Republic of Indonesia

National AIDS Commission

Country Report
On
Follow-up to the Declaration of Commitment
On HIV/AIDS
(UNGASS)

Reporting period 2001-2003

Jakarta, May 2003
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FOREWORD

The Republic of Indonesia is one of the 189 countries that signed the Declaration of Commitment (DOC) on HIV/AIDS of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS on 25-27 June 2001.

The Declaration states that the countries should develop appropriate monitoring and evaluation mechanism to assist with follow-up in measuring and assessing progress, and develop appropriate monitoring and evaluation instruments, with adequate epidemiological data.

This progress report is prepared according to the Guidelines of UNAIDS for monitoring the UNGASS Declaration of Commitment on HIV/AIDS and covers the period 2001-2003.

On 28 March 2002, the Indonesian Cabinet held a Special Cabinet Meeting on HIV/AIDS and endorsed a national commitment to HIV/AIDS that prioritizes HIV/AIDS in development planning, which requires a 20 million US$ funding annually. The Cabinet also endorsed a range of technical strategies and foci consistent with the UNGASS Declaration of Commitment.

On 23 April 2002, as a follow up to the Special Cabinet Meeting, a Country Consultation took place and the National AIDS Movement (NAM) was launched.

The Ministry of Health has formulated a strategic plan (2003-2007), while the National AIDS Commission has formulated a new National AIDS Strategy to replace the 1994 document, which was launched on 9 May 2003.

We are very grateful to Ms. Jane Wilson (UNAIDS CPA), for facilitating the preparation of the report, to Dr. Endang Sedyaningsih Mamahit (NIHRD) for doing the AIDS Programme Effort Index (API) survey and to Dr. Suriadi Gunawan for data collection and drafting the progress report.

Financial assistance from UNAIDS is gratefully acknowledged.

We also would like to thank the representatives of the ministries/government agencies, UN agencies, bilateral agencies and NGOs who provided data and reviewed the draft report.

Jakarta, May 2003

Dr. Farid W. Husain
Secretary
National AIDS Commission
LIST OF ABBREVIATIONS

AIDS : Acquired Immunodeficiency Syndrome
APINDO : Asosiasi Pengusaha Indonesia (Indonesia Business Association)
ASA : Aksi Stop AIDS (FHI/USAID/MOH AIDS project)
ASEAN : Association of South East Asian Nations
AusAID : Australian Agency for International Development
BKKBN : Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Coordinating Board)
BPS : Badan Pusat Statistik (Central Statistics Agency)
BSS : Behaviour Surveillance Survey
CBO : Community Based organization
CDC-EH : Communicable Disease Control-Environmental Health
CPA : Country Programme Adviser
CSW : Commercial sex worker
DEPKEPES : Departemen Kesehatan (Ministry of Health)
DOC : Declaration of Commitment
FDA : Food and Drug Administration
FHI : Family Health International
FSW : Female sex worker
GFATM : Global Fund to Fight AIDS, TB and Malaria
GIPA : Greater Involvement of persons with AIDS
HIV : Human Immunodeficiency Virus
ICAAP : International Congress on AIDS in Asia-Pacific
IDP : Internally displaced person
IDU : Injecting drug user
ILO : International Labour Organization
IOM : International Organization of Migration
IPPF : International Planned Parenthood Federation
KfW : Kreditanstalt fur Wiederaufbau
KPA : Komisi Penanggulangan AIDS (National AIDS Commission)
M&E : Monitoring and evaluation
MOH : Ministry of Health
MTCT : Mother to child transmission
MSM : Men who have sex with men
NAC : National AIDS Commission
NAM : National AIDS Movement
NAP : National AIDS Programme
NGO : Non-governmental Organization
NIHRD : National Institute of Health Research & Development.
OCHA : Office for Coordination of Humanitarian Assistance.
ODHA : Orang dengan HIV/AIDS (PLWHA)
OI : Opportunistic Infection
PAF : Project Acceleration Fund
PKBI : Perkumpulan Keluarga Berencana Indonesia (Indonesian Family Planning Association)
PLWHA : Person living with HIV/AIDS
POKDISUS : Kelompok Studi Khusus (AIDS Study Group of Cipto Mangunkusumo Hospital)
SEAPICT : South East Asia & Pacific Intercountry Team
STI : Sexually transmitted infection
UI : Universitas Indonesia
UN : United Nations
UNAIDS : UN Programme on HIV/AIDS
UNDAF : UN Development Assistance Framework
UNDCP : UN Drug Control Programme
UNDP : UN Development Programme
UNESCO : UN Education, Social and Cultural Organization
UNFPA : UN Fund for Population Activities
UNGASS : UN General Assembly Special Session (on HIV/AIDS)
UNHCR : UN High Commissioner for Refugees
UNICEF : UN Children’s Fund
UNV : UN Volunteers
USAID : United States Agency for International Development
VCT : Voluntary Counseling & testing
WB : World Bank
WFP : World Food Programme
WHO : World Health Organization
YKB : Yayasan Kusuma Buana (NGO)
YPI : Yayasan Pelita Ilmu (NGO)
1. INTRODUCTION

