir
		31	Kab. Prabumulih
		32	Kab. Banyuasin
9	Lampung	33	Kota Bandar Lampung
		34	Kab. Tulang Bawang
10	Bangka Belitung	35	Kota Pangkal Pinang
		36	Kab. Bangka
		37	Kab. Bangka Barat
11	DKI Jakarta	38	Kota Jakarta Selatan
		39	Kota Jakarta Pusat
		40	Kota Jakarta Barat
		41	Kota Jakarta Timur
		42	Kota Jakarta Utara
		43	Kab. Kepulauan Seribu
12	Banten	44	Kab. Tangerang
		45	Kota Tangerang
		46	Kota Serang
13	Jawa Barat	47	Kota Bandung
		48	Kota Bekasi
		49	Kota Bogor
		50	Kota Cirebon
		51	Kab. Cirebon
		52	Kab. Indramayu
		53	Kab. Karawang
		54	Kab. Bekasi
14	Jawa Tengah	55	Kota Semarang
		56	Kota Surakarta
		57	Kota Banyumas
		58	Kab. Semarang
		59	Kab. Cilacap
		60	Kab. Kendal
		61	Kab. Batang
		62	Kota Tegal
		63	Kota Kediri
		64	Kab. Kediri
		65	Kab. Blitar
15	D.I. Yogyakarta	66	Kota Yogyakarta
		67	Kab. Sleman
		68	Kab. Gunung Kidul
16	Jawa Timur	69	Kota Surabaya
		70	Kab. Banyuwangi
		71	Kab. Mojokerto
		72	Kab. Jember
		73	Kota Malang
		74	Kab. Sidoarjo
17	Bali	75	Kota Denpasar
		76	Kab. Badung
		77	Kab. Buleleng
		78	Kab. Bangli
18	Nusa Tenggara Barat	79	Kota Mataram
		80	Kab. Lombok Barat
		81	Kab. Lombok Timur
19	Nusa Tenggara Timur	82	Kota Kupang
		83	Kab. Belu
		84	Kab. Ngada
20	Kalimantan Barat	85	Kota Pontianak
		86	Kota Singkawang
21	Kalimantan Selatan	87	Kota Banjarmasin
		88	Kab. Tabalong
		89	Kab. Tanah Bumbu
22	Kalimantan Timur	90	Kota Samarinda
		91	Kota Balikpapan
		92	Kab. Kutai Kartanegara
		93	Kab. Kutai Timur
23	Kalimantan Tengah	94	Kota Palangka Raya
		95	Kab. Kotawaringin Barat
		96	Kab. Kotawaringin Timur
		97	Kab. Kapuas
24	Sulawesi Selatan	98	Kab. Pinrang
		99	Kota Makassar
		100	Kota Pare-Pare
		101	Kab. Sidrap
		102	Kab. Janeponto
25	Sulawesi Utara	103	Kota Manado
		104	Kab. Minahasa
		105	Kab. Bolaang Mongondow
26	Sulawesi Tengah	106	Kota Palu
		107	Kab. Donggala
27	Sulawesi Tenggara	108	Kota Kendari
		109	Kab. Muna
		110	Kota Bau Bau
28	Sulawesi Barat	111	Kota Mamuju
		112	Kab. Mamuju Utara
		113	Kab. Polewali Mandar
29	Gorontalo	114	Kota Gorontalo
		115	Kab. Gorontalo
		116	Kab. Pohuwato
30	Maluku	117	Kota Ambon
		118	Kab. Maluku Tengah
		119	Kab. Maluku Tenggara
		120	Kab. Kepulauan Aru
31	Maluku Utara	121	Kota Ternate
		122	Kota Halmahera Utara
		123	Kab. Kepulauan Sula
32	Papua	124	Kab. Nabire
		125	Kota Jayapura
		126	Kab. Jayapura
		127	Kab. Jayawijaya
		128	Kab. Merauke
		129	Kab. Mimika
		130	Kab. Paniai
33	Papua Barat	131	Kab. Manokwari
		132	Kota Sorong
		133	Kab. Sorong
		134	Kab. Fak-fak
		135	Kab. Kaimana
		136	Kab. Teluk Bintuni
		137	Kab. Raja Ampat

Chapter 5: Implementation of Action Plan

Implementation of the response to AIDS in Indonesia has strengthened in the past two years. The Mid Term Review of the 2007-2010 National Strategy and Action Plan evaluated three aspects: program coverage, effectiveness, and sustainability, all of which showed improvement over time. This is of course closely related to improvement in overall management from planning and implementation of activities to monitoring and evaluation.

Not withstanding the progress, there remains room for improvement in order to overcome existing weaknesses and obstacles which might limit future accomplishments. Specific areas needing additional attention include:

1. Weak leadership in several government departments and regions has led, thus far, to inadequate support policies as well as severely limited program implementation.
2. Improvement is needed in management, including, budget design more sharply focused to facilitate achievement of targets as well budget management which is more transparent.
3. Strengthening of logistics management, particularly for ARV and methadone, to ensure sufficient ARV and methadone stock is reliably available in treatment service sites when needed.
4. Improvement of coordination and partnership at provincial and district level to overcome difficulties experienced by some local AIDS Commissions in their effort to coordinate with government departments, implementing agencies, local NGOs and other stake holders in the response to HIV and AIDS.
5. Increased involvement of key populations, particularly for prevention programs.
6. Improvement of monitoring and evaluation, particularly at local level (province and district) and related to the work of government departments.

Scaling-up of the response to AIDS in the next five years will need improved performance by stakeholders at all levels in managing the implementation of their respective Action Plans. In the period 2010-2014 the weaknesses (1-6 above) will also need to be addressed.

The National AIDS Strategy and Action Plan is the national reference document for implementing partners of all levels (national, provincial, district) in the response to AIDS. Stakeholders may elaborate their own Action Plans but they should be in conformity with the broad framework, based on the principles, strategies, and activities laid out in this document, and contribute to achievement of progress toward national goals and targets.

All AIDS programs in Indonesia should be implemented with a high level of seriousness and under committed leadership; with effective mechanisms of coordination; in partnership with other actors including community groups and key populations. All programs are to be managed in full compliance with the principles and applying practices of results-based programming and good governance.

5.1. Governance and Leadership

Strong leadership is required at all levels of the response – national, sectoral, provincial, institutional, and in the community – from policy makers to program implementers. The strength of the leadership is demonstrated by (1) political commitment on the part of leaders in responding to HIV and AIDS in their respective areas of jurisdiction, (2) establishment of necessary policies to create enabling environments supporting

implementation of a comprehensive response tailored to local needs, concerns and actions and backed by adequate budget to realize the commitment, (3) establishment of the policy or policies needed to promote achievement of agreed targets in a coordinated and sustained manner, as well as (4) provision of direction and guidance to promote coordinated responses and action among various stakeholders.

This National Strategy and Action Plan are to be carried out following the principles of good governance, emphasizing transparency, accountability, as well as lack of collusion, corruption, and nepotism.

The distinguishing features of good governance in the AIDS response at all levels are the following:

1. **Accountability:** a culture of accountability for the management of the response to AIDS is promoted at all levels
2. **Monitoring and Supervision:** monitoring and supervising implementation of the AIDS response are carried out with involvement of members of the communities and beneficiaries of programs under review.
3. **Sensitivity and Responsiveness:** program interventions and services are presented in ways that are sensitive and responsive to the evolving situation and the needs and concerns of those using the services
4. **Professionalism:** program implementers are competent, skilled, and responsible in providing easy, quick, affordable, and friendly services. If program implementers are service providers, they take pride in maintaining a high level of client satisfaction.
5. **Efficiency and Effectiveness:** available resources are used as effectively and responsibly as possible.
6. **Transparency:** openness and transparency are practiced in program implementation creating an environment of trust and cooperation among all partners.
7. **Equality:** opportunity is provided for all to participate to the full extent of their capacity and participation is encouraged among those who are less active.
8. **Vision:** management of the AIDS response and associated programs are based on a clear and agreed vision.
9. **Compliance with the Law:** 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.

These principles of good governance need to be realized at all levels. The success of their implementation at the national level will be reflected in a strengthening of NAC's capacity to coordinate and monitor the national response to the epidemic. These principles will also contribute to strengthening of government commitment, including attention to domestic budget, development of policies and regulations supportive of implementation of the response, as well as partnership with international partners. At provincial and district levels, the adherence to these principles is uneven. Steady improvement will be needed in some areas to strengthen their application.

5.2. Coordination of Implementation

Coordination of implementation of the National Strategy and Action Plan takes place at all

stages of work, from planning through implementation to monitoring and evaluation.

5.2.1. Coordination of Planning

The National AIDS Commission Secretariat coordinates the planning and implementation of the National Strategy and Action Plan through a National planning and budgeting forum and utilizing existing government development frameworks and mechanisms. At the provincial level, the Provincial AIDS Commission Secretariat will organize their own coordination plan using local mechanisms. Action plans of government departments and at provincial level will be elaborated further on an annual basis by the relevant departments and provinces.

The planning process should be harmonized with the national development planning mechanism in the National Mid-Term Development Plan (*RPJMN*) at the national level and the consultative local development process[16] (*Musrenbang – Musyawarah Rencana Pembangunan*).

5.2.2. Coordination of Implementation

In implementing the National Strategy and Action Plan, the National AIDS Commission Secretariat leads the coordination of program implementation at all levels. This includes coordination between programs, coordination among relevant policies, as well as coordination among provinces and districts. Effective coordination of program implementation will lead to improved understanding of what works and what doesn't through sharing of program experience and will contribute to attainment of program targets in all 33 provinces.

5.2.3. Monitoring and Evaluation Coordination

The AIDS Commissions Secretariat carries out monitoring and evaluation at all levels so that implementation of the response to HIV and AIDS will be as planned and will produce useful data and information. In carrying out this work the Working Group for Monitoring and Evaluation is guided by national guidelines on monitoring and evaluation of the response.

5.2.4. Harmonization and Synchronization of Implementation of Action Plan

In implementation of the National Strategy and Action Plan there needs to be harmonization and synchronization of programs which are similar but carried out by different stakeholders. Elements subject to harmonization review should include determination of targets, funding, and geographic area within which activity will take place. The process of harmonization and synchronization is led by the AIDS Commission Secretariat and carried out periodically as planned and as long as the work is underway.

5.2.5. Coordinating Mechanism

All coordination related to implementation of the AIDS National Strategy and Action Plan including coordination of planning, implementation, monitoring and evaluation as well as harmonization and synchronization for a given area is done by the respective AIDS Commission Secretariat. The work is carried out through coordination meetings convened for all relevant partners either regularly or on an ad hoc basis by the AIDS Commission Secretariat. Participant organizations/ institutions in any meeting prepare information related to their own activity and relevant to the meeting agenda in advance. The outcome

[16] Succession of planning meetings starting at district level and culminating with meeting at national level.

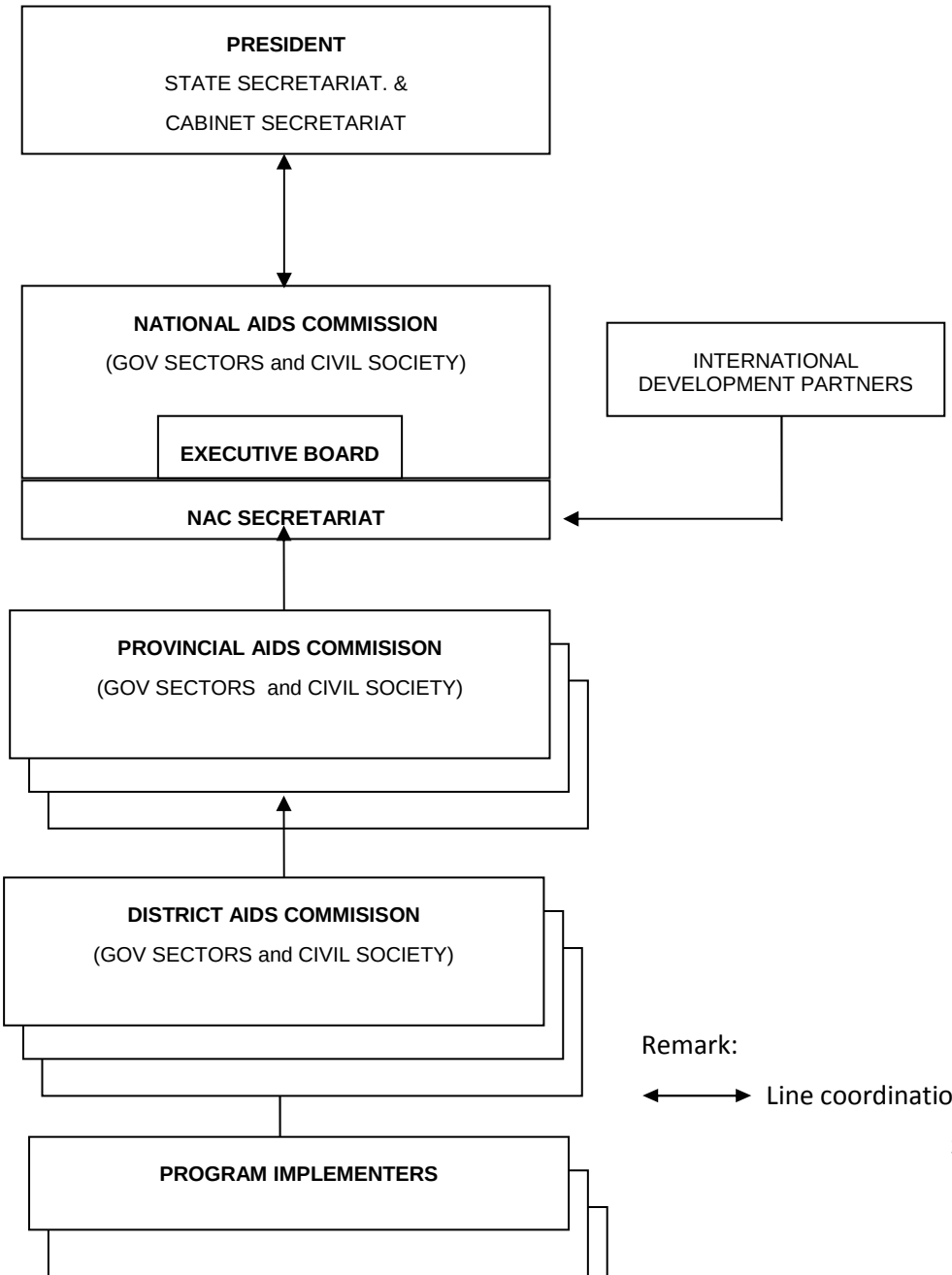
of the meeting is provided to all partners to coordination for appropriate follow up. Ideally, at the subsequent meeting, reports on implementation of follow up are given by participants and discussed.

Throughout the program implementation cycle, coordination and consultation meetings take place frequently and occur in a variety of forms. For example: meetings of NAC members; regional meeting of Provincial AIDS Commissions, meetings on a specific programming issue convened by the NAC Secretariat; meetings of implementing partners, working groups or task forces to consult with the relevant AIDS Commission Secretariat and so forth. The highest level of coordination takes place in a periodic Indonesian cabinet meeting. A special session for discussion of HIV and AIDS is chaired by the President.

Coordination meetings to discuss policies are organized by the National AIDS Commission Plenary session, or by Commission's Implementing Team. Operational coordination is organized by the Secretariat or by task forces appropriate to the assignment.

National AIDS Commission Secretariat leads coordination meetings at regional levels, as well as organizing coordination meetings with neighboring countries. Provincial AIDS Commission organizes coordination meetings focused on local issues.

Diagram 5.1. Coordination of Implementation of AIDS National Action Plan



5.2.6. Implementers of the National AIDS Strategy and Action Plan

Government and the community elements work to achieve the common goals of the Action Plan implement the program in line with their respective and mutually complementary roles and responsibilities.

a. Government Institutions

At the national level, government units participating in the national response to HIV and AIDS include: technical departments (for example health, education, social affairs etc.), offices of State Ministers (for example office of State Minister for Empowerment of Women and others), national armed forces, national police force, and other state bodies/ institutions. Participation and responsibility of these various national institutions/ bodies/ agencies for implementation of the National Action Plan is in line with their respective mandates and is coordinated by National AIDS Commission Secretariat. At the provincial level, government institutions are comparable to those at the national level but are provincial level units. Coordination, again, is the responsibility of the Provincial AIDS Commission Secretariat. A comparable pattern is in place at the district/ city level.

b. Civil Society

Civil society has the right to participate in state, national, and community activities. Flowing from this, community groups have the right and obligation to contribute to the improvement of the country through economic participation, public service, voluntary work and other activities which improve the life of the community.