Indonesia, the largest archipelago in the world (over 17,000 islands) has a population of over 215 million people. It is a heterogeneous country consisting of over 250 different ethnic groups, each with its own language, but Indonesian, the national language is widely spoken.

Around 85% of the population are Moslems (making Indonesia the largest Moslem country in the world), but other religions like Christianity, Hinduism, Buddhism and Confucianism are found.

Indonesia has been experiencing steady economic growth between 1970s and middle 1990s but the Asian economic crisis in 1997 hit the country very hard. Indonesia is still facing a multidimensional crisis that prevents full scale implementation of HIV/AIDS prevention and control programmes. It is also still in a transition from centralized authoritarian to a more decentralized democratic administration.

The gross Domestic Product is around US$1000 per capita per year. Less than US$15 per capita is spent for health (around 30% by the government).

This is the first report to be submitted to the UN General Assembly on biennial basis as a follow-up to the Declaration of Commitment (DOC) signed in June 2001 at the UNGASS on HIV/AIDS.

The report has been compiled with knowledge and involvement of government departments/agencies, UN agencies, bilateral donor agencies and non-governmental organizations active in HIV/AIDS care and prevention. A workshop to prepare the report was held on 30 April 2003.

A survey to measure the AIDS Programme Effort Index (API) was done in March 2003.

Data on financial resources and available data on national programmes and behaviour trends were collected in April 2003.

No population based or special surveys to collect the core indicators for implementation of DOC (UNGASS) have been undertaken, but are planned for the next biennial report.

HIV/AIDS is not spread evenly through the population in Indonesia. It is a diverse epidemic, with some provinces and populations experiencing higher levels of
infection the others and different transmission routes. The highest rates are found in Papua, where it is 30 times the national average. Generalizations have limited value.

During the process of data assembling and report writing it became clear that existing data were not easily obtainable in the format recommended by the UNGASS DOC guidelines. Nevertheless the exercise served to sensitize key stakeholders to data and information requirements.

The importance of monitoring and evaluation became more apparent and the National AIDS Commission will be taking steps to improve the system in the near future.
2. STATUS AT A GLANCE

2.1. National commitment and actions

● National Composite Policy Index: 65% (see annex 2)
● Government funds spent on HIV/AIDS. This was US$3.25 million in 2002, while international donors spent US$ 7.6 million.

2.2. National Programme & Behaviour

- Prevention

● Modules for life-skills-based education prepared and 28 master teachers trained. A total of 580 senior high schools have introduced life skills based education.
● Around 200 companies have workplace policies & programmes. Tripartite Declaration on Commitment to combat HIV/AIDS in the World of Work signed in February 2003.
● Around 5% of HIV+ pregnant women received a course of ARV to reduce MTCT

- Care/treatment

● Approx. 90% of male patients and 80% of female patients with STIs at health care facilities (supported by bilateral projects) are appropriately diagnosed, treated and counseled. BSS show that only 50% of STI patients go to health facilities or private practitioners

- Knowledge/Behaviour

● Approx. 38.4% of senior high school students (15-19 years old) in Jakarta can both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission or prevention.
● Approx. 10% of people engaging in commercial sex use condoms consistently, however 41% reported use of condom during last commercial sex.
● Approx 1.5% of 160,000 IDUs are reached with HIV/AIDS prevention services. Harm reduction (needle exchange and methadone substitution) have been initiated as pilot projects.

- Impact

● 8 per 10,000 or 0.08% of people aged 15-29 years are estimated to be HIV infected
● Approx 120 infants are estimated to be borne by 400 HIV infected mothers in 2002
3. OVERVIEW OF THE HIV/AIDS EPIDEMIC

AIDS was first detected in 1987 in a foreign tourist and as of 31 March 2003 a total of 1058 AIDS cases and 2556 HIV infections have been reported to the Ministry of Health.

The numbers reported were: 178 cases in 2000, 219 cases in 2001, 345 cases in 2002.

Provinces which have reported the highest numbers of AIDS cases are Jakarta (329 cases), Papua (326 cases), East Java (167 cases), Riau (47 cases), West Java (43 cases), Bali (42 cases), North Sumatra (23 cases), North Sulawesi (20 cases), Central Java (13 cases), Yogyakarta (13 cases), West Kalimantan (13 cases). The highest rate (20 AIDS cases per 100,000) is found in Papua. The other provinces reported less than 10 cases, while 10 provinces reported only HIV infections. All provinces, except South East Sulawesi have reported HIV infections (found through blood screening, sentinel surveillance) and diagnostic testing.

Most of the HIV infected (77%) were men, while the highest proportion was found among the 20-29 years age group (41.7%) and 30-39 years age group (21%). There were only 11 cases (1%) among 0-4 years age group.

The mode of transmission (cumulative) was heterosexual (51.8%), injecting drug use (23.8%), homosexual (10.3%) perinatal (1.2%), blood products (0.2%), and unclear (3.3%). The proportion of transmission by injecting drug use rose rapidly since 1999, especially in Jakarta and the large cities in Java and Bali. For the first quarter of 2003, the proportion of transmission by injecting drug use was 33.3% of reported AIDS cases). Over 90% of HIV infected IDUs are males. Surveys in Jakarta indicate that HIV prevalence among IDUs rose from 15% in 1999 to 47% at the end of 2001. A prevalence of 20% HIV infection was found among IDUs in Jakarta prisons in 2002.

Prevalence of HIV infection among female commercial sex workers have risen from an average of 1% in 1995-1996 to over 5% in many provinces since 2000. The highest prevalence have been found in Merauke (Papua): 26.4%, Tanjung Pinang (Riau): 8.6%, Bali: 6.5% and West Java: 5%. These data suggest the existence of a concentrated HIV epidemic since 2000 in those provinces.
The highest CSW prevalence rates found in sentinel sites in the provinces were as follows:

<table>
<thead>
<tr>
<th>Province</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Papua : Merauke</td>
<td>26.4%</td>
</tr>
<tr>
<td>Sorong</td>
<td>6.6%</td>
</tr>
<tr>
<td>Jakarta</td>
<td>3.6%</td>
</tr>
<tr>
<td>Riau</td>
<td>8.6%</td>
</tr>
<tr>
<td>Bali</td>
<td>6.5%</td>
</tr>
<tr>
<td>West Java</td>
<td>5.5%</td>
</tr>
<tr>
<td>Yogyakarta</td>
<td>2.3%</td>
</tr>
<tr>
<td>East Java</td>
<td>2.3%</td>
</tr>
<tr>
<td>West Kalimantan</td>
<td>1.9%</td>
</tr>
<tr>
<td>East Nusa Tenggara</td>
<td>1.8%</td>
</tr>
<tr>
<td>Bengkulu</td>
<td>1.7%</td>
</tr>
<tr>
<td>South Sumatra</td>
<td>1.3%</td>
</tr>
<tr>
<td>East Kalimantan</td>
<td>1.3%</td>
</tr>
<tr>
<td>Central Sulawesi</td>
<td>1.0%</td>
</tr>
<tr>
<td>North Sumatra</td>
<td>0.6%</td>
</tr>
<tr>
<td>Jambi</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

Among transvestites or “waria” in Jakarta prevalence rates have risen from 6% in 1997 to 21% in 2002. A study in 2002 found a prevalence of 2.5% HIV infection among MSM in Jakarta.