In the context of HIV and AIDS, community groups have important roles and support government in responding to the epidemic. For example, there are community groups consisting of people living with HIV and key populations, as well as community service organizations, service professionals, organizations of professionals, institutions of higher education and so forth.

All are part of civil society and contribute importantly to Indonesia's response to HIV and AIDS participating actively in policy formulation, planning and program implementation as well as in monitoring and evaluation.

c. Business World and the Private Sector

The vulnerability of workers to HIV infection has encouraged the business world and private sector to design workplace-specific programmes of AIDS prevention education programs for their workers. The International Labour Organization (ILO) supports the implementation of these activities. The number of people that can be reached through the world of work and private sector is large and experience has demonstrated that appropriately designed programs can be highly effective. For all these reasons the National AIDS Strategy and Action Plan encourages and promotes scaling-up AIDS programs based in the workplace.

d. International Development Partners

International partners – bilateral, multilateral, international NGOs and foundations –have contributed financial and technical support to the HIV and AIDS response in Indonesia.

5.3. Principle of Partnership

Partnership in implementation of the response to AIDS aims to achieve a common understanding of the policy informing the National Strategy and Action Plan including policy related to budget and the importance of increasing access to capacity development activity.

Government and the community from national to provincial, district, city, and neighborhood levels, should apply the principles of partnership as follows:

a. Program preparation and ownership: Partners competencies and resources for contributing to the partnership need to be considered to ensure that during the process of reaching consensus on the division of labor and shared ownership of a program the relative strengths and weaknesses are recognized.

b. Accountability: Partners have the obligation to account fully on their respective contribution and performance in the context of the agreed partnership.

c. Accessibility: Partners have responsibility to assure open accessibility of partners to partnership activities

d. Adaptability: The ability of government institutions to sustain program activity initiated in partnership with external partners needs to be developed to assure the future of essential programs.

e. Quality: program quality will be steadily improved to meet quality standards to which community is entitled.

Assistance provided by international partners will be in line with the principles of partnership in this document, as well as its derivative documents. Memoranda of Understanding for collaboration with external partners and related to the National response to AIDS are signed by the Indonesian government only after receiving comments and input from Indonesian groups relevant to the proposed programme as well as representatives of key populations and people living with HIV who have been democratically selected by their respective communities.

Chapter 6: Resource Needs and Resource Mobilization

Resource requirements for Indonesia's National response to AIDS include human, financial, and infrastructure resources.

6.1. Human Resources

"Human resources" are the staff required for program planning, implementation, and management as well as well as staff for monitoring and evaluation at all levels and in every participating/ partner institution.

Each program which is planned, carried out, monitored and evaluated has distinct human resource needs which vary in skill, knowledge, and number from program to program.

To ensure efficient use of resources, each program determines its minimum staff requirements. Program development, in turn, builds these human resource needs into program plans.

Every person has the potential to realize his/ her role as an adaptive, transformative and social being, who is capable of managing his/ herself to achieve a full, balanced, and sustainable life. In view of this human resources should be prepared through a planned work-related program. In addition to effective competency-based staff recruitment and placement, a good personnel plan includes regular opportunities for capacity building, a clear career path, a competitive standard of compensation, as well as establishment and maintenance of a good working environment. Specifically, in connection with human resource management related to HIV and AIDS, serious attention must be given to gender equality, meaningful involvement of people living with HIV, as well as appropriateness of personnel management and development of staff knowledge (social and technical) about the field HIV and AIDS.

6.1.1 Human Resource Needs

Human resource needs (see table below) are calculated to achieve 80% of comprehensive program targets. The first step in preparation of this estimate was calculation of human resource needs relative to the yearly target of each program. Using the minimum standard needed for effective program implementation, the number of staff needed was identified per program area per year. It is assumed that staff needs will increase each year. In addition to human resource needs for service units at the field level, human resources are also needed for program management at district levels, such as in district office of Department of Health, the Secretariat of the District AIDS Commission and so forth. An estimate of human resource needs for program implementation during the life of the Strategy and Action Plan (2010-2014) is shown in remarks under table 6.1

Taking the example of the harm reduction program, human resource program estimates include staff needed for needle exchange and methadone maintenance therapy program. To calculate the human resource needs, the annual service need was calculated, along with the total number of service sites.

The table below is a summary of staff needs in 137 districts selected for the implementation of 2010 – 2014 National Strategy and Action Plan.

Table 6.1. Summary of estimated Human Resource Needs for Implementation of 2010 – 2014 National Action Plan

Kind of Human Resources Need	2010	2011	2012	2013	2014
A. Field Level					
Peer educator	26.780	44.130	57.180	67.610	79.800
Outreach worker	26.780	26.780	26.780	26.780	26.780
Supervisor of field activites	26.780	26.780	26.780	26.780	26.780
Program manager in district level	at least 1 in each district				
B. Services					
Counsellor for any kinds of services (CST, VCT, STD, PMTCT, HR)	7.900	13.050	16.500	19.410	22.900
Medical specialist for CST program	1.670	2.850	3.680	4.380	5.210
General medicine (CST, VCT, IMS, PMTCT, LJASS, PTRM)	2.540	3.990	4.920	5.690	6.620
Laborant (CST, VCT, IMS, PMTCT)	4.190	6.760	8.500	9.960	11.710
Nurses (CST, VCT, IMS, PMTCT, LJASS, PTRM)	2.230	3.530	4.430	5.170	6.040
R/R Staffs	2.890	4.500	5.460	6.270	7.270
Nutritionist	1.690	2.930	3.780	4.490	5.330
Midwife	20	80	100	110	120
Case manager	3.340	5.700	7.360	8.760	10.420
C. Management					
Program manager	137	137	137	137	137
Monitoring, evaluation & surveilance	274	274	274	274	274
Finance & administration	274	274	274	274	274
Secretary of AIDS Commission	137	137	137	137	137

Human Resource Calculation for Field work

- 80 people of key population can be supported by 1 peer educator
- 5 peer educators supported by 1 outreach worker
- 5 outreach workers supervised by 1 field supervisor

Human Resource Calculation for Health Care Providers

Based on availability of staff, total hours of work, and effectiveness of service, an assumption was made on the number of people who could be served each year as follows

- Each VCT unit could serve 720 people per year
- Each unit providing STI service could serve 720 people per year
- Each unit providing CST service could serve 720 people per year
- Each PMTCT unit could serve 360 people per year
- Each LASS unit could serve 300 people per year
- Each PTRM unit could serve 100 people per year

Note: Calculations of human resource needs here follow recommendations of the *AIDS Commission in Asia.* These calculations are provided as a guideline to government departments and AIDS community activists at national, provincial, and district level. Human resource needs would need to be based on local needs and conditions.

6.1.2. Human Resource Mobilization

The response to HIV and AIDS requires competent staff. However, often such staffs are often not readily available. Preparation of appropriate staff can be carried out as follows:

a. Recruitment

Open, publicly advertised staff recruitment for positions with adequate pay can be a method to invite competent individuals to apply for work. This can be done for any skill level required, from field staff to managerial positions.

When open recruitment is not an option, task shifting can be considered either from within the institution or using the government's policy for work placement.

b. Improving the knowledge and skills of existing staff

Capacity development of existing personnel can be carried out through training, internship, field study, coaching, and mentoring. All provinces are expected to provide their current personnel with opportunity for training, capacity development and up-grading. It is important that a supportive environment and appropriate infrastructure are provided in such activity. Post training evaluation, on-going mentoring and guidance must be factored

into training programs to ensure effectiveness in cases where participants are expected to use new information and skills in their work.

c. Strengthening Training Capacity

Currently, AIDS-related capacity building programs are conducted by different sectors in line with their respective mandates. For example: (1) Ministry of Health conducts training on treatment, VCT, surveillance, and other health programs; (2) NAC conducts training on program management, prevention of HIV through sexual transmission, harm reduction, advocacy, monitoring and evaluation, and structural intervention; (3) Civil Society organizations conduct training related to peer education, outreach, communication, community system strengthening, strategic planning and advocacy; (4) International Partners conduct or support training on advocacy, program management, or specific technical skills.

To respond to the continuing shortage of appropriate human resources in the field of HIV and AIDS as well as to provide program implementers with skills and information, a mechanism is being developed to identify training and capacity building needs as well as alternatives to meet those needs. One of the best ways to meet these needs is through collaboration with existing educational institutions, universities, and training centres. Innovative methods should be used, including, for example increased use of internet use, e-learning, and tele-video conference etc.

d. Provision of Technical Assistance

If the need for specific expertise cannot be locally fulfilled in a timely manner, a mechanism to provide short-term technical assistance should be developed. Technical assistance is required to ensure effective and efficient program implementation, and is usually used for a short-term period. Technical assistance can be sought from outside, however local resources should always be the first choice. Provinces that have achieved success in program implementation can also provide technical assistance to other provinces. Technical assistance is best used for specific program area that requires a high level of expertise.

Stakeholders, government or civil society, who requires technical assistance, should identify their specific needs through a rapid assessment process. Technical assistance may be required for rapid assessment, program review, planning, communication, resource mobilization, monitoring and evaluation, management, or related to cross cutting program areas such as gender, human rights, work related to key populations and community mobilization.

It is very important to evaluate the success and the impact of technical assistance provided. Indicators of success include a transfer of knowledge and skills to local partners, satisfactory report from the client, and improved capacity for program implementation.

6.2. Financial Resources

The implementation of 2010 – 2014 National Strategy and Action Plan will require significant financial resources. Funding sources for the AIDS program include national and local (provincial and district) budgets, private sector, community institutions, as well as international partners. Contributions of importance are not limited to financial resource. The monetary value of in-kind contributions can also be quantified and counted as financial contribution. For example, a community based activity may provide personnel or facilities for an activity either of which, if purchased, would be significant expenses. National and

international private sector bodies can join in the response by implementing AIDS programs of benefit to their own staff or can contribute to community effort as an activity in their corporate social responsibility program.

6.2.1. Financial Resource Needs

The financial needs for the implementation of 2010-2014 Action Plan were calculated using the Resource Needs Module (RNM). Program areas included in the calculation are prevention, care and treatment, mitigation, and creation of conducive environment. Targets for each program area were used as the basis of the calculation, using the unit cost for prevention and treatment programs which has already been approved at the national level. Unit cost used for impact mitigation activities followed recommendation of the Ministry of Social Affairs. Cost for creation and maintenance of conducive environments, management, monitoring, evaluation, and research activities were calculated together at the rate of 8-13% of the total program needs. The situation of the epidemic and priority areas are also taken into consideration in budget calculation. The estimates in this budget were calculated with the goal in mind of scaling-up effective programs in order to bring the epidemic under control.

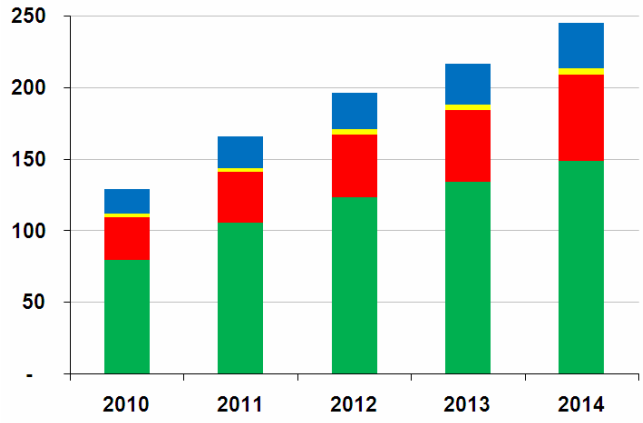
It is estimated that funding needed to carry out the National Action Plan 2010 – 2014 totals the equivalent of US$ 1.1 billion. The funds will be used to cover the work of the four main programs areas: (1) prevention (57%), (2) care, support and treatment (28%), (3) impact mitigation (2%), and (4) creation of an enabling environment, program management, monitoring and evaluation and research (13%). Prevention activities are focused on delivery effective programs in 137 districts across the 33 provinces of Indonesia where more than 80% of the key populations live. The table 6.2 (below) gives the summary of financial resources needed for implementation of the National Strategy and Action Plan each year.

Table 6.2 : Annual financial resource needs for each program 2010 - 2014 in USD

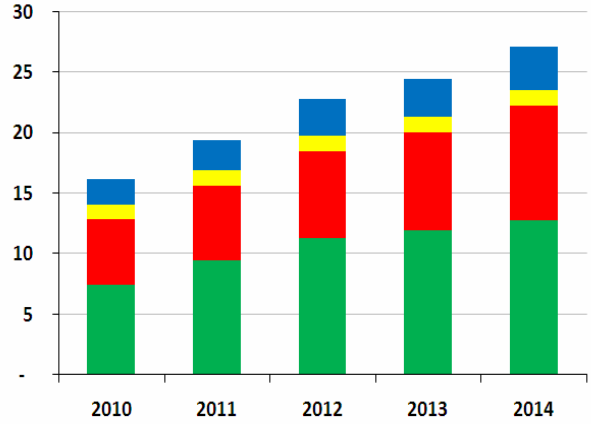
Area	2010	2011	2012	2013	2014
1. Prevention	82.143.664	101.000.849	115.029.488	122.167.131	134.459.271
2. Care and treatment services	48.368.285	58.156.756	69.192.777	67.268.145	77.311.546
3. Mitigation	3.706.099	4.205.602	4.654.201	5.062.440	5.422.720
4. Enabling environment, Policy, Management, Monev and Operational Research	18.017.685	21.971.361	25.359.011	25.977.219	29.039.798
Total	152.235.733	185.334.568	214.235.477	220.474.935	246.233.335

There are differences in the results of funding needs in the two provinces of Papua and West Papua where the epidemic has reached the stage of a low-level generalized epidemic compared to those of other parts of Indonesia with a "concentrated" epidemic. In the case of the generalized epidemic, the fund needed for care, treatment, and mitigation will be relatively larger than those of the areas with the concentrated epidemic, in which the fund needed for prevention will be larger than care and mitigation.

Graphic 6.1. Funding need for implementation of Action Plan in 31 provinces 2010-2014



Graphic 6.2. Funding need for implementation of Action Plan in Papua and West Papua 2010-2014



Prevention **Care and Treatment** **Mitigation** **Enabling Environment.**

Table 6.3. Fund Needed for Implementation 2010-2014 by Component of Program and Activities