The prevalence of HIV infection among pregnant women is 0.35% in Riau, 0.25% in Papua in 1999 and in Jakarta (among women who came for voluntary testing & counseling) it rose from 1.5% in 2000 to 2.7% in 2001.

The prevalence on HIV infection among voluntary blood donors started to rise in 1998. It is now 20 per 100,000 nationally, but in Jakarta it is 70 per 100,000.

The exact number of HIV infections cannot be known, but a group of Indonesian and international experts estimated that in 2002 there are between 90,000 to 130,000 HIV infected people in Indonesia (average 110,000).

This include: 43,000 injecting drug users, 8000 sex workers, 36,000 clients of sex workers, 10,000 MSM, 1,500 transvestites, 6,000 clients of transvestites, and 24,000 partners of those risk behaviour groups. The size of these high risk behaviour groups is estimated at 160,000 for IDUs, 250,000 for female CSWs, 1 million for MSM, 12,000 for warias (transvestites), 8.2 million clients of female CSWs and 6.5 million partners of those high risk behaviour groups. This is over 16 million people at higher risk for HIV.
Recent behaviour surveillance surveys (BSS) data indicates that knowledge of HIV and how it is transmitted is fairly high, but this apparently has little impact on risk behaviour. In a survey of IDUs, for example, 100% of the respondents knew that HIV can be spread by sharing needles, but nevertheless, 53% reported using someone’s else needle at the last injection, while 84% passed their needle on to others.

Most female CSWs in the cities know that condoms can prevent HIV and STIs, but condom use with all clients in the last week was only 12.1%, while use of condom with the last client was 40%. Perception of risk is still very low among female CSMs, their clients and men who have sex with men (MSM).

A study of 1600 sailors, port workers and truckers in 3 cities (Jakarta, Surabaya and Manado) shows that close to half of the respondents have had commercial sex in the previous year and only 10% had used a condom consistently.

The percentage of high school boys in Jakarta who reported ever having sex was 22.9%, while among high school girls it was 4.3% in 2000. Around 25% of the boys (who ever had sex) did it with a female CSW.

The BSS of 2002 found that only 38.4% of high school students (15 – 19 years old) can correctly identify ways of HIV transmission and reject major misconception about HIV transmission. A study of young people (15-24 years) in West Java, South Kalimantan and East Nusa Tenggara found that 93.3% know that HIV can be transmitted by sexual intercourse, but only 35% know that sharing needles can transmit HIV, while 15.2% believe that normal social contact transmit HIV (UI – UNFPA-BKKBN study).

The prevalence of sexually transmitted infections (STIs) among pregnant women is considerable, notably for chlamydia (5-7%) and trichomoniasis (1-4%) while syphilis and gonorrhoea is around 1%.

Prevalence of STIs are much higher among female CSWs: syphilis 2-10%, gonorrhoea 10-20%, and chlamydia 10-30%.

Among “warias” or transvestites in Jakarta the prevalence of syphilis was 60%, pharyngeal gonorrhoea 20%, and chlamydia 10%.

These high rates of STIs reported across the country increase the vulnerability to HIV transmission.

Considerable rates of antibiotic resistance has also been observed. A recent study of antibiotic resistance in Jakarta found resistance of N.gonorrhoea to penicilline of 80%, to tetracycline of 90%, to chloramphenicol of 80%, to sulphametoxazole of 70%, and quinolones of 1.5%.
4. NATIONAL RESPONSE TO THE EPIDEMIC

4.1 National commitment and action

In 1986, before the detection of the first case of AIDS/HIV infection, the Ministry of Health (MOH) established an AIDS Working Group chaired by the Head of the National Institute of Health Research & Development (NIHRD).

When the first cases of AIDS was detected in 1987 in Bali and Jakarta, the MOH established a National AIDS Committee under the chairmanship of the Director General of Communicable Disease Control & Environmental Health (CDC-EH).

When the first indigenous HIV transmissions (among female sex workers) were detected in 1990, the NAC was reorganized to include representatives from other ministries and sectors.

Recognizing the threat that a widespread AIDS epidemic would pose to national development, a Presidential Decree in 1994 established a multisectoral National AIDS Commission under the chairmanship of the Coordinating Minister for People’s Welfare, while the Minister of Health was appointed as one of the four vice chairs. The Presidential Decree also requires the formation of Provincial and District /City AIDS Commissions to be chaired by Governors and District Chiefs/Mayors.


This led to the interest of international donors and funding agencies which provided over US$50 million in the period 1995-2000, such as WHO (US$1.2 million), UNDP (US$0.4 million), UNFPA (US$1.5 million), UNAIDS (US$1.2 million), World Bank (US$5 million), USAID (US$21 million) and AusAID (US$15 million).

The Government budget for AIDS in 1995-2000 was approx US$1.5 million a year (the majority of it to buy reagents for HIV testing of blood and surveillance). Over 80% of the government budget was provided by MOH.

In line with the National Strategy, which requires a partnership between the government and the community in the fight against HIV/AIDS, NGOs played an important role. There are now over 200 NGOs which are active in HIV/AIDS.
The onset of the economic crisis in late 1997 and the fall of the New Order. Government under President Soeharto in May 1998 led to a number of changes. Due to the fall of the value of Indonesian Rupiah, the Government budget was insufficient to buy reagents for screening over 1 million blood transfusions. However, donor agencies (AusAID, USAID, UNFPA, WHO, etc) were able to assist, so that blood safety could be maintained.

New elections in 1999 resulted in a new government under President Abdurrachman Wahid and Vice President Megawati. The new government dissolved the Office of the Coordinating Minister for People’s Welfare. The Minister of Health was appointed as NAC Executive Chairman and the Secretariat was moved to the office of the Vice President. When President Abdurrachman Wahid was replaced by Megawati in late 2001, a new cabinet was formed in the office of the Coordinating Minister for People’s Welfare was reinstated. The NAC is now again chaired by the Coordinating for People’s Welfare (Mr. Jusuf Kalla) with the Minister of Health (Dr. Achmad Sujudi) acting as executive chairman.

The Indonesian delegation to UNGASS on HIV/AIDS consisted of the Minister of Health, the Minister of Women’s Empowerment and 9 other delegates (members of Parliament, government officials and representatives from NGOs) and Indonesia together with 189 UN member countries signed the Declaration of Commitment.

The Minister of Health organized two press conferences after his return from New York to brief civil society, government agencies and bilateral and multilateral partners. Returning delegates reported back about UNGASS, the positions taken by Indonesia in the negotiations and the implications of the Declaration of Commitment. As Indonesia has very limited sources, the newly established Global Fund to fight AIDS, TB and Malaria (GFATM) was seen as an important source of future funding. The UNGASS DOC was translated into Bahasa Indonesia and circulated across the country.

An other result of Indonesia’s participation in UNGASS was the resolution of the Government’s position about estimates of HIV infection and the emergence of a new policy position, notably on harm reduction strategy.

Since 2001, cheaper antiretroviral drugs are available through a special arrangement between a company in India and the AIDS Study Group of Cipto Mangunkusumo Hospital (POKDISUS) in Jakarta. The project is supported by the Indonesian FDA and MOH and is currently providing ART to around 600 patients) at a cost of US$700 per patient per year. A UN industry Working Group was established in 2002 to develop better access to ARV and discuss the possibility of producing generic antiretroviral drugs in Indonesia. This will be feasible if over 2000 patients will be treated with antiretrovirals.
The Indonesian Employers Association (APINDO), UNAIDS, ILO and Yayasan Kusuma Buana (YKB) initiated HIV prevention in the workplace since 1997 and around 200 companies have participated. A number of 24 companies have received awards for committed efforts to prevent HIV in the workplace since 1997. In February 2003 the Tripartite Declaration on Commitment to combat HIV/AIDS in the world of work was signed by the Minister of Manpower, the chairmen of the Indonesian Chamber for Trade & Industry & the Indonesian Employers Association and several chairmen of trade unions. An Indonesian Business Coalition to combat HIV/AIDS was also established.