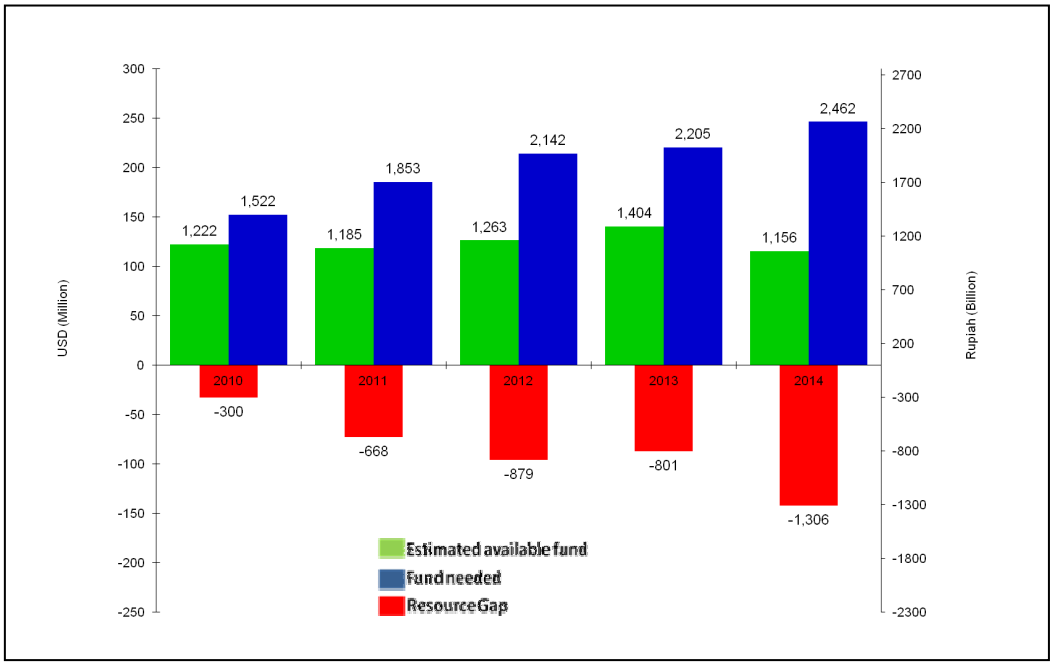
Component of Program and Activities	2010	2011	2012	2013	2014
PREVENTION	82.143.664	101.000.849	115.029.488	122.167.131	134.459.271
Priority populations					
Direct Sex workers	8.406.786	8.853.102	10.540.474	10.342.923	10.429.936
Indirect Sex workers	3.828.325	3.427.541	4.031.827	3.860.275	3.899.421
Men who have sex with men	10.655.209	14.150.134	16.631.562	18.022.439	20.512.621
Waria	1.866.250	1.870.664	1.884.464	1.897.747	1.909.792
Injecting drug users	12.407.956	19.997.696	21.085.720	22.182.087	23.273.871
Prison population	4.316.011	4.977.659	5.236.666	5.495.674	5.754.682
Clients of SW	7.415.367	11.928.054	16.504.413	20.338.517	24.208.725
Youth	10.693.491	11.057.231	11.551.149	12.001.785	12.502.581
Workplace program	1.532.916	1.573.217	1.614.069	1.655.537	1.696.906
Service Delivery					
Condom provision: Papua	25.678	61.052	110.280	174.003	342.100
STI management	1.059.176	1.217.552	1.337.998	1.459.479	1.581.491
Voluntary counseling and testing	12.380.522	13.376.471	14.946.239	15.159.318	18.748.978
Prevention of mother-to-child transmission	280.152	201.017	211.534	234.256	255.074
Mass media	7.235.438	8.269.072	9.302.706	9.302.706	9.302.706
Post-exposure prophylaxis	40.387	40.387	40.387	40.387	40.387
CARE, SUPPORT AND TREATMENT	48.368.285	58.156.756	69.192.777	67.268.145	77.311.546
Home-based care	18.306.353	24.606.525	28.455.662	32.067.006	35.785.114
Palliative care	18.625	36.670	60.949	91.637	129.440
Diagnostic testing	248.772	320.907	392.324	463.055	532.995
OI treatment	1.254.509	1.772.887	2.350.843	2.960.507	3.590.819
Prophylaxis for opportunistic infections	284.504	382.714	490.250	606.700	730.468
Laboratory tests for ARV therapy	4.654.567	6.155.403	7.520.131	5.474.236	6.680.357
Anti-retroviral therapy	23.600.955	24.881.650	29.922.618	25.605.003	29.862.353
MITIGATION	3.706.099	4.205.602	4.654.201	5.062.440	5.422.720
Orphan, widow care and general economic support	3.706.099	4.205.602	4.654.201	5.062.440	5.422.720
POLICY, ADVOCACY, ADMINISTRATION AND RESEARCH	18.017.685	21.971.361	25.359.011	25.977.219	29.039.798
Enabling environment	3.002.947	3.661.894	4.226.502	4.329.536	4.839.966
Management and administration	3.002.947	3.661.894	4.226.502	4.329.536	4.839.966
Research and Surveillance	6.005.895	7.323.787	8.453.004	8.659.073	9.679.933
Monitoring and evaluation	6.005.895	7.323.787	8.453.004	8.659.073	9.679.933
TOTAL	152.235.733	185.334.568	214.235.477	220.474.935	246.233.335

6.2.2. Needs analysis for Financial Resources

In order to reach the target set for the five years 2010-2014, there is an annual increase in the target for each year. In order to reach the new targets and sustain program services for those already covered, funding, thus, also needs to increases annually. Thus far, financial resources for the response to AIDS in Indonesia have come from a combination of domestic and international sources, including national and local government budgets and bilateral and multilateral donors.

Domestic financial resources (government at central, provincial and district level) have shown significant increase in the past few years. Between 2006 and 2008 the need for external support decreased from 70% (2006) to 50% (2008). Nonetheless, there remains a large funding gap for the implementation of National Action Plan 2010 – 2014. (see graphic 6.3)

Graphic 6.3: Estimate of Funding Needs, Availability and Gap for the Implementation of National Action Plan 2010 – 2014.



6.2.3. Financial Resource Mobilization

In Indonesia mobilization of financial resources for the AIDS response is coordinated by National AIDS Commission. Funding from both government and international partners is used to support the response to AIDS from central to provincial and district level. Mobilization of government resources follows the government budgeting process while the mobilization of resources from international partners (both bilateral and multilateral) follows previously agreed mechanisms, using this document as the main reference for partnership related to HIV and AIDS.

The National AIDS Commission prepares and submits funding proposal to international partners, following consultation meeting between NAC and international partners to determine which programs they could fund which are part of the National Strategy and Action Plan. Other funding support is directed to and through one financial management mechanism, the Indonesian Partnership Fund for HIV and AIDS (IPF) led by the National AIDS

Commission. Fund management is by the National AIDS Commission itself or its another institution so designates and who would be accountable and report to the NAC.

At the provincial and district levels, financial contributions from civil society or the private sector are managed by the local AIDS commissions and used for implementation of program activity as stipulated in their written Action Plan.

6.3. Commodities and Infrastructure

Commodities and infrastructure include (1) service sites, (2) supplies and material for prevention, (3) supplies and materials for surveillance, (4) supplies and materials for care, support and treatment, (5) materials for information, education, communication, as well as other supplies and materials to support the AIDS response.

6.3.1. Infrastructure and Commodity Needs

Planning, to meet commodity and infrastructure needs is based on calculation of program needs related to targets and needs reflected in the management plan for logistics. Needs include prevention as well as care and treatment programs.

Commodities for prevention include the condoms and lubricants to prevent sexual transmission, sterile needles/ syringes to prevent transmission through contaminated injecting equipment, and also various IEC materials to provide information for behavior change. Other commodities for prevention or other programs which may be needed can be identified by relevant organizations.

Using targets of the National Action Plan as base, commodity and infrastructure needs for prevention, care and treatment programs are estimated as follows:

Table 6.4. Commodity and Infrastructures Needs for Prevention, Care, Support and Treatment : 2010-2014

Infrastructures Need	2010	2011	2012	2013	2014
Condom Outlet	10.710	17.650	22.870	27.040	31.920
VCT	1.670	2850	3680	4380	5210
STI	540	600	650	680	710
Care, support and treatment	700	610	610	620	630
PMTCT	20	80	100	110	120
Needle and syringe exchange	350	510	540	580	650
Methadone	310	460	490	520	580

The table above shows the summary of needs for health services and other infrastructure in the implementation of National Strategy and Action Plan 2010 – 2014. For example, assuming that in 2010 two hundred people from key populations access each condom outlet. That would mean that 10,710 condom outlets in 137 districts need to be staffed and equipped to serve 2 million people with condoms and other supplies.

6.3.2. Mobilization of commodities and infrastructure

The implementing partners, government sectors and units responsible for the service delivery should meet the resource needs for their respective programs. The quality and quantity of resources should be increased gradually. They are also expected to socialize and build capacity of all those involved in their logistic management activity, at national,

provincial, and district levels.

All resources (which could include infrastructure, supplies, commodities or equipment) which are contributed by NGOs International partners or others should be reported to the government technical department and relevant AIDS Commission for inclusion in on-going resource tracking as well as monitoring and evaluation of program coverage and achievements.

6.3.3. Management of Logistics

Management of infrastructure and commodities (their planning, procurement, storage, utilization, monitoring, and quality assurance) for the AIDS response is carried out in accordance with procurement regulations and guidelines on management of supplies

Good supply and logistic management should ensure that the beneficiaries receive all the resources of appropriate quality, as needed in adequate quantity and delivered in a timely manner. Mechanisms to obtain feedback from beneficiaries should be established in order to be alerted to problems before bottlenecks occur and supplies are disrupted.

Chapter 7: Monitoring and Evaluation

This chapter describes annual coverage targets for prevention which will be intensively monitored to evaluate the implementation of 2010-2014 National Strategy and Action Plan. This chapter also explains the framework and performance indicators which will be used for comprehensive evaluation of program performance, from initial input through to impact. It also explains mechanisms and capacity building that are still needed.

7.1. Annual Targets for Coverage

As explained in Chapter 3 (Strategies for Response to HIV and AIDS), by 2014 program implementation is expected to cover at least 80% of key populations. To achieve universal access targets by 2014 annual targets have been set to ensure that key populations and people living with HIV can access prevention, care, support, and treatment services that they need.

Universal access targets pertaining to prison inmates and injecting drug users should be achieved by 2011, while targets pertaining to female sex workers will be achieved by 2012, and targets pertaining to MSM and clients of sex workers will be achieved by 2014. Therefore, by 2014 it is hoped that at least 60% of the key populations should have reduced their risk behavior and that they will continue safe practice into the future. At least 60% of key population engaging in unsafe sexual intercourse will use condom consistently, 60% of IDUs will use clean needles/ syringes consistently, 60% PLHIV requiring ARV will have access to and utilize the treatment, and funding needs for HIV and AIDS programs will be fulfilled, with 70% of the resources coming from in-country resources.

Annual coverage targets for prevention among key populations can be seen in the table below:

Table 7.1. Targets of Coverage for Prevention Programs targeting Key Populations

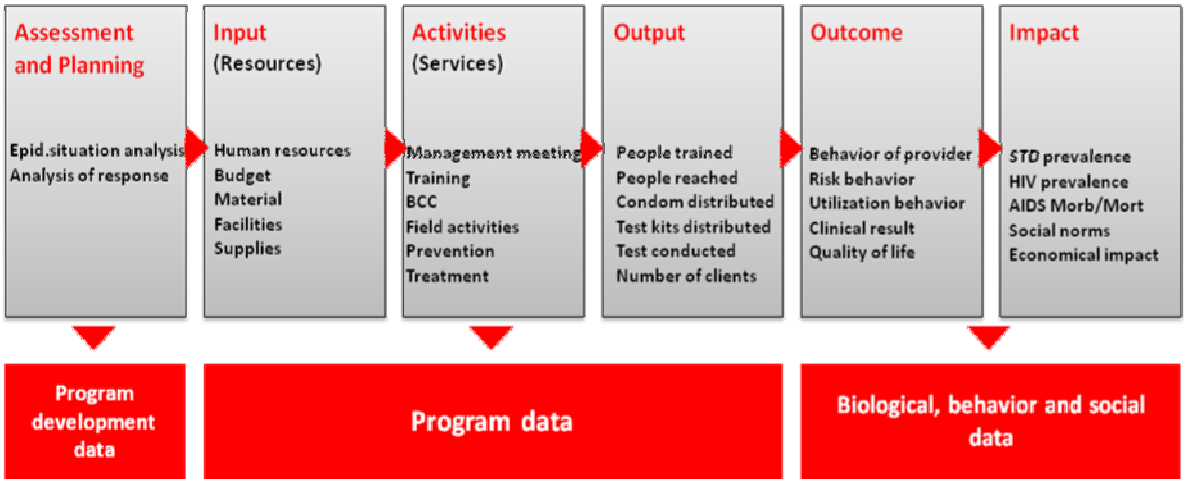
Population	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
IDU	50,420	28%	129,420	55%	189,600	80%	202,980	85%	216,360	90%	241,900	100%
FSW	93,930	51%	142,500	60%	167,510	70%	192,800	80%	206,130	85%	219,420	90%
Transgender	27,180	90%	27,180	90%	28,880	95%	30,600	100%	30,600	100%	30,600	100%
MSM	63,980	8%	205,830	25%	373,280	45%	501,300	60%	588,910	70%	677,120	80%
Client	403,030	15%	1,018,440	30%	1,539,180	45%	2,067,120	60%	2,428,370	70%	2,792,240	80%
Prisoner	23,130	30%	78,660	60%	104,880	80%	111,435	85%	117,990	90%	131,100	100%
Intimate Partner		0%	42,176	2%	106,650	5%	214,910	10%	324,585	15%	544,450	25%

The targets mentioned above are targets for prevention programs for each of the key populations. The achievement of these targets will be regularly monitored using an intensive monitoring scheme (monthly, quarterly, per semester, and annually).

7.2. Performance Framework and Indicators

Monitoring and evaluation using a framework to evaluate each phase of program implementation, starting from input, through activity, output, outcome, and finally program impact, can be illustrated as follows:

Diagram 7.1. Monitoring and Evaluation Framework



NAC holds the key role in collecting reports from all sectors related to main performance indicators in order to evaluate the progress of the AIDS response. The monitoring and evaluation framework provides explanation for the performance indicators, details of which are as follows:

7.2.1. Input Indicators

Input indicators include funding support from both national and international sources, policy development, the status of policy implementation, and institutional development at all levels - National, provincial, district, and municipal. This indicator is important to evaluate progress toward program sustainability.

7.2.2. Process Indicators

The process indicators include national program implementation -- blood safety, ART service, PMTCT, co-managed treatment of TB and HIV, HIV testing, impact mitigation and education.

7.2.3. Output Indicators

The output indicators measure program coverage, specifically among key populations and the general population in the two provinces of Papua and Papua West. National program coverage measures the number of people of key populations reached by behavior change programming, including education programs, peer education communication, individual/ group risk assessment, access to condoms and safe injecting equipment, VCT services, STI treatment, and care, support, and treatment. The annual targets for program coverage are shown in annex 3. Routine evaluation of achievement on these indicators is important to monitor the progress of program implementation.

7.2.4. Outcome Indicators

Outcome indicators are used to evaluate to what extent program implementation among key populations is changing risk behavior to safe behavior and achieving treatment program objectives. These indicators are important to evaluate program effectiveness.

7.2.5. Impact Indicators

The impact indicators are used to measure the impact of programs of the National Response in controlling the AIDS epidemic. This is done by calculating HIV and STI prevalence among people of key populations, as well as general population in Papua and West Papua.

More detailed information about indicators -- names of indicators, data collection frequency, measuring method, and responsible institution for each indicator, is attached in annex 6

7.3. Monitoring and Evaluation Mechanism

7.2.1. Data Collection Methods

NAC collaborates with Ministry of Health and other government departments, civil society organizations and international partners in conducting national monitoring and evaluation of the response to HIV and AIDS in order to generate the data needed for monitoring program performance and strategic program information. NAC uses the findings to evaluate program implementation and to help identify if there are regions or programs with issues that require support, improvement or change. Data collection methods can be listed as follows:

a. Surveillance

HIV, AIDS and STI surveillance is the responsibility of the Ministry of Health. The following is a list of surveillance exercises regularly conducted:

- HIV Surveillance

  Once a year, the Ministry of Health conducts surveillance of HIV among female sex workers. HIV surveillance should be expanded to include all key populations. Depending on the nature of the epidemic, surveillance should also be carried out among pregnant women.

- IBBS (Integrated Bio-Behavior Surveillance)

  In the past IBBS was conducted on a limited basis in selected priority provinces. In the future IBBS will be done on a regular basis in all priority provinces.

- STI Surveillance

  This activity can be integrated into the IBBS.

- ARV Resistance Survey
- Estimate of total number of people among the key populations
- Estimate of PLHIV

b. Other Data Collection:

- Monitoring of institutional strengthening (NAC)
- Monitoring of program expenditures (NAC)
- Mapping location of "hot spots", key populations, available services, and NGOs
- Monitoring progress of prevention services (NAC)
- Monitoring progress related to behavior change activity (NAC)
- Monitoring progress of treatment services (NAC)
- Monitoring of impact mitigation services (Ministry of Social Affairs)

- Monitoring of program coverage (NAC)
- Operational Research (NAC)

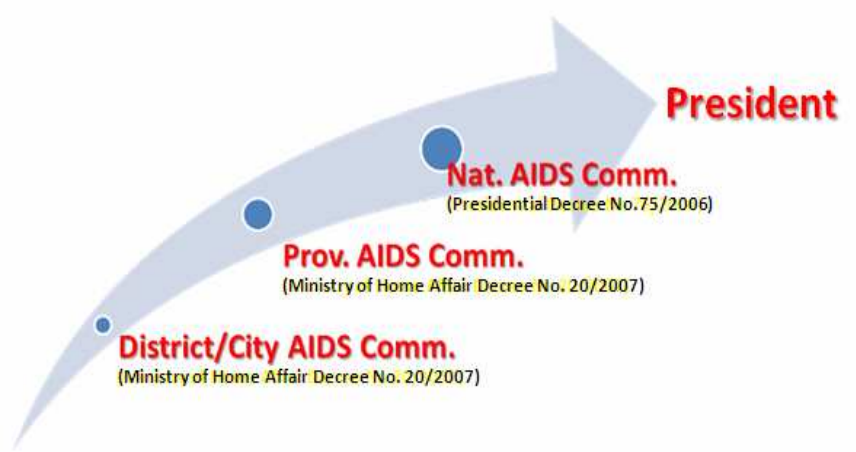
  There is considerable research to be done in the field of HIV and AIDS. The most relevant for the next five years will be operational research to improve program effectiveness particularly related to prevention, treatment, and impact mitigation programs.

7.3.2. Monitoring and Reporting

Monitoring of progress toward achievement of coverage targets needs to be conducted in the field periodically and intensively, particularly at district and municipal level.

A reporting mechanism has been designed and is in place to channel data from all levels into the national monitoring system. The reporting flow is pictured below:

Diagram 7.2. Reporting Flow



The basic mechanism for reporting on the response to AIDS is regulated in Article 13 of the Presidential Regulation No. 75/ 2006, and Article 12 of Regulation No. 20/ 2007 of the Minister of Home Affairs. Once a month program implementers at field level are expected to report their activities to related sectors at District/ city level where activities take place. The reports of the work of different implementing groups should be compiled by the relevant government departments and sent to the District AIDS Commission. The District AIDS Commission will send the reports to Provincial AIDS Commission, who, in turn, will send them to the National AIDS Commission. The National AIDS Commission uses these monthly reports for analysis of program implementation and to prepare periodic reports for the President. Data coming through this reporting system is also used to help Indonesia fulfill global commitments, such as periodic UNGASS reports and reports on progress toward achievement of Universal Access and the MDGs.

To share evaluation of the progress of the implementation of National Strategy and Action Plan 2010 – 2014, NAC will prepare an annual report on program coverage.

7.3.3. Program Evaluation

A 'Joint Periodic Performance Reviews' carried out by AIDS Commissions at every level will be the mechanism used for evaluation. Evaluations should be conducted by government and civil society reviewers every 6 months, at mid-point (mid-term review) and at the end of

the present AIIDS National Strategy and Action Plan 2010-2014. The main performance indicators are: coverage, effectiveness and sustainability.

The mid-term and final evaluations include monitoring of both the status of the epidemic and of implementation of the response. A complete evaluation of the response to the epidemic will include review of political involvement, policy environment, institutional governance, capacity to provide strategic information, capacity to develop strategic plans, status of resources, implementation of prevention, treatment, and impact mitigation programs (including review of program coverage and effectiveness), as well as evaluation of community involvement (civil society).

7.3.4. Information Usage

The data produced through the monitoring and evaluation process is not "just for the record" but is to be used to improve program implementation at the field level as well as becoming part of the evaluation report. It should also be used in coordination meetings at each level.

To facilitate data gathering data from related sectors for evaluation as well as for decision-making, strong working relations should be established between the AIDS Commissions of each level and their partners. Coverage data should be analyzed every month at District level making possible immediate program adjustments, as needed. A monitoring meeting should be held every 3 months at the provincial level, while a comparable meeting should be held at the national level every 6 months.

Ideally, more comprehensive, in-depth and analytical reports will be made available for discussion and to inform program implementation every 6 months, at a minimum at least once a year.

7.4. Capacity Building

Every priority district across Indonesia has a system for collaboration between government and civil society for periodic data collection. There is at least one part-time staff member in the District, Provincial and National AIDS Commission who is responsible for this task and who should be in contact with all relevant organizations/ institutions to obtain the data needed.

Nonetheless, the appointed staff or the implementing organization often does not have the skill or experience to provide reports of good quality in a timely manner. This situation occurs at all levels, from district to national. To overcome this situation, capacity building for monitoring and evaluation is needed and should be planned and budgeted for as part of the overall response to HIV and AIDS.

Such a capacity building program should include assessment of existing capacity for monitoring and evaluation and strengthening of the capacity of AIDS Commission members (including government and non-government members) to conduct various monitoring and evaluation activities, organize training on data management and analysis, data quality assurance, technical guidance and assistance, and development of guidelines as needed by each institution.

Chapter 8: Conclusion

This document presents the Indonesian National Strategy and Action Plan responding to HIV and AIDS. It begins with an explanation of the main challenges that will be faced over the next 5 years, (2010 to 2014), as well as laying out strategies to be used to overcome the challenges identified. This is follow by identification of the main programs areas to be covered -- prevention, care, treatment, support, and impact mitigation. The document then describes how those programs will be managed, the resources needed to implement them, and the monitoring and evaluation systems to be used during implementation of the national response.

This is the main document describing Indonesia's national response to HIV and AIDS. It needs to be further elaborated with the addition of plans and guidelines for operationalizing specific aspects of the Action Plan including an operational plan, a scheme for management of procurement, identification and description of technical assistance needs, and a communication strategy.

So long as they are in line with this National Strategy and Action Plan 2010-2014, other strategies and policies related to the response such (programs reaching out to children, adolescents, women and an existing communication strategy) should be continued and as needed brought into conformity with the new program.

This document, the development of which was guided by the National Mid-Term Development Plans for 2010-2014, will be used as a reference in developing budgets at national, provincial and district levels. The planning process will be facilitated by the National Development Planning Agency (BAPPENAS), while Ministry of Home Affairs is responsible for the integration at provincial and district levels. This document will also be used as a reference in mobilization of other financial resources from both domestic and international sources.

This National Strategy and Action Plan was developed after a series of planning cycles and should be reviewed during the annual review process and at the time of the overall mid-term review. Findings in these meetings will be used for program improvement as well as to inform future program development and planning.

REFERENCES

Aburizal Bakrie (2009). Minister of Social Welfare Speech on Governor's (Chair of AIDS Commission) Meeting to Response HIV and AIDS in Indonesia, 10th Agustus 2009, Bali, Indonesia.

AIDS Ambassadors and Champions (2009). Declaration on the response to HIV and AIDS in Asia and the Pacific. 9 August 2009, 9th ICAAP, Bali, Indonesia

Ani Yudhoyono (2009) Remarks of the AIDS Ambassador of Indonesia on the occasion of a meeting of AIDS Ambassadors and champions at the 9th ICAAP, 9 Agustus 2009, Bali, Indonesia.

BAPPENAS (2009). Health and Nutrition Development in Indonesia: overview and the trend. Background study for RPJMN 2010-2014. National Planning and Development Agency, Jakarta.

Central Bureau of Statistics & Ministry of Health (2007). Risk Behavior and HIV Prevalence in Tanah Papua (data collection 2006), Jakarta.

Community Forum, 9th ICAAP. Recommendations (2009). 9th August 2009. Bali, Indonesia

Indonesia Round 8 proposal HIV sector (2009). Indonesia response to HIV: Goverment and Civil Society Partnership in 12 Provinces

Kaldor, John. (2006). Impact HIV and AIDS in Papua Nugini, Indonesia and Timor Leste, 2005-2025. Ausaid Canberra

Mboi, Nafsiah (2009). Strategy and policies to response HIV AIDS 2010- 2014. Presentation document presented on occasion of a meeting the National Planning and Budgeting Forum on HIV AIDS, BAPPENAS, 6 July 2009

Ministry of Health (2008). Mathematic Modeling on HIV epidemic in Indonesia 2008-2014. MoH, Jakarta

Ministry of Health (2009). Quarterly Report on HIV and AIDS, June 2009. MoH, Jakarta

Ministry of Health & Central Bureau of Statistics. (2008) Integrated Biological and Behavior Surveillance (IBBS) Most at Risk Population in Indonesia 2007, Jakarta

Ministry of Health & National AIDS Commission (2006). Size Estimation of PLHIV. Jakarta

National AIDS Commission (2007). National Action Plan on AIDS 2007-2010, NAC – Jakarta

National AIDS Commission (2007). National Strategy on AIDS 2007 -2010 NAC, Jakarta

National AIDS Commission (2008) Indonesia country report on the follow up to declaration of commitment on HIV and AIDS UNGASS AIDS

National AIDS Commission (2008) National AIDS Spending Assesment 2007, Jakarta

National AIDS Commission (2009) Mid Term Review Report: Strategy and National Action Plan on AIDS 2007-2010, Draft August 2009. NAC - Jakarta

Rugg et al (2004). Global advances in HIV and AIDS monitoring and evaluation. New Direction for Evaluation. Hoboken, NJ Wiley Periodicals. Inc.

Susilo Bambang Yudhoyono (2009). Speech of the President of the Republic of Indonesia occasion of the openning of the 9th ICAAP, 9 August 2009, Bali, Indonesia

UNAIDS (1999), Guide to the Strategic Planning process for a national respons to HIV dan AIDS. UNAIDS, Geneva

UNAIDS (2006) Working document. M&E of HIV Prevention Programs for Most-At-Risk Populations.

UNAIDS (2007) Monitoring the Declaration of Commitment on HIV dan AIDS: Guidelines on construction of core indicators, 2008 reporting UNAIDS, Geneva

UNAIDS (2008) Practical Guidelines for Intesifying HIV prevention: Towards universal accsess- UNAIDS, 2008

UNAIDS (2008) Report of global AIDS epidemic 2008.

UNAIDS & WHO (2008) Priority intervention. HIV dan AIDS prevention, treatment and care in the health sector. WHO, Geneva.

Annex 1. HIV and AIDS related regulations, policies and laws

1. Republic of Indonesia Constitution 1945
2. Legislation Number 6/1974, Priority Areas, Social Welfare
3. Legislation Number 23/ 1992 Health
4. Ministry of Education Regulation No.9/U/1997 HIV/AIDS Prevention Through Education, supported by Ministry of Education Regulation No.303/U/1997 Implementation Guidelines
5. Legislation Number 39/ 1999 Human Rights
6. Legislation Number 23/ 2002 Child Protection
7. Legislation Number 25/ 2004 National Development Planning
8. Legislation Number 40/ 2004 National Social Insurance System
9. Legislation Number 17/ 2007 National Long-term Development Planning 2005 -2025
10. Legislation Number 11/ 2009 Social Welfare
11. Government Regulation Number 42/ 1981 Welfare Services for the Poor
12. Presidential Decree Number 75/ 2006 National AIDS Commission
13. Regulation Number 02/PER/MENKO/KESRA/I/2007 National HIV & AIDS Policy for Reducing Harm Arising from Injection of Narcotic, Psychotropic, & Other Addictive Substances
14. Regulation Number 03/PER/MENKO/KESRA/I/2007 Composition, Responsibility and Members, National AIDS Commission
15. Regulation Number 04/ PER/MENKO/KESRA/2007 Management Manual for AIDS Commission in National, Province and District Levels
16. Regulation Number 05/ PER/MENKO/KESRA/2007 Organization and Management of National AIDS Commission
17. Regulation Number 06/ PER/MENKO/KESRA/2007 Excecutive Team of National AIDS Commission
18. Regulation Number 07/ PER/MENKO/KESRA/2007 National Strategy on HIV and AIDS 2007-2010
19. Regulation Number 08/ PER/MENKO/KESRA/2007 National Guidelines on Monitoring, Evaluation and Reporting of HIV dan AIDS
20. Ministry of Home Affair Regulation Number 20/ 2007 Manual for Province and District Level Response to HIV and AIDS: Establishment of AIDS Commissions and Community Empowerment
21. Ministry of Health Decree Number 760/Menkes/SK/VI/2007 List of Hospitals Officially Designated for ARV treatment program for PLHIV
22. Ministry of Home Affair Regulation Number 32/ 2008 Manual for Programming HIV Program in Local Government Budget for year 2009
23. Ministry of Manpower and Transmigration Number 68/ 2004 Prevention of HIV and AIDS in Work Place Settings

ANNEX 2

Detail Activities of Strategy and National Action Plan 2010-2014

This activity table serves as guidance for program implementers at district level. Each of the selected 137 districts will analyze the AIDS epidemic situation in their district and choose priority activities and sub activities to be implemented that correspond to their needs. However, all of the four program areas should be covered: Prevention; Care; Impact Mitigation and Enabling Environment in order to reach the objectives set out in the RAN.

The development of the two-year operational work plan (2010-2011) used criteria for priority setting and resource allocation based on epidemic level (number of people living with HIV; number of key populations; rising HIV incidence and prevalence) and other socio-economic conditions influential to AIDS epidemic situation. The work plan includes prioritized activities, targets and indicators, responsible institutions, budget source and allocation, and geographic locations.

a. Prevention

Main Activity	Lead Responsible Sector	Target	Activity
Prevention of Sexual Transmission of HIV	▪ NAC ▪ Ministry of Health, ▪ National Family Planning Board, ▪ Ministry of Communication and Informatic, ▪ Department of Religious Affair, ▪ Ministry of National Education, Civil Society	80% of key populations reached through effective and comprehensive prevention program 60% of key population practice healty lifestyle and use condom in unsafe sex situations	▪ Outreach interventions to most at risk populations (minimum 8 times per year) to increase consistent condom use, including improving understanding and knowledge of HIV prevention; increasing risk assessment ability, as well as expanding to access to prevention services.
			▪ Ensuring availability of quality condoms and lubricants; including promotion and social marketing and developing local policies to encourage 100% condom (including male and female condoms).
			▪ Implement comprehensive STI prevention and treatment program, including screening for STI, diagnosis and treatment, focusing on providing friendly services and without discrimination.
			▪ Periodic Presumptive Treatment of STI with quality assurance of treatment program and access to appropriate medicines.
			▪ Proper HIV diagnosis through VCT program, including health provider initiated offer of VCT and other methods under the 3C principle (Counseling, Consent, Confidential).
			▪ Enhance structural interventions and involve all stakeholders in program implementation particularly communities of key population with relevant public sectors and civil society group (NAC, health sector, community and religious leaders). Focus to be placed on ensuring adequate networking and coordination among key sectors; improve quality of treatment and recovery program; capacity strengthening for program implementers and policy development to ensure supportive environment and human rights & gender-based approaches.

Main Activity	Lead Responsible Sector	Target	Activity
			▪ Integrate HIV response programs into reproductive health services which covers improvement of maternal and child health, family planning, reproductive tract infections, and adolescent reproductive health program under HIV response program.
			▪ In Papua and West Papua Provinces, the prevention program at mentioned above tailored to general population and youth, include provide the life skill and education to practice the healthy and safe behavior through in school and out school program and involving the community organization, faith based organization and religious leader.
Prevention of HIV transmission from sharing contaminated injecting equipment	▪ NAC ▪ Ministry of Health, ▪ Ministry of Justice and Human Right ▪ Indonesian Police Department ▪ Ministry of National Education, ▪ Civil Society	100% of IDUs reached with effective and comprehensive prevention program 60% of IDUs stop sharing and use clean needle/syringe and adopt healthy lifestyle	▪ Outreach interventions to IDUs and their partners (minimum 8 times per year) to increase consistent condom use, including improving understanding and knowledge of HIV prevention; increasing risk assessment ability, as well as expanding to access to prevention services such as access to syringe and needle program, methadone substitution therapy at health service.
			▪ From outreach workers and program sites, drug users receive support including counseling for psychological and addiction problems, offer drug dependency treatment and referral to health services where they can receive VCT, ARV therapy, counseling for treatment adherence, and treatment for opportunistic infections and co-infections including STI and Hepatitis C.
			▪ Establish NSP program
			▪ Establish methadone program
			▪ Short course training to increase skill and capacity building based on the need include education scholarship
			▪ Enhance structural interventions and involve all stakeholders in program implementation particularly communities of key population with relevant public sectors and civil society group (NAC, health sector, community and religious leaders). Focus to be placed on ensuring adequate networking and coordination among key sectors; improve quality of treatment and recovery program; capacity strengthening for program implementers and policy development to ensure supportive environment and human rights & gender-based approaches.
HIV prevention program for inmates in prison/ closed settings (This program is for inmates who are drug	▪ NAC ▪ Ministry of Health, ▪ Ministry of Justice and Human Right ▪ Indonesian	100% of inmates reached through information about HIV prevention and harm reduction from drug use.	▪ Address policy gaps in addressing drug-related harm in prisons and detention centres.
			▪ As part of the comprehensive harm reduction program for injecting drug users, provide drug substitution therapy for inmates in closed settings to reduce/stop injecting drug use.
			▪ Provide HIV prevention education, and information for accessing condoms, lubricants, bleach to prevent HIV infection.