The MOH established an Ad Hoc Committee to prepare a strategic plan for HIV/AIDS Control 2003-2007 in August 2001. This was supported by UNAIDS and UNDP and was a creative solution to the unresolved status of the Secretariat of NAC at that time. The completion of this Strategic Plan was a precondition for the submittance of proposals to the GFATM. This was successful and in 2003 an allocation of US$2.5 million for HIV/AIDS was given to Indonesia from the first round. A Country Coordinating Mechanism (CCM) was also established and included representation from NGOs, private sector and related government agencies.

A special cabinet meeting on HIV/AIDS was held on 28 March 2002. The Minister of Health briefed the cabinet on recent increase of HIV transmission in the country and the UNGASS Doc. The cabinet decided to give HIV/AIDS a higher priority, improve intersectoral coordination, revitalize the NAC, start a national AIDS movement. Special cabinet meeting on HIV/AIDS will be held annually.

On 23 April 2002 a National Consultation took place as a follow up to the Special Cabinet Meeting on HIV/AIDS. With over 300 participants from across the country, the new National AIDS Movement (NAM) was launched. Immediately after the opening, five Indonesians living with or affected by HIV/AIDS addressed the meeting and spoke of their experience of discrimination and of their hopes for the outcome of the meeting, and called for the government to support them. This was a strong demonstration of commitment to the GIPA principle.

In August 2002, the NAC, with the help of a team of consultants and the support from UNAIDS, UNDP, AusAID and USAID, developed the new multisectoral AIDS strategy. Through a consultative and participatory process with civil society, the provinces, the private sector and PLWAs, the new National AIDS Strategy was finalized in April 2003 and launched on 9 May 2003 in the presence of Dr Peter Piot, the UNAIDS Executive Director.

Another factor in this process was Indonesia’s participation in the International Congress on AIDS in Asia and the Pacific (ICAAP) in Melbourne, October
2001. The Minister of Health participated in the Ministerial Forum organized by the Australian Minister of Foreign Affairs and signed the Ministerial statement. He also visited a needle exchange programme in Melbourne.

Following the Asia Pacific Ministerial Forum during ICAAP 2001, attention turned to ASEAN Summit at Brunei Darussalam in December 2001 at which ten Heads of States endorsed the ASEAN Declaration on HIV/AIDS. This regional framework is consistent with the UNGASS DOC and reflects increased political will in the South East Asian Region.

The UN system also responded to UNGASS with increased activities. In 2002, the United Nations Country Team in Indonesia completed the UN Development Assistance Framework (UNDAF), the blueprint for the UN’s support to Indonesia, within which HIV/AIDS is a cross-cutting theme. Following the new multisectoral AIDS strategy, the UN is starting the development of the UN implementation Support Plan ensuring that the UN system support is consistent with the new national strategy. UNAIDS Project Acceleration Funds (PAF) for the Biennium are being used to support the national planning process, the building of partnerships and the preparedness of UN Agencies to support their Government counterparts related to issues such as conflicts and internally displaced people (IDPs), work place policy, economic impact studies, health planning, scaling up of youth prevention programmes, trafficking of women and children, etc.

UNDP has carried out capacity building of NAC in 2 provinces i.e. North Sumatra and East Kalimantan, and supported NAC at the central level, including the revision of the National AIDS strategy.

WHO support focuses on the Ministry of Health and include: strengthening of HIV/AIDS surveillance, improved STI services, blood safety, pilot projects for 100% condom use among high risk behaviour groups and methadone substitution for IDUs.

World Bank developed a loan of US$23 million in 1996-98, but only US$5 million was utilized for AIDS and the remainder was used for social safety net to deal with the economic crisis. Current considerations for HIV/AIDS include: support for ministries to mainstream HIV/AIDS into development projects e.g. legal reform (prisons), civil service reform; understanding the economic effects of HIV/AIDS on development, understanding current HIV/AIDS expenditures and the cost of scaling up interventions, retrofitting existing projects with HIV/AIDS.