Main Activity	Lead Responsible Sector	Target	Activity
offenders)	Police Department ▪ Ministry of National Education, ▪ Civil Society	80% of inmates access VCT, HIV prevention and harm reduction services	▪ For inmates who seek support, provide health services and treatment for opportunistic infections and co-infections including STI and Hepatitis C .
			▪ Referral to diagnostic health service include VCT or health provider initiative based on 3C principal (counseling, consent, confidential) and opportunistic infection services including STD infection IMS, Hep B, Hep C, TB dan AIDS for those who need it.
			▪ Referral to pre-release service (counseling, methadone, treatment, care and support)
			▪ Enhance structural interventions and involve all stakeholders in program implementation particularly communities of key population with relevant public sectors and civil society group (NAC, health sector, community and religious leaders). Focus to be placed on ensuring adequate networking and coordination among key sectors; improve quality of treatment and recovery program; capacity strengthening for program implementers and policy development to ensure supportive environment and human rights & gender-based approaches.
Prevention of HIV transmission from Mother to Child	▪ NAC ▪ Ministry of Health, ▪ Ministry of National Education, ▪ Civil Society	100% of pregnant women who are known to be HIV positive receive ARV prophylaxis	▪ Training to strengthen capacity of health workers and community workers in providing quality services to women in program to prevent transmission of HIV infection from mother to child.
			▪ Training for health workers to increase positive attitude in providing a friendly service for HIV positive women and their children (aim is to address stigma and discrimination within health care settings)
			▪ Provide reproductive health and basic PMTCT information for adolescents and men and women in reproductive age as part of maternal and child health service program
			▪ Planned pregnancy counseling for HIV positive women and their partners, (including ensuring access to condoms and other contraceptives)
			▪ Counseling and distribution of ARV prophylaxis for HIV positive pregnant women, during pregnancy and post-natal.
			▪ Counseling and assistance to ensure safe delivery that is suitable to the condition of the HIV positive pregnant woman.
			▪ Counseling and support in provision of safe baby food, that corresponds to the mother's choice and her condition; AFASS approved baby formula or exclusive breast milk for 6 months.
			▪ Post-natal psychological and social support for mother and child, including health service assistance such as PCR tests for infants.
			▪ Enhance structural interventions and involve all stakeholders in program implementation particularly communities of key population with relevant public

Main Activity	Lead Responsible Sector	Target	Activity
			sectors and civil society group (NAC, health sector, community and religious leaders). Focus to be placed on ensuring adequate networking and coordination among key sectors; improve quality of treatment program; capacity strengthening for program implementers and policy development to ensure supportive environment and human rights & gender-based approaches.
Prevention for client of sex workers through work place program (Assumption number of clients from work place setting is 30% from total clients. Source: MoH HIV and AIDS Quarterly Report 2008)	▪ NAC ▪ Ministry of Manpower and Transmigration ▪ BNP2TKI ▪ Ministry of Health ▪ Ministry of National Education ▪ Civil Society	80% of clients reached through effective and comprehensive prevention program 60% of key population practice healthy lifestyle and use condom in unsafe sex situations	▪ Training HIV prevention, IEC program, voluntary counseling and testing, for corporations and their employees
			▪ Dissemination of information and education on HIV and AIDS, focusing on healthy and responsible behaviour in the workplace
			▪ Ongoing outreach for healthy and responsible behavior, which covers improving knowledge and understanding in religious norms, increasing risk assessment ability, as well as increasing access to prevention including condom use for every risky sex act.
			▪ Develop referral system to increase access to Voluntary Counseling and Testing Services and STI management
			▪ Develop referral system to increase access to HIV treatment, care and support for those who are eligible for ARV therapy.
			▪ Coordinate and involve companies to conduct media campaign on anti discrimination in the workplace
			▪ Implement comprehensive programs to fight stigma and discrimination towards people living with HIV within workplace settings.
			▪ Enhance structural interventions and involve all stakeholders in program implementation particularly communities of key population with relevant public sectors and civil society group (NAC, health sector, community and religious leaders). Focus to be placed on advocating capacity building among companies and other key sectors; and policy development to ensure supportive environment and human rights & gender-based approaches.
Prevention for migrant workers who are client of sex workers through migrant worker program (Assumption: number of clients	▪ NAC ▪ Ministry of Manpower and Transmigration ▪ BNP2TKI ▪ Ministry of Health ▪ Ministry of National	80% of clients reached through effective and comprehensive prevention program 60% of key population	▪ Improve coordination of data collection and reporting on need of migrant workers related HIV and AIDS
			▪ Training of trainers for PAP instructors, BP3TKI, NGOs, PPTKIS and migrant workers
			▪ Training for counselors and develop HCT guidelines for pre-departure migrant workers to be used by health service providers, NGO and migrant workers
			▪ Advocate and develop integrated VCT and CST services for pre-departure migrants, at arrival countries and for returning migrants

Main Activity	Lead Responsible Sector	Target	Activity
who are migrant workers is 20% from total clients. Source: MoH HIV and AIDS Quarterly Report 2008)	Education ▪ Civil Society	practice healthy lifestyle and use condom in unsafe sex situations	▪ Enhance structural interventions and involve all stakeholders in program implementation particularly communities of key population with relevant public sectors and civil society group (NAC, health sector, community and religious leaders). Focus to be placed on ensuring adequate networking and coordination among key sectors; improve quality of treatment program; capacity strengthening for program implementers and policy development to ensure supportive environment and human rights & gender-based approaches.
HIV prevention and IEC program for young people who are vulnerable or at risk for HIV infection	▪ NAC ▪ Ministry of National Education ▪ Ministry of youth ▪ Department of Religious Affair Ministry of Health ▪ Civil Society	10% of youth receive information on HIV prevention 60% of youth practice healthy lifestyle	▪ Training for adolescents to protect themselves against HIV infection.
			▪ Training of peer educators on HIV and AIDS for adolescents.
			▪ Development and dissemination of youth-friendly IEC materials on HIV and AIDS, and reproductive health targeting young people through appropriate and effective communication channels.
			▪ Integrate life skills education program into general health education to empower young people with knowledge and capacity to protect themselves from HIV infection.
			▪ Increase availability of youth-friendly health clinics where young people can receive comprehensive health- and HIV-related IEC and services .
			▪ Enhance structural interventions and involve all stakeholders in program implementation particularly communities of key population with relevant public sectors and civil society group (NAC, health sector, education sector, community and religious leaders). Focus to be placed on ensuring adequate networking and coordination among key sectors; improve quality of treatment program; capacity strengthening for program implementers and policy development to ensure supportive environment and human rights & gender-based approaches.

Treatment, Care and Support

Main Activity	Lead Responsible Sector	Target	Activity
Develop the competency of health service units, strengthen capacity where	▪ NAC ▪ Ministry of Health ▪ Ministry of National Education ▪ Civil Society	Ensure quality health services and increase community members access to health	▪ Establish more health service units (for VCT, CST, PMTCT) while reviewing and improving their quality where necessary, ensuring friendly, human rights based, and gender sensitive services.
			▪ Increase the number and quality of health personnel who provide care, support and treatment for PLHIV through education system (incorporation of HIV and

Main Activity	Lead Responsible Sector	Target	Activity
needed and ensure optimal coordination between key health units		services	AIDS issues into training and degree program curriculum)
			▪ Training and education of health workers on friendly service for PLHIV especially women and children.
			▪ Strengthen coordination or establish coordinating mechanisms (where not existing) between health service units; referral hospitals, community health centers, health laboratories and community caregivers and community support groups for people living with HIV.
			▪ Where necessary, improve management of health-related commodities and equipment, particularly to prevent drug stock-out from disrupting ARV treatment program.
			▪ Provision of affordable and adequate HIV diagnostic testing.
			▪ Implement quality assurance and routinely monitor quality to improve program performance of health care providers to respond to the needs of people living with HIV.
Provide services to prevent and treat HIV-related opportunistic infections and other co-infections	▪ NAC ▪ Ministry of Health ▪ Civil Society	100% PLHIV access to prevention and treatment of opportunistic infection with they need	▪ Strengthen the health facilities for referral treatment (TB, IMS, Hep C, Hep B, etc) to be integrated to VCT service
			▪ Training treatment management for PLHIV who had TB
			▪ Ensure access to essential medicines and treatment for all people living with HIV who have opportunistic infections and co-infections (Hepatitis C) with supportive counseling and treatment adherence programs.
			▪ Increase availability of quality treatment, care and support programs for people living with HIV who have opportunistic infections. Also implement quality assurance and routinely monitor quality to improve program performance of health care providers.
Provide ARV treatment to people living with HIV	▪ NAC ▪ Ministry of Health ▪ Civil Society	100% of PLHIV access to ARV treatment, in line with WHO guidelines, aiming to improve health of PLHIV.	▪ Provision of ARV to PLHIV in need of treatment, including HIV positive inmates and children (with attention to ensuring optimal supply chain management systems for undisrupted supply of ARVs and related health commodities and equipments)
			▪ Counseling related the managing drug side effects, drug resistance, and treatment adherence
			▪ Monitoring treatment adherence programs integrated into comprehensive health services provided by public health centers, NGO and peer groups.
			▪ Provide nutrition support PLHIV who need it to facilitate effective ARV treatment and adherence
			▪ Improve diagnostic services and increase accessibility (CD 4, viral load)
			▪ Implement quality assurance for health service delivery programs to ensure that services correspond to the needs of PLHIV.
			▪ Enhance structural interventions and involve all stakeholders in program implementation particularly

Main Activity	Lead Responsible Sector	Target	Activity
			communities of key population with relevant public sectors and civil society group (NAC, health sector, community and religious leaders). Focus to be placed on ensuring adequate networking and coordination among key sectors; improve access to ARV for PLHIV and quality of treatment program; capacity strengthening for program implementers and policy development to ensure supportive environment and human rights & gender-based approaches.
Psychological and Social Support	▪ NAC ▪ Ministry of Social and Welfare ▪ Ministry of Health ▪ Civil Society	Provision of psychological and social support	▪ Strengthen skills and capacity of peer support groups and community-based organizations to provide psychological and social support for PLHIV.
			▪ HIV education and IEC targeting key community members and opinion leaders to reduce stigma and discrimination against HIV positive people and their families.
			▪ Provide training for HIV treatment case managers to improve care and support for people living with HIV and their families.
			▪ Provide education and training for communities to increase the psychological and social support
Provide training and skills building opportunities for PLHIV	▪ Ministry of Social and Welfare ▪ Ministry of Health ▪ Civil Society	Capacity building for PLHIV	▪ Provide education and training for PLHIV to increase access to health services
			▪ Provide training for communities and peer support groups

Impact Mitigation

Main Activity	Lead Responsible Sector	Target	Activity
Impact mitigation	▪ Ministry of Social and Welfare ▪ Ministry of Health ▪ Civil Society	100% of PLHIV who meet the criteria receive access for social mitigation	▪ Improve access to health and nutritional care, basic development and education support for children infected with HIV and affected by AIDS who are orphaned or whose families are less privileged and having low income.
			▪ Provision of learning and training programs on income generation, resource mobilization, and accessing small business loans or micro-credit for people living with HIV with low income particularly widows, single parents and those experiencing negative socio-economic impact from HIV and AIDS.
			▪ Increase availability and access to scholarships for continuing education, short courses and sponsorship for capacity building and training programs for PLHIV.

Main Activity	Lead Responsible Sector	Target	Activity
			▪ Provide the capacity development to increase skill PLHIV and key population through non formal education, short course training and vocational.
			▪ Intensify efforts to work with families and communities to attain greater understanding and gain support for people living with HIV.
			▪ Enhance structural interventions and involve all stakeholders in program implementation particularly communities of key population with relevant public sectors and civil society group (NAC, health sector, community and religious leaders). Focus to be placed on ensuring adequate networking and coordination among key sectors; improve access to ARV for PLHIV and quality of treatment program; capacity strengthening for program implementers and policy development to ensure supportive environment and human rights & gender-based approaches.

Conducive Environment

Main Activity	Lead Responsible Sector	Target	Activity
Strengthening Institutional Development and Management Capacity	▪ Ministry of Welfare ▪ Ministry of Home Affair ▪ NAC	100% the related sectors (government and non government) implement the AIDS program as their role and function	▪ Institutional infrastructure strengthening for AIDS Commission in central and regional level.
			▪ Strengthening monitoring and evaluation mechanism to monitor the progress level of the responses.
			▪ Capacity building to ensure routine dissemination of information pertaining AIDS response.
			▪ Developing policies needed to ensure a better response sustainability.
			▪ Improve and strengthen the role of civil society, particularly people living with HIV, in every stage of planning, implementation, monitoring, and decision-making process.
			▪ Capacity building on legal aspects; human rights and gender-based approaches for program implementers and key population.
Program management, including planning; implementation and evaluation			▪ Develop strategic planning, action planning, and participatory program planning.
			▪ Establish a planning and budgeting forum to ensure program sustainability, promoting program synergy and harmonization.
			▪ Capacity building for program implementers to ensure effectiveness and efficiency.
			▪ Capacity building for people living with HIV and key population networks to improve meaningful participation in achieving program targets and goals.
			▪ Routine dissemination of information pertaining to AIDS response, as well as transparent information about budget at national and regional level.

Main Activity	Lead Responsible Sector	Target	Activity
			▪ Implement comprehensive M&E program to review program performance and report on progress in achieving targets set out in the RAN. See chapter 7 for complete list of M&E tools and reports to be used including program reports, surveillance area required and operation research.
Increase coordination and harmonization in policy development process	▪ Ministry of Welfare ▪ Ministry of Home Affair ▪ NAC ▪ Ministry of Justice and Human Right	All related relevance sectors active and providing report of program as their role and function	▪ Periodic review of national and regional policies involving key population and people living with HIV as the main beneficiaries to determine whether the policy is suitable with the actual condition.
			▪ Periodic coordination meeting between sectors regarding policies to avoid conflicting policies.
			▪ Meeting between civil society and sectors to reduce the impact of conflicting policy.
Development of new policies	▪ Ministry of Welfare ▪ Ministry of Home Affair ▪ NAC ▪ Ministry of Justice and Human Right	Policies developed as required	▪ Work with education sector; media and faith-based organizations to promote zero-tolerance policy for stigma and discrimination towards key population groups and people living with HIV. Develop mechanisms to monitor occurrences of discrimination and provide assistance where needed..
			▪ Develop policies to support priority AIDS response interventions, such as the 100% condom use policy; IDU management policy; and care, support and treatment policy.
			▪ Develop regional regulations and policies for AIDS response to ensure program sustainability and reduce stigma and discrimination against people living with HIV and key population
			▪ Develop operational guidelines and technical guidelines for interventions targeting key population
Provide legal support to PLHIV and key population	▪ Ministry of Welfare ▪ Ministry of Home Affair ▪ NAC ▪ Ministry of Justice and Human Right	Existence of legal assistance mechanism accessible by those PLHIV and key population who need it.	▪ Provision of legal consultation space for key population
			▪ Provision of legal assistance and support law enforcement to reduce stigma and discrimination experienced by people living with HIV
			▪ Supporting advocacy efforts conducted by key population groups with assistance from legal expert groups for AIDS

ANNEX 3

Annual Target of Program Coverage

IDUs

Population Size	231.000		235.300		237.000		238.800		240.400		241.900	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	50.420	21,8%	129.420	55%	189.600	80%	202.980	85%	216.360	90%	241.900	100%
Needle and syringe exchange program	32.879	14,2%	103.530	44%	151.680	64%	162.380	68%	173.090	72%	193.520	80%
VCT	9.358	18,6%	103.530	44%	151.680	64%	162.380	68%	173.090	72%	193.520	80%
MMT	6.758	13,4%	31.060	13%	45.500	19%	48.720	20%	51.930	22%	58.060	24%
Care and support	1.107	11,8%	134.121	57%	135.090	57%	136.116	57%	137.028	57%	137.883	57%

Note:
1. Target of IDUs who receive NSEP is 80% of IDUs from IDUs reached BCC program
2. Target of IDUs who receive VCT is 80% from IDUs who reached of BCC program
3. Target of IDUs who receive MMT is 30% from IDUs reached by NSEP program
4. Target of IDUs who receive care and support is 57% of total IDUs.
   The percentage of inmate who need care and support based on asumption the prevalence of HIV+ among IDUs which is 57% (IBBS, 2007)

Inmates

Population Size	99.420		131.100		131.100		131.100		131.100		131.100	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	37.567	37,8%	78.660	60%	104.880	80%	111.435	85%	117.990	90%	131.100	100%
VCT	4.285	11,4%	62.928	48%	83.904	64%	89.148	68%	94.392	72%	104.880	80%
MMT	79	0,2%	23.598	18%	31.464	24%	33.431	26%	35.397	27%	39.330	30%
Care and support	528	12,3%	74.727	57%	3.933	3%	6.555	5%	9.177	7%	9.177	7%

Note:
1. Target of inmates who receive VCT is 80% from imnate who reached BCC program
3. Target of inmates who receive MMT is 30% from IDUs reached by NSEP program

3. Target of inmates who receive care and support is 57% from total inmate.
   The percentage of inmate who need care and support based on asumption the prevalence of HIV+ among inmate as well as same with IDUs prevalence which is 57% (IBBS, 2007)

Direct Female Sex Workers (FSW)

Population Size	135.000		137.700		138.700		139.700		140.600		141.300	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	65.045	48,2%	82.620	60%	97.090	70%	111.760	80%	119.510	85%	127.170	90%
Periodic treatment	16.347		66.100	48%	77.670	56%	89.410	64%	95.610	68%	101.740	72%
STI Screening	59.983		32.220	23%	37.870	27%	43.590	31%	46.610	33%	49.600	35%
VCT	17.705		66.100	48%	77.670	56%	89.410	64%	95.610	68%	101.740	72%
Care and support	N/A		14.252	10%	14.355	10%	14.459	10%	14.552	10%	14.625	10%