UNFPA’s previous activities included support for blood transfusion services (safe motherhood) and current initiative focuses on outreach to sex workers and clients, and implementation of integrated essential reproductive health package in a youth friendly manner in 4 provinces.
ILO played a leading role in the mobility and HIV/AIDS study. It now focuses on a two-pronged strategy: (1) the implementation of the ILO code of practice on HIV/AIDS and (2) mainstreaming HIV/AIDS into the ILO country programme operations. Activities include: seminar on HIV/AIDS in the world of work, translating of ILO Code of Practice on HIV/AIDS into Indonesian, introducing HIV/AIDS as part of occupational safety & health and developing a training programme on prevention of HIV/AIDS in the world of work.

UNESCO in collaboration with UNICEF focuses on including HIV/AIDS in youth activities. UNESCO and Ministry of National Education held a large Youth & HIV/AIDS workshop in March 2003. There are a wide range of potential entry points from activities related with youth leaders and culture.

UNICEF focuses on prevention of HIV infection among young people with three components: life skills education, peer education and youth friendly health services; prevention of mother to child transmission; communication, advocacy and social mobilization.

UNV is focusing on a project to enhance involvement of PLWHAs.

Other UN agencies like WFP, OCHA, UNHCR, IOM, UNDCP do not as yet have special staff to deal with HIV/AIDS but has shown interest to participate in the fight against HIV/AIDS and are conducting needs assessments in their fields.

Bilateral donors like USAID, AusAID and KfW who have been active in 1995-2000 have started phase 2 of their projects

- USAID through FHI developed the ASA (Aksi Stop AIDS) project with MOH. This is a 5 year project (2000-2004) with a total budget of UD$36 million, and activities in 10 provinces. The ASA programme works to promote safe sexual behaviour, reduce the harm of drug injection, strengthen HIV and STI care and treatment, track risk behaviour and the spread of HIV, strengthen the capacity of local governments and NGOs and encourage the active participation of private companies in HIV prevention.

- AusAID through GRM International Pty Ltd developed the Indonesia HIV/AIDS Prevention & Care Project Phase II. This is a 5 year project (2003-2007) with a total budget of A$34 million (or US$21 million), covering activities in 6 provinces and at the national level. It covers policy & advocacy, national standards, monitoring the epidemic and response, prevention of sexual and IDU transmission, and care support and treatment for HIV/AIDS & STIs.

- KfW (Kreditanstalt fur Wiederaufbau) through DKT international funding a DM20 million project (2000-2003) to promote condoms.
4.2. Funding for HIV/AIDS

The national budget in 2001 was US$2.9 million. This increased to US$3.25 million in 2002 and US$5.7 million in 2003.

The breakdown of the budget according to the different ministries/agencies can be seen in table 1.

<table>
<thead>
<tr>
<th>Department/Agency</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health</td>
<td>2,604,983</td>
<td>2,590,110</td>
<td>4,342,000</td>
</tr>
<tr>
<td>2. Prov/District</td>
<td>257,718</td>
<td>485,352</td>
<td>831,765</td>
</tr>
<tr>
<td>(10 provinces)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Religion</td>
<td>13,000</td>
<td>40,000</td>
<td>216,695</td>
</tr>
<tr>
<td>4. Social welfare</td>
<td>-</td>
<td>79,266</td>
<td>71,858</td>
</tr>
<tr>
<td>5. Defence</td>
<td>6,200</td>
<td>1,148</td>
<td>111,755</td>
</tr>
<tr>
<td>6. Education</td>
<td>19,721</td>
<td>61,964</td>
<td>84,500</td>
</tr>
<tr>
<td>7. Women’s Affairs</td>
<td>4,860</td>
<td>39,068</td>
<td>7,510</td>
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<tr>
<td>8. Communications</td>
<td>10,000</td>
<td>-</td>
<td>2,500</td>
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<tr>
<td>9. Internal Affairs</td>
<td>5,108</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>10. Manpower</td>
<td>1,000</td>
<td>7,226</td>
<td>-</td>
</tr>
<tr>
<td>11. Family Planning</td>
<td>14,805</td>
<td>18,082</td>
<td>6,946</td>
</tr>
<tr>
<td>12. Red Cross</td>
<td>16,500</td>
<td>22,754</td>
<td>7,500</td>
</tr>
<tr>
<td>Total</td>
<td>2,953,845</td>
<td>3,244,970</td>
<td>5,678,899</td>
</tr>
</tbody>
</table>

Source: NAC

The Government budget provides only 30% of funding for HIV/AIDS. Around 70% is provided by foreign donors, which amounts to US$6.1 million in 2001, US$7.6 million in 2002 and US$16.9 million in 2003. The breakdown of the source of donor funding can be seen on table 3.