Note:
1. Target of direct female sex workers who receive periodic treatment is 80% from direct FSW who reached BCC program
2. Target of direct FSW who receive STi screening is 39% of direct FSW who reached BCC program
   The percentage is assume based on STI prevalence among FSW which is 39%. Source IBBS-MoH, 2007
3. Target of direct FSW who receive VCT service is 80% from direct FSW who reached BCC program

4. Target of direct FSW who receive care and support is 10.35% from total direct FSW.
   The percentage of direct FSW who need care and support based on asumption the prevalence of HIV+ among them which is 10.35% (IBBS, 2007)

Indirect Female Sex Worker

Population Size	98.000		99.800		100.600		101.300		101.900		102.500	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	28.884	29,5%	59.880	60%	70.420	70%	81.040	80%	86.620	85%	92.250	90%
Periodic treatment	3.088		47.900	48%	56.340	56%	64.830	64%	69.290	68%	73.800	72%
STI Screening	12.468		18.560	19%	21.830	22%	25.120	25%	26.850	26%	28.600	28%
VCT	7.158		47.900	48%	56.340	56%	64.830	64%	69.290	68%	73.800	72%
Care and support	N/A		4.581	5%	4.618	5%	4.650	5%	4.677	5%	4.705	5%

Note:
1. Target of indirect female sex workers who receive periodic treatment is 80% from direct FSW who reached BCC program
2. Target of indirect FSW who receive STi screening is 31% of direct FSW who reached BCC program
   The percentage is assume based on STI prevalence among FSW which is 31%. Source IBBS-MoH, 2007
3. Target of direct FSW who receive VCT service is 80% from direct FSW who reached BCC program

4. Target of direct FSW who receive care and support is 5% from total direct FSW.
   The percentage of direct FSW who need care and support based on asumption the prevalence of HIV+ among them which is 5% (IBBS, 2007)

Client Female Sex Workers

Population Size	3.334.200		3.394.800		3.420.400		3.445.200		3.469.100		3.490.300	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	511.807	15,4%	1.018.440	30%	1.539.180	45%	2.067.120	60%	2.428.370	70%	2.792.240	80%
STI treatment	N/A		10.184	0,3%	15.392	0,5%	20.671	0,6%	24.284	0,7%	27.922	0,8%
VCT	11.245	2,2%	509.220	15%	769.590	23%	1.033.560	30%	1.214.190	35%	1.396.120	40%
Care and support	N/A		101.844	3,0%	102.612	3,0%	103.356	3,0%	104.073	3,0%	104.709	3,0%

Note:
1. Target of client female sex workers who receive STI treatment is 1% from client FSW who reached BCC program
   The percentage is assume based on STI prevalence among client which is 31%. Source IBBS-MoH, 2007
2. Target of client female sex workers who receive VCT service is 80% from client FSW who reached BCC program
3. Target of client FSW who receive care and support is 3% from total client FSW.
   The percentage of client FSW who need care and support based on asumption the high prevalence of HIV+ among them which is 3% (IBBS, 2007)

Man Who Have Sex with Man (MSM)

Population Size	809.000		823.300		829.500		835.500		841.300		846.400	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	53.867	6,7%	205.830	25%	373.280	45%	501.300	60%	588.910	70%	677.120	80%
STI treatment	9.094	1,1%	6.170	0,8%	11.200	1,4%	15.040	1,8%	17.670	2,1%	20.310	2,4%
VCT	10.246	1,3%	41.170	20%	134.380	36%	240.620	48%	329.790	56%	433.360	64%
Care and support	N/A		57.631	7%	58.065	7%	58.485	7%	58.891	7%	59.248	7%

Note:
1. Target of MSM who receive BCC program is 80% of total MSM (include lo risk MSM)
2. Target of MSM who receive STI treatment is 3% from MSM who reached BCC program
   The percentage is assume based on STI prevalence among MSM which is 3%. Source IBBS-MoH, 2007
3. Target of MSM who receive VCT is 80% from MSM who reached BCC program
3. Target of MSM who receive care and support is 7% from total MSM
   The percentage of MSM who need care and support based on asumption the prevalence of HIV+ among them which is 7% (IBBS, 2007)

Waria (Transgender)

Population Size	29.700		30.200		30.400		30.600		30.900		31.100	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	26.730	90,0%	27.180	90%	28.880	95%	30.600	100%	30.600	100%	30.600	100%
Periodic treatment	2.197	8,2%	21.740	72%	23.100	76%	24.480	80%	24.720	80%	24.880	80%
STI Screening	8.365	31,3%	12.770	42%	13.570	45%	14.380	47%	14.520	47%	14.620	47%
VCT	5.202	17,5%	21.740	72%	10.860	36%	11.510	38%	11.620	38%	11.690	38%
Care and support	N/A		8.758	29%	8.816	29%	8.874	29%	8.961	29%	9.019	29%

Note:
1. Target of waria who receive periodic treatment is 80% from waria who reached BCC program
2. Target of waria who receive STI screening is 47% of waria who reached BCC program
   The percentage is assume based on STI prevalence among waria which is 31%. Source IBBS-MoH, 2007
3. Target of waria who receive VCT service is 80% from waria who reached BCC program
4. Target of direct FSW who receive care and support is 29% from total direct FSW.
   The percentage of direct FSW who need care and support based on asumption the prevalence of HIV+ among them which is 29% (IBBS, 2007)

Intimate Partners of Key Population

Population Size	2.092.203		2.108.800		2.133.000		2.149.100		2.163.900		2.177.800	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	N/A		42.176	2%	106.650	5%	214.910	10%	324.585	15%	544.450	25%
STI treatment	N/A		8	0,02%	53	0,05%	215	0,10%	487	0,15%	1.361	0,25%
VCT	N/A		675	2%	4.266	4%	17.193	8%	38.950	12%	108.890	20%
Care and support	N/A		63.264	3%	63.990	3%	64.473	3%	64.917	3%	65.334	3%

Note:
1. Intimate partner is woman sexual partner of key population include IDUs partner, client of female sex worker partners, and MSM partners
2. Target of waria who receive periodic treatment is 80% from waria who reached BCC program
2. Target of intimate partner who receive STI treatment is 1% of intimate partner who reached BCC program
   The percentage is assume based on STI prevalence among them is same with client, which is 31%. Source IBBS-MoH, 2007
3. Target of intimate partner who receive VCT service is 80% from intimate who reached BCC program
4. Target of intimate parnter who receive care and support is 3% from total population size. It assume the risk of intimate partner come from their partner (key population)

General Population in Papua and West Papua Province

Population Size	1.929.900		1.992.800		2.041.000		2.088.300		2.136.700		2.183.700	
Program Intervention	Baseline 2009		Target 2010		Target 2011		Target 2012		Target 2013		Target 2014	
Behavior and communication change	N/A		498.200	25%	1.020.500	50%	1.252.980	60%	1.495.690	70%	1.746.960	80%
STI treatment	676	0,04%	2.491	0,5%	10.205	1,0%	15.036	1,2%	20.940	1,4%	27.951	1,6%
VCT	4.553	0,3%	398.560	20%	816.400	40%	1.002.384	48%	1.196.552	56%	1.397.568	64%
Care and support	373	0,8%	47.827	2,4%	48.984	2,4%	50.119	2,4%	51.281	2,4%	52.409	2,4%

Note:
1. Target of general population who receive STI treatment is 2% of total populationwho reached BCC program
   The percentage is assume based on STI prevalence among them is same with client, which is 31%. Source IBBS-MoH, 2007
2. Target of general population who receive VCT service is 80% from people who reached BCC program
3. Target of population who receive care and support is 2,4% from total population size.
   The percentage of population for those provinces who need care and support based on asumption the prevalence of HIV+ in Papua is 2.4% (IBBS, 2006)

Care, Support and Treatment

Intervention	Baseline 2009		Target 2010	Target 2011	Target 2012	Target 2013	Target 2014
Care, Support	16.133		502.424	435.845	442.437	448.880	452.403
Pregnant woman who HIV+ receiving ARV Prophylaxis	226		5.730	6.340	6.890	7.320	8.170
PLHIV receiving ARV treatment	13.189	46,0%	25.200	30.150	34.750	39.200	43.400

Note:
1. The number of target care support present of in this section is cummulative number people who need care and support from IDUs, Direct FSW, Indirect FSW, Client, MSM, Waria, Intimate partner and general population in Papua
2. The target of pregnant woman who HIV+ receiving ARV prophylaxis quote from MoH plan 2009-2014
3. The target of ARV prophylaxis quote from MoH plan as national target that state in Round 8 proposal document

Annex 4.

Selection Process of Priority District

Selection process based on criteria listed above has been carried out, involving both national and regional stakeholders, particularly Ministry of Health as Primary Recipient of GF Round 1 and Round 4, as well as the NAC, the responsible entity for strengthening Provincial and District AIDS Commissions.

In the first selection process, 71 districts in 12 provinces were selected. The 12 provinces are: North Sumatra, Riau, Riau Islands, South Sumatra, DKI Jakarta, West Java, Central Java, East Java, Bali, South Sulawesi, Papua and West Papua. The first selection process was carried out in conjunction with the GF Round 8 proposal submission.

The second selection process still follows the criteria above, 65 districts with the most risk and the highest disease burden in 21 provinces were selected. The decision to identify districts outside the initial 12 provinces was taken to address the current AIDS epidemic situation in Indonesia, where HIV infection has been found in 214 districts, from all 33 provinces.

The priority areas were selected as the focus of program implementation with financial resources from national level efforts.

The areas in the 12 provinces first selected have received support from Round 8 Global Fund, beginning in 2009 and ending in mid-2014. During this time all provinces supported by Global Fund Round 8 grants are expected to new develop funding from local or outside sources in order to sustain and, if needed, expand programmed begun with Global Fund support.

The second set of selected areas is currently waiting for confirmation of support from Round 9 Global Fund. List of selected districts is attached.

In the context of decentralization, every province can determine their of priority areas, taking into consideration the local nature of the epidemic and their ability to mount and sustain a response to AIDS.

Annex 5. Geographic Focus: Districts/ Cities Selected

A. List of Districts/ Cities Selected (supported by GF Round 8)

No	District/ City	Province	IDU	Prisoner	IDU + Prisoner	FSW	Client	MSM	Transgender	PLHIV
1	Kota Jakarta Timur	DKI Jakarta	10,830	6,210	17,040	8,660	110,120	13,020	350	8,860
2	Kota Bandung	West Java	2,580	11,090	13,670	3,490	32,390	11,220	250	1,800
3	Kota Jakarta Pusat	DKI Jakarta	8,050	3,030	11,080	6,150	61,080	4,320	200	5,330
4	Kota Medan	North Sumatera	4,020	3,930	7,950	1,850	33,370	9,640	190	2,250
5	Kota Ujung Pandang	South Sulawesi	6,330	350	6,680	640	8,380	5,620	300	3,060
6	Kota Palembang	South Sumatera	4,330	1,890	6,220	2,750	41,370	6,440	260	2,980
7	Kota Bogor	West Java	4,590	1,160	5,750	800	12,830	4,840	120	2,710
8	Kota Jakarta Barat	DKI Jakarta	5,640	-	5,640	13,360	179,160	10,810	130	5,660
9	Kota Jakarta Selatan	DKI Jakarta	5,620	-	5,620	4,810	43,790	10,050	410	3,940
10	Cirebon	West Java	4,280	1,110	5,390	440	7,400	9,520	120	2,750
11	Kota Surabaya	East Java	4,230	1,060	5,290	9,180	170,830	14,000	760	4,290
12	Kota Malang	East Java	2,140	2,260	4,400	540	9,290	4,080	120	1,310
13	Kota Jakarta Utara	DKI Jakarta	3,620	-	3,620	5,940	74,600	7,420	250	3,870
14	Kota Bekasi	West Java	2,280	1,260	3,540	2,300	32,570	11,040	210	1,750
15	Deli Serdang	North Sumatera	1,900	1,610	3,510	780	16,970	7,420	170	1,220
16	Kota Batam	Riau Islands	3,480	-	3,480	5,570	38,560	3,380	240	2,250
17	Kota Semarang	Central Java	1,860	700	2,560	2,410	37,150	7,270	140	1,390
18	Kota Pekan Baru	Riau	1,220	1,210	2,430	1,800	32,110	3,630	50	1,010
19	Badung	Bali	1,320	660	1,980	1,130	15,130	2,110	160	1,090
20	Kota Denpasar	Bali	1,760	-	1,760	5,060	90,720	2,740	80	3,370
21	Mojokerto	East Java	1,550	190	1,740	360	6,590	2,380	80	840
22	Cilacap	Central Java	820	920	1,740	340	5,470	7,400	50	570

No	District/ City	Province	IDU	Prisoner	IDU + Prisoner	FSW	Client	MSM	Transgender	PLHIV
23	Blitar	East Java	1,600	-	1,600	430	9,490	1,230	180	900
24	Karawang	West Java	920	620	1,540	2,300	31,080	9,440	70	730
25	Simalungun	North Sumatera	820	720	1,540	650	15,190	3,720	170	650
26	Kediri	East Java	1,050	450	1,500	1,400	30,690	6,970	140	990
27	Kota Cirebon	West Java	520	940	1,460	610	8,140	700	110	410
28	Kota Kediri	East Java	980	450	1,430	1,120	13,790	580	150	660
29	Sidoarjo	East Java	690	550	1,240	350	6,170	9,110	190	490
30	Banyuwangi	East Java	720	440	1,160	890	18,590	6,940	350	740
31	Kota Dumai	Riau	540	550	1,090	320	4,840	560	50	320
32	Jember	East Java	260	740	1,000	990	18,490	9,940	150	550
33	Ogan Komering Ilir	South Sumatera	430	530	960	370	6,040	1,580	50	300
34	Karimun	Riau Islands	580	320	900	2,350	35,210	1,040	20	790
35	Labuhan Batu	North Sumatera	270	570	840	450	9,850	2,150	60	290
36	Banyuasin	South Sumatera	800	-	800	270	4,430	870	40	430
37	Indragiri Hilir	Riau	340	450	790	940	18,200	3,080	380	510
38	Bengkalis	Riau	380	400	780	1,270	24,490	3,320	490	630
39	Indramayu	West Java	480	290	770	2,930	45,340	7,820	370	960
40	Kampar	Riau	230	360	590	750	14,570	580	80	310
41	Kota Pare-Pare	South Sulawesi	460	110	570	410	14,670	260	150	430
42	Kota Surakarta	Central Java	270	290	560	3,130	41,070	2,510	80	860
43	Batang	Central Java	560	-	560	760	12,580	1,590	270	500
44	Tegal	Central Java	370	170	540	890	14,350	6,290	300	500
45	Banyumas	Central Java	260	270	530	940	14,410	7,030	110	400
46	Pelalawan	Riau	530	-	530	370	7,090	300	160	340
47	Rokan Hilir	Riau	230	250	480	850	16,110	1,060	360	390

No	District/ City	Province	IDU	Prisoner	IDU + Prisoner	FSW	Client	MSM	Transgender	PLHIV
48	Pinrang	South Sulawesi	330	100	430	430	16,840	710	120	410
49	Jeneponto	South Sulawesi	330	50	380	720	21,230	720	140	460
50	Kota Prabumulih	South Sumatera	160	180	340	630	10,720	160	220	270
51	Semarang	Central Java	190	150	340	560	9,020	4,320	40	270
52	Sidenreng Rappang	South Sulawesi	240	50	290	1,090	21,590	520	100	390
53	Buleleng	Bali	80	200	280	1,100	10,390	2,780	70	340
54	Kendal	Central Java	110	160	270	1,060	14,540	4,180	40	280
55	Kota Jayapura	Papua	200	20	220	1,290	6,830	1,040	80	2,450
56	Bangli	Bali	110	60	170	100	2,100	250	-	110
57	Manokwari	West Papua	50	80	130	480	6,920	360	10	1,700
58	Sorong	West Papua	120	10	130	260	1,840	80	10	760
59	Jayawijaya	Papua	30	60	90	180	1,920	620	10	3,050
60	Nabire	Papua	20	60	80	880	11,400	370	70	1,530
61	Kota Sorong	West Papua	70	-	70	1,040	6,000	370	240	2,010
62	Merauke	Papua	50	-	50	860	5,070	420	10	2,090
63	Fakfak	West Papua	10	40	50	330	3,360	140	20	620
64	Jayapura	Papua	20	-	20	450	6,730	230	20	1,020
65	Kota Tanjung Pinang	Riau Islands	20	-	20	1,660	13,890	820	70	240
66	Mimika	Papua	10	-	10	620	8,750	640	30	1,560
67	Paniai	Papua	10	-	10	40	570	130	10	1,330
68	Teluk Bintuni	West Papua	-	-	-	250	3,870	100	30	450
69	Kaimana	West Papua	-	-	-	320	3,210	100	20	440
70	Raja Ampat	West Papua	-	-	-	-	-	40	-	380
71	Bekasi	West Java	1,450	-	1,450	3,860	57,530	9,840	1,320	1,910