Table 3
Foreign Donor Funding for HIV/AIDS
2001-2003
(in US Dollars)

<table>
<thead>
<tr>
<th>Donor</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. USAID/ASA</td>
<td>2,462,343</td>
<td>6,340,441</td>
<td>8,300,000</td>
</tr>
<tr>
<td>2. Aus AID</td>
<td>2,700,000</td>
<td>2,700,000</td>
<td>4,080,000</td>
</tr>
<tr>
<td>3. KFW</td>
<td>440,138</td>
<td>330,159</td>
<td>579,024</td>
</tr>
<tr>
<td>4. UN agencies</td>
<td>500,000</td>
<td>1,000,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>5. GF ATM</td>
<td>-</td>
<td>-</td>
<td>2,500,000</td>
</tr>
<tr>
<td>Total</td>
<td>6,102,481</td>
<td>7,673,300</td>
<td>16,959,024</td>
</tr>
</tbody>
</table>

Source: NAC & MOH&UNAIDS
5. NATIONAL PROGRAMME & BEHAVIOUR

5.1 Prevention

No reliable indicators are available at the present as no surveys to collect the UNAIDS-UNGASS core indicators have been undertaken. Some data related to the indicators from BSS and other studies will be reported.

5.1.1. Percentage of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year.

A manual on Life Skills Education for senior high school students have been prepared by the Ministry of National Education and UNICEF. The first batch of training of 28 master trainers and a baseline study on the risk and vulnerability of young people (13-15 years) have been implemented. A total of 580 senior high schools have implemented life skills education. UNESCO held a large youth focused workshop in March 2003 and will work with UNICEF to assist the Ministry of National Education to plan for youth activities focused on HIV/AIDS.

5.1.2. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes.

The Indonesian AIDS Foundation and Kusuma Buana Foundation have prepared modules for HIV/AIDS education in the work place and around 200 companies have used them. Since 1997 a number of 24 companies have received for their efforts to prevent HIV among their workers. The award was given by the Indonesian Employers Association (APINDO) and Kusuma Buana Foundation. A Tripartite Declaration on commitment to combat HIV/AIDS in the world pf work was signed by the Government (Minister of Manpower), the Indonesian Chamber of Commerce & Industry, and several Trade Unions in March 2003. The ASA project and ILO will work with the private sector to prevent the spread of AIDS and mitigating its impact in the world of work.

5.1.3. Percentage of HIV+ pregnant women receiving a complete course of ARV Prophylaxis to reduce the risk of MTCT.

Limited studies in some high prevalence areas show that pregnant women have been infected by HIV. The prevalence is 0.25% in Merauke, Papua and in Jakarta a pilot project of VCT for pregnant women found a prevalence 1.5% in 2000 which increased to 2.7% in 2001.
The number of HIV+ pregnant women is estimated at 400 in 2002. Only 20 have received ARV to reduce the risk of MCTC. This gives a percentage of 5% approximately.

5.2. Care/Treatment

5.2.1. Percentage of patients with STIs at health care facilities who are appropriately diagnosed, treated and counseled

An analysis of medical records of around 4000 STI patients who visited clinics which are supported by the ASA project revealed that 83% of them are appropriately managed. This percentage is 93% for males and 82% for females. No data are available from government clinics. Their percentages of appropriate treatment are probably lower.

BSS has found that only 50% of STI patients go to a health facility or medical practitioner for treatment, while the other 50% self treat by buying antibiotics over the counter or seek alternative/traditional treatments.

5.2.2. Percentage of people with advanced HIV infection receiving HRV combination therapy

The number of HIV infected who have developed AIDS is estimated