B. List of Selected Districts/ Cities (Proposed supported by GF 9)

No	District/ City	Province	IDU	Prisoner	IDU + Prisoner	FSW	Client	MSM	Transgender	PLHIV
1) Districts/Cities which has capacity to conduct the program										
1	Kota Tangerang	Banten	2,640	3,410	6,050	480	7,620	8,060	100	2,500
2	Tangerang	Banten	5,330	-	5,330	1,540	26,690	16,380	20	3,000
3	Serang	Banten	660	750	1,410	80	670	8,840	100	450
4	Sleman	DI Yogyakarta	2,690	200	2,890	700	8,640	4,820	200	1,390
5	Kota Yogyakarta	DI Yogyakarta	1,490	450	1,940	1,000	14,110	1,130	80	1,050
6	Gunung Kidul	DI Yogyakarta	790	80	870	290	3,820	1,400	-	380
7	Kota Pontianak	West Kalimantan	2,140	390	2,530	1,520	18,150	2,420	220	1,300
8	Kota Singkawang	West Kalimantan	480	250	730	780	8,240	780	160	430
9	Kota Banjarmasin	South Kalimantan Selatan	2,730	800	3,530	500	5,470	2,800	130	1,380
10	Tanah Bumbu	South Kalimantan Selatan	1,000	-	1,000	390	5,780	280	110	570
11	Tabalong	South Kalimantan Selatan	840	110	950	70	990	230	10	400
12	Kota Balikpapan	East Kalimantan	2,520	-	2,520	1,570	21,120	2,310	560	1,300
13	Kota Samarinda	East Kalimantan	1,730	570	2,300	1,840	27,590	3,100	790	1,400
14	Kutai Timur	East Kalimantan	830	-	830	1,600	13,900	900	220	430
15	Kutai Kartanegara	East Kalimantan	780	-	780	2,220	19,330	2,370	310	570
16	Bandar Lampung	Lampung	2,780	1,040	3,820	660	10,840	3,880	110	1,430
17	Tulang Bawang	Lampung	1,180	-	1,180	1,010	18,130	950	290	860
18	Kota Ambon	Maluku	110	280	390	1,030	10,140	1,060	100	220
19	Maluku Tengah	Maluku	360	-	360	260	2,340	1,540	10	200
20	Maluku Tenggara	Maluku	30	70	100	900	11,360	250	170	200
21	Kepulauan Aru	Maluku	50	-	50	810	9,650	80	90	360
22	Kota Mataram	NTB	240	270	510	500	6,560	830	30	230

No	District/ City	Province	IDU	Prisoner	IDU + Prisoner	FSW	Client	MSM	Transgender	PLHIV
23	Lombok Timur	NTB	70	90	160	230	2,620	1,920	40	100
24	Lombok Barat	NTB	20	-	20	420	4,440	3,240	50	120
25	Belu	NTT	1,120	190	1,310	380	4,350	350	20	620
26	Ngada	NTT	610	90	700	40	380	230	-	280
27	Kota Kupang	NTT	130	460	590	930	10,470	1,400	50	190
28	Kota Manado	North Sulawesi	680	590	1,270	1,870	21,270	2,100	310	720
29	Minahasa	North Sulawesi	410	310	720	210	1,490	1,440	50	240
30	Bolaang Mongondow	North Sulawesi	330	100	430	190	2,440	2,280	10	210
31	Kota Padang	West Sumatera	1,670	510	2,180	390	6,330	3,740	30	890
32	Kota Bukittinggi	West Sumatera	1,080	230	1,310	-	-	240	-	490
33	Kota Sawah Lunto	West Sumatera	30	200	230	210	2,550	120	20	50
2) Districts/ Cities which still need capacity improvement before implementing the program										
34	Kota Bengkulu	Bengkulu	1,230	-	1,230	870	15,720	670	380	880
35	Bengkulu Utara	Bengkulu	220	-	220	10	70	1,540	-	120
36	Rejang Lebong	Bengkulu	170	-	170	360	6,190	1,180	100	200
37	Kota Gorontalo	Gorontalo	90	260	350	890	11,630	360	80	70
38	Pohuwato	Gorontalo	120	10	130	250	2,930	130	60	90
39	Gorontalo	Gorontalo	20	20	40	210	2,570	1,820	110	80
40	Kota Jambi	Jambi	1,030	720	1,750	820	14,920	2,260	110	800
41	Tanjung Jabung Timur	Jambi	890	-	890	110	1,630	970	20	430
42	Bungo	Jambi	680	200	880	50	580	290	10	320
43	Kerinci	Jambi	700	70	770	-	-	1,360	-	330
44	Kota Palangka Raya	Central Kalimantan	850	-	850	610	5,260	930	90	440
45	Kapuas	Central Kalimantan	370	-	370	390	3,410	1,610	30	230
46	Kotawaringin Barat	Central Kalimantan	100	140	240	1,090	13,730	990	230	290

No	District/ City	Province	IDU	Prisoner	IDU + Prisoner	FSW	Client	MSM	Transgender	PLHIV
47	Kotawaringin Timur	Central Kalimantan	70	90	160	940	10,130	1,400	220	230
48	Bangka	Bangka Belitung Islands	1,110	80	1,190	530	8,120	1,200	250	680
49	Kota Pangkal Pinang	Bangka Belitung Islands	650	290	940	1,080	13,370	390	200	470
50	Bangka Barat	Bangka Belitung Islands	710	20	730	420	5,150	200	70	430
51	Kota Ternate	North Maluku	430	320	750	530	8,290	380	20	250
52	Halmahera Utara	North Maluku	180	-	180	230	3,810	200	70	160
53	Kepulauan Sula	North Maluku	130	-	130	170	2,710	140	50	110
54	Kota Banda Aceh	Nangroe Aceh Darussalam	390	-	390	-	-	640	-	180
55	Pidie	Nangroe Aceh Darussalam	170	90	260	130	2,850	1,980	20	140
56	Kota Lhoksumawe	Nangroe Aceh Darussalam	130	110	240	200	4,330	170	60	140
57	Gayo Lues/Aceh	Nangroe Aceh Darussalam	150	50	200	-	-	80	-	70
58	Mamuju Utara	West Sulawesi	430	-	430	120	2,950	120	40	240
59	Polewali Mandar	West Sulawesi	140	170	310	390	5,330	1,500	30	150
60	Mamuju	West Sulawesi	280	-	280	120	2,060	610	10	160
61	Kota Palu	Central Sulawesi	1,360	1,030	2,390	670	8,960	1,480	100	790
62	Donggala	Central Sulawesi	950	-	950	380	5,050	2,080	10	500
63	Kota Kendari	South-East Sulawesi	160	400	560	480	7,350	1,130	100	160
64	Muna	South-East Sulawesi	160	110	270	200	2,650	1,120	20	120
65	Kota Bau Bau	South-East Sulawesi	50	200	250	540	7,250	280	40	120

Annex 6.

Detail Budget to Implement Strategy and Action Plan 2010-2014

Area and Activities	2010	2011	2012	2013	2014
Prevention-related activities	**82.143.664**	**101.000.849**	**115.029.488**	**122.167.131**	**134.459.271**
Priority populations					
Direct Sex workers	8.406.786	8.853.102	10.540.474	10.342.923	10.429.936
Indirect Sex workers	3.828.325	3.427.541	4.031.827	3.860.275	3.899.421
Men who have sex with men	10.655.209	14.150.134	16.631.562	18.022.439	20.512.621
Waria	1.866.250	1.870.664	1.884.464	1.897.747	1.909.792
Injecting drug users	12.407.956	19.997.696	21.085.720	22.182.087	23.273.871
Prison population	4.316.011	4.977.659	5.236.666	5.495.674	5.754.682
Clients of SW	7.415.367	11.928.054	16.504.413	20.338.517	24.208.725
Youth	10.693.491	11.057.231	11.551.149	12.001.785	12.502.581
Workplace program	1.532.916	1.573.217	1.614.069	1.655.537	1.696.906
Service Delivery					
Condom provision: Papua	25.678	61.052	110.280	174.003	342.100
STI management	1.059.176	1.217.552	1.337.998	1.459.479	1.581.491
Voluntary counseling and testing	12.380.522	13.376.471	14.946.239	15.159.318	18.748.978
Prevention of mother-to-child transmission	280.152	201.017	211.534	234.256	255.074
Mass media	7.235.438	8.269.072	9.302.706	9.302.706	9.302.706
Post-exposure prophylaxis	40.387	40.387	40.387	40.387	40.387
Care and treatment services	**48.368.285**	**58.156.756**	**69.192.777**	**67.268.145**	**77.311.546**
Home-based care	18.306.353	24.606.525	28.455.662	32.067.006	35.785.114
Palliative Care	18.625	36.670	60.949	91.637	129.440
Diagnostic testing	248.772	320.907	392.324	463.055	532.995
OI treatment	1.254.509	1.772.887	2.350.843	2.960.507	3.590.819
Prophylaxis for opportunistic infections	284.504	382.714	490.250	606.700	730.468
Laboratory tests for ARV therapy	4.654.567	6.155.403	7.520.131	5.474.236	6.680.357
Anti-retroviral therapy	23.600.955	24.881.650	29.922.618	25.605.003	29.862.353
Mitigation	**3.706.099**	**4.205.602**	**4.654.201**	**5.062.440**	**5.422.720**
Orphan care	637.069	740.773	836.755	926.086	1.006.795
General economic support	3.069.030	3.464.829	3.817.446	4.136.354	4.415.925
Policy, advocacy, administration and rese	**18.017.685**	**21.971.361**	**25.359.011**	**25.977.219**	**29.039.798**
Enabling environment	3.002.947	3.661.894	4.226.502	4.329.536	4.839.966
Management and administration	3.002.947	3.661.894	4.226.502	4.329.536	4.839.966
Research and Surveillance	6.005.895	7.323.787	8.453.004	8.659.073	9.679.933
Monitoring and evaluation	6.005.895	7.323.787	8.453.004	8.659.073	9.679.933
TOTAL	**152.235.733**	**185.334.568**	**214.235.477**	**220.474.935**	**246.233.335**

Annex 7.

Indonesia Performance National Indicators

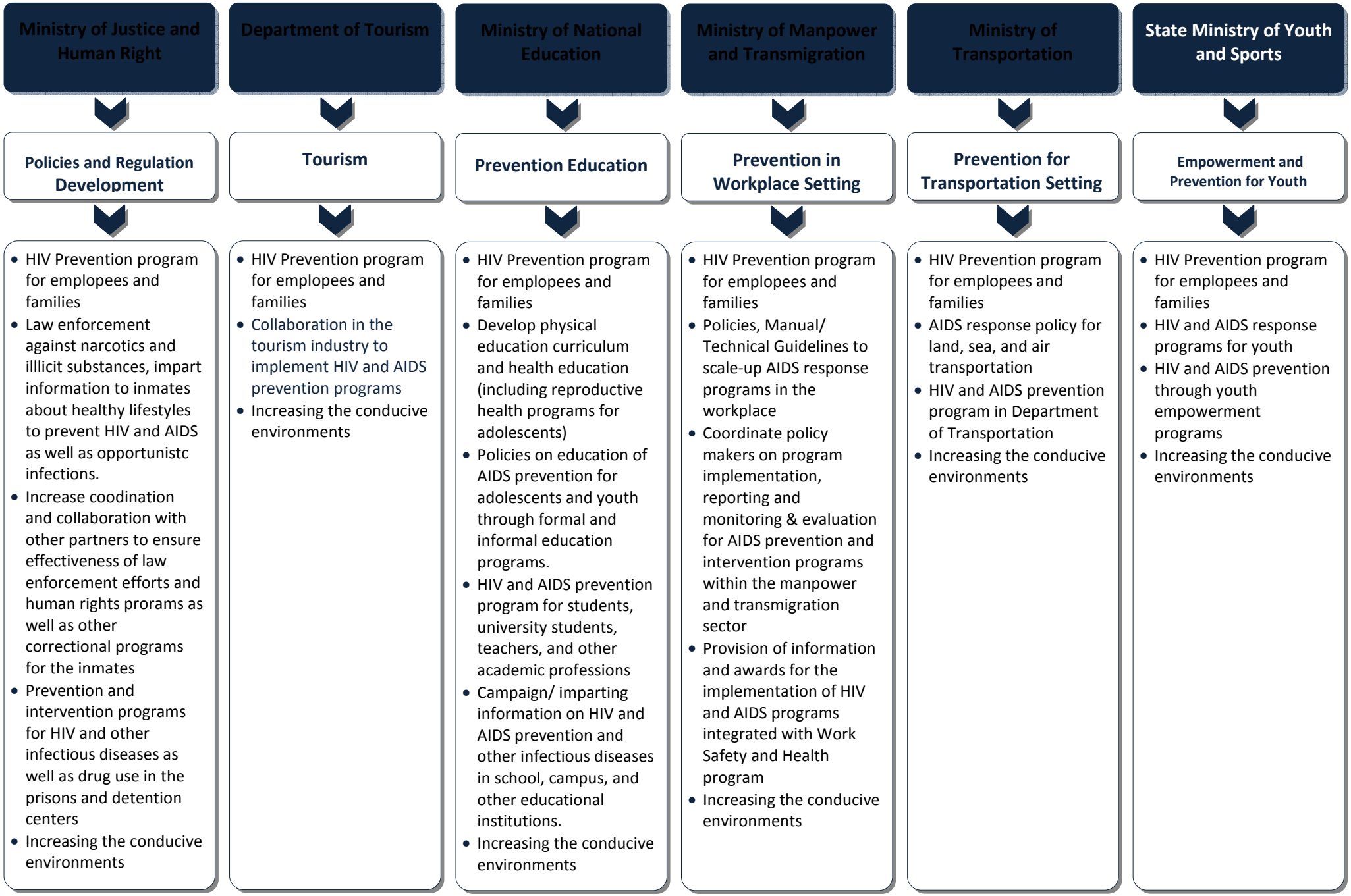
No	Indicator	Frequency of data collection	Methodology	Responsible Institution
INPUT				
Spending				
1.	Domestic and international AIDS spending by categories and financing	Every two years	National AIDS Spending Assessment (NASA)	National AIDS Commission
Policy development and implementation status				
2.	*National Composite Policy Index (NCPI)* Coverage area: prevention, care, support and treatment, human right, civil society involvement, gender, work place program, stigma and discrimination, monitoring evaluation)	Every year	National Composite Policy Index questionnaire	National AIDS Commission
Institution Strengthening				
3	Percentage of Provincial AIDS Commission that experience development of the stage: initial-development-sustainable, based on the criteria (7 out of 14 components)	Every year	Questionnaire	NAC
PROCESS: NATIONAL PROGRAMME				
Blood Safety				
4	Percentage of donated blood units screened for HIV in a quality assured manner	Every year	FRAME tool (Framework for Assessment, M&E of blood transfusion services): Rapid assessment	Ministry of Health (MoH) and Indonesia Red Cross
Anti Retroviral Therapy				
5	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Every year	Programme monitoring	MoH

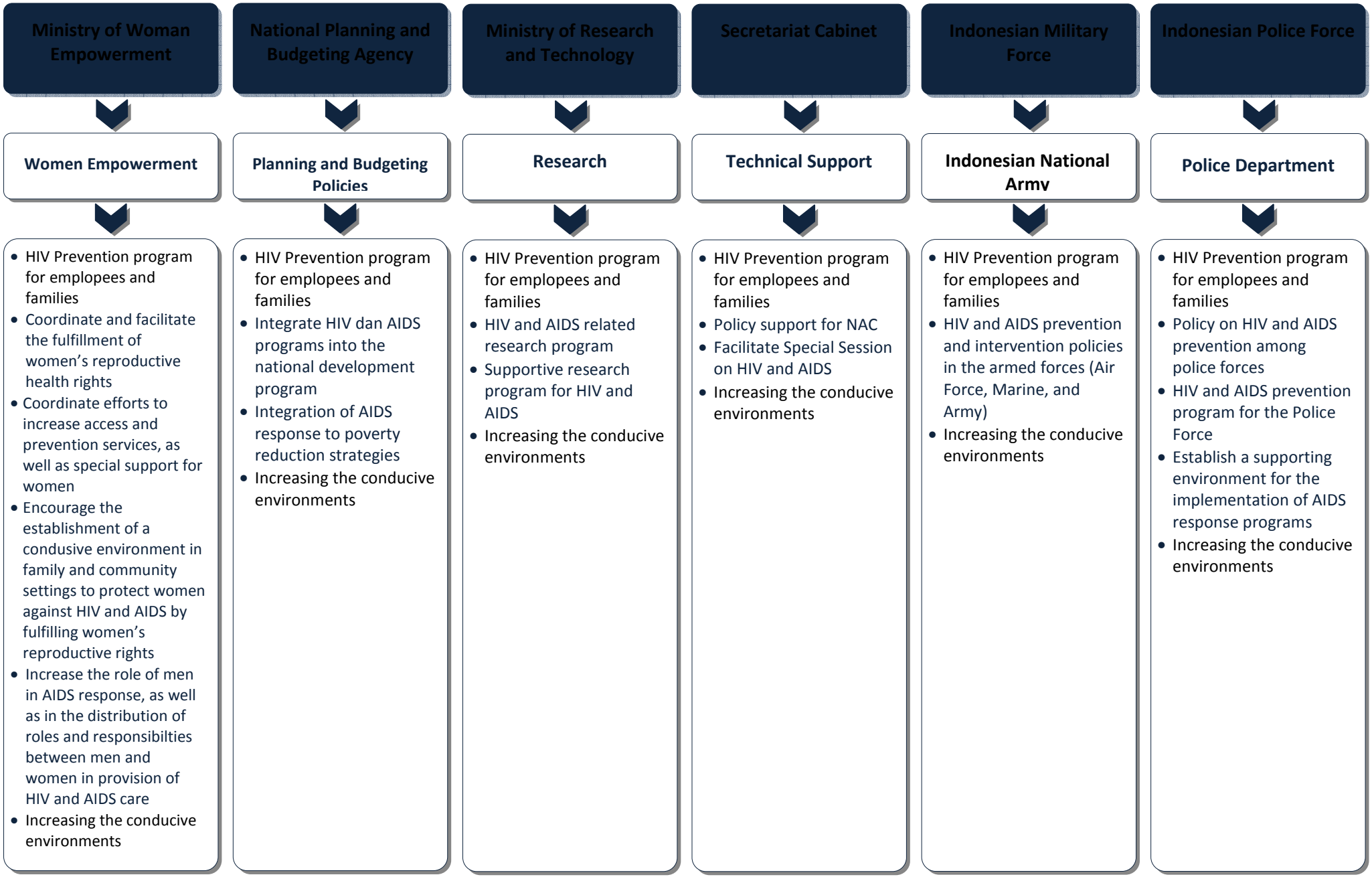
No	Indicator	Frequency of data collection	Methodology	Responsible Institution
PMTCT				
6	Percentage of HIV positive pregnant women who receive antiretroviral medicines to reduce the risk of mother to child transmission	Every year	Programme monitoring and HIV surveillance	MoH
Co management TB/HIV				
7	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Every year	Programme data	MoH
HIV test				
8	Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know the results	Every two-three years	Integrated Bio Behavior Surveillance in Tanah Papua	MoH
9	Percentage of most at risk populations that have received an HIV test in the last 12 months and who know the results	Every two years	Integrated Bio Behavior Surveillance among MARPs (IBBS MARPs)	MoH
Education				
10	Percentage of schools that provided life skills-based HIV education within the last academic year	Every two years	School based survey	Ministry of Education
Social mitigation				
11	Percentage of orphans and and vulnerable children whose households received free basic external support in caring for the child	Every for-five years	Demographic Health Survey (DHS)	Ministry of Social Welfare
OUTPUT				
12	Percentage of most at risk population reached with HIV prevention programmes*)	Every two years	IBBS MARPs	MoH

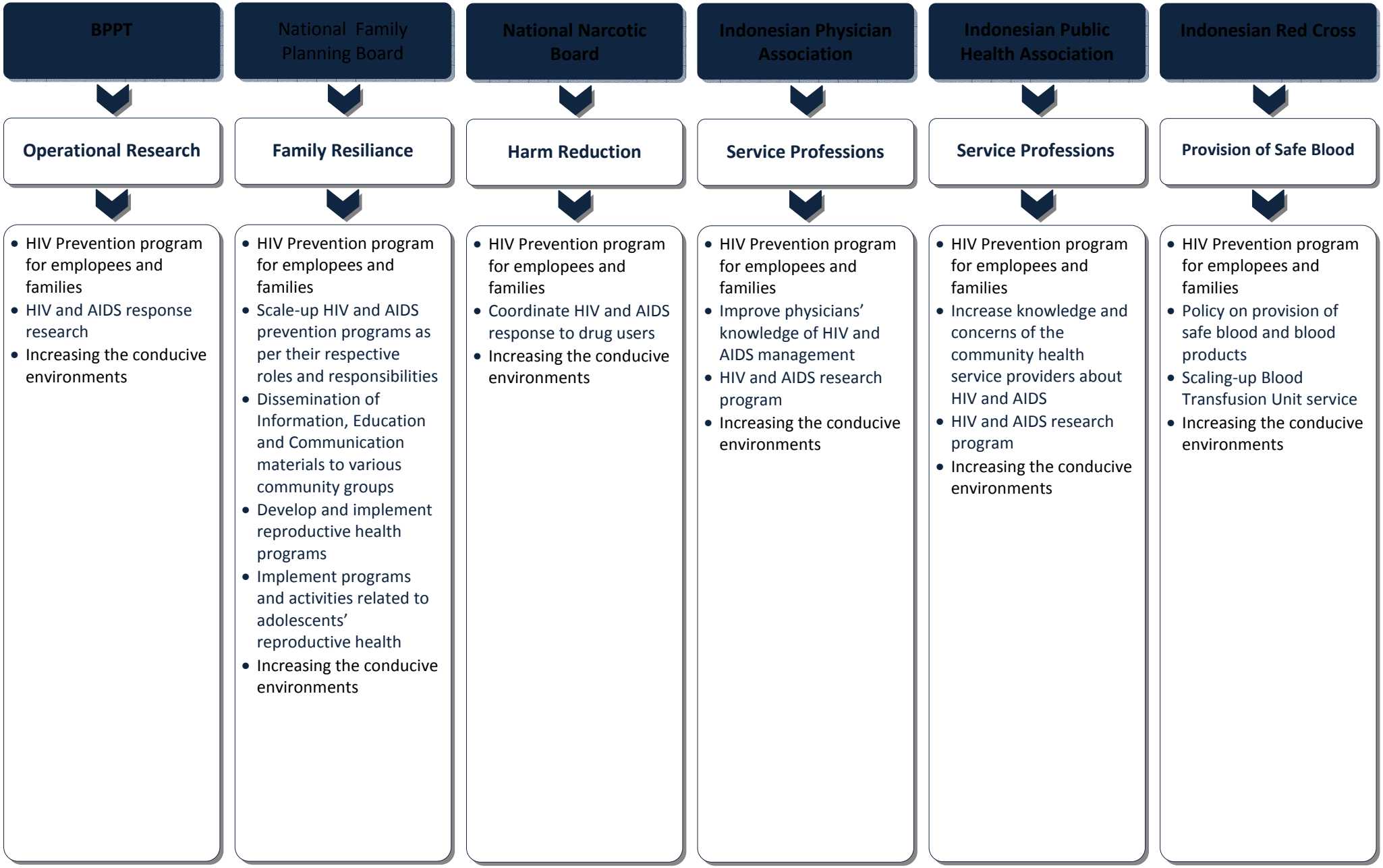
No	Indicator	Frequency of data collection	Methodology	Responsible Institution
OUTCOME				
13	Current school attendance among orphans and among non-orphans aged 10-14	Every four-five years	DHS	MoH
14	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major conception about HIV transmission	Every four-five years	Youth Adolescent Reproductive Survey (YARHS) as DHS sub module	MoH
15	Percentage of MARPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Every two years	IBBS MARPs	MoH
16	Percentage of young women and men who have had sexual intercourse before age of 15	Every two years	Reproductive Survey (YARHS) as DHS sub module	MoH
17	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Every three to four years	IBBS in Tanah Papua	MoH
18	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse*	Every three to four years	IBBS Tanah Papua	MoH
19	Percentage of female and male sex workers reporting the use of a condom with their most recent client	Every two years	IBBS MARPs	MoH
20	Percentage of men reporting the use of condom the last time they had anal sex with a male partner	Every two years	IBBS MARPs	MoH
21	Percentage of injecting drug users who report the	Every two years	IBBS MARPs	MoH

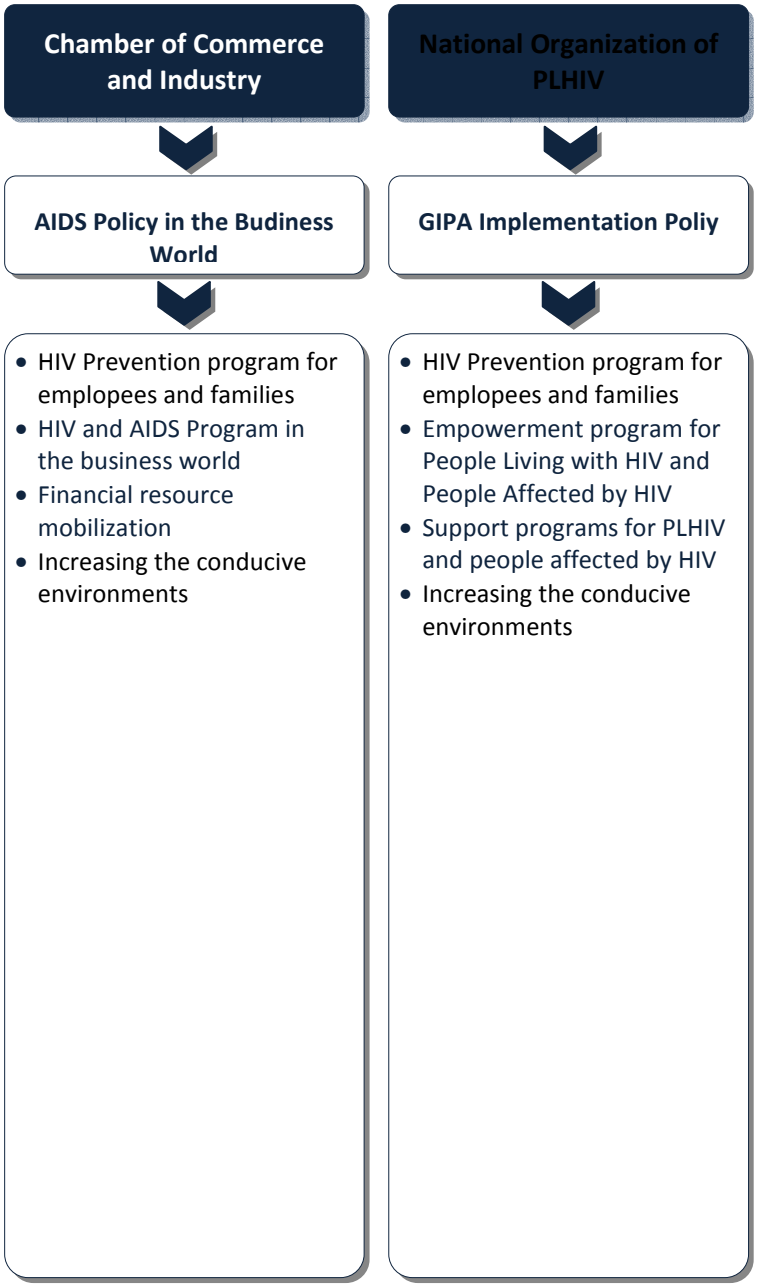
No	Indicator	Frequency of data collection	Methodology	Responsible Institution
	use of a condom at last sexual intercourse			
22	Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Every two years	IBBS MARPs	MoH
IMPACT				
23	Percentage of young women and men aged 15-24 who are HIV infected*	Every five years	YARHS, sub module DHS	MoH
24	Percentage of MARPs who are HIV infected	Every year Every two years	Sentinel surveillance IBBS MARPs	MoH
25	STI prevalence among MARPs	Every two years	IBBS MARPs	MoH
25	Percentage of adult population aged 15-49 who are HIV infected	Every three-four years	IBBS Tanah Papua	MoH
26	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral theraphy	Every year	Programme monitoring	MoH
27	Percentage of infants born to HIV infected mothers who are infected	Every year	Treatment protocol and efficacy study	MoH

Annex 8. Roles and Functions of National AIDS Commission Members in the AIDS Response


Ministry of Justice and Human Right
Policies and Regulation Development
HIV Prevention program for emplopees and families
Law enforcement against narcotics and illlicit substances, impart information to inmates about healthy lifestyles to prevent HIV and AIDS as well as opportunistc infections.
Increase coodination and collaboration with other partners to ensure effectiveness of law enforcement efforts and human rights prorams as well as other correctional programs for the inmates
Prevention and intervention programs for HIV and other infectious diseases as well as drug use in the prisons and detention centers
Increasing the conducive environments
Department of Tourism
Tourism
HIV Prevention program for emplopees and families
Collaboration in the tourism industry to implement HIV and AIDS prevention programs
Increasing the conducive environments
Ministry of National Education
Prevention Education
HIV Prevention program for emplopees and families
Develop physical education curriculum and health education (including reproductive health programs for adolescents)
Policies on education of AIDS prevention for adolescents and youth through formal and informal education programs.
HIV and AIDS prevention program for students, university students, teachers, and other academic professions
Campaign/ imparting information on HIV and AIDS prevention and other infectious diseases in school, campus, and other educational institutions.
Increasing the conducive environments
Ministry of Manpower and Transmigration
Prevention in Workplace Setting
HIV Prevention program for emplopees and families
Policies, Manual/ Technical Guidelines to scale-up AIDS response programs in the workplace
Coordinate policy makers on program implementation, reporting and monitoring & evaluation for AIDS prevention and intervention programs within the manpower and transmigration sector
Provision of information and awards for the implementation of HIV and AIDS programs integrated with Work Safety and Health program
Increasing the conducive environments
Ministry of Transportation
Prevention for Transportation Setting
HIV Prevention program for emplopees and families
AIDS response policy for land, sea, and air transportation
HIV and AIDS prevention program in Department of Transportation
Increasing the conducive environments
State Ministry of Youth and Sports
Empowerment and Prevention for Youth
HIV Prevention program for emplopees and families
HIV and AIDS response programs for youth
HIV and AIDS prevention through youth empowerment programs
Increasing the conducive environments


Ministry of Woman Empowerment
National Planning and Budgeting Agency
Ministry of Research and Technology
Secretariat Cabinet
Indonesian Military Force
Indonesian Police Force
Women Empowerment
Planning and Budgeting Policies
Research
Technical Support
Indonesian National Armv
Police Department
• HIV Prevention program for emplopees and families
• Coordinate and facilitate the fulfillment of women's reproductive health rights
• Coordinate efforts to increase access and prevention services, as well as special support for women
• Encourage the establishment of a condusive environment in family and community settings to protect women against HIV and AIDS by fulfilling women's reproductive rights
• Increase the role of men in AIDS response, as well as in the distribution of roles and responsibilties between men and women in provision of HIV and AIDS care
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Integrate HIV dan AIDS programs into the national development program
• Integration of AIDS response to poverty reduction strategies
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• HIV and AIDS related research program
• Supportive research program for HIV and AIDS
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Policy support for NAC
• Facilitate Special Session on HIV and AIDS
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• HIV and AIDS prevention and intervention policies in the armed forces (Air Force, Marine, and Army)
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Policy on HIV and AIDS prevention among police forces
• HIV and AIDS prevention program for the Police Force
• Establish a supporting environment for the implementation of AIDS response programs
• Increasing the conducive environments


BPPT
National Family Planning Board
National Narcotic Board
Indonesian Physician Association
Indonesian Public Health Association
Indonesian Red Cross
Operational Research
Family Resiliance
Harm Reduction
Service Professions
Service Professions
Provision of Safe Blood
• HIV Prevention program for emplopees and families
• HIV and AIDS response research
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Scale-up HIV and AIDS prevention programs as per their respective roles and responsibilities
• Dissemination of Information, Education and Communication materials to various community groups
• Develop and implement reproductive health programs
• Implement programs and activities related to adolescents' reproductive health
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Coordinate HIV and AIDS response to drug users
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Improve physicians' knowledge of HIV and AIDS management
• HIV and AIDS research program
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Increase knowledge and concerns of the community health service providers about HIV and AIDS
• HIV and AIDS research program
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Policy on provision of safe blood and blood products
• Scaling-up Blood Transfusion Unit service
• Increasing the conducive environments


Chamber of Commerce and Industry
National Organization of PLHIV
AIDS Policy in the Budiness World
GIPA Implementation Poliy
• HIV Prevention program for emplopees and families
• HIV and AIDS Program in the business world
• Financial resource mobilization
• Increasing the conducive environments
• HIV Prevention program for emplopees and families
• Empowerment program for People Living with HIV and People Affected by HIV
• Support programs for PLHIV and people affected by HIV
• Increasing the conducive environments

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National HIV and AIDS Strategy and Action Plan 2010-2014

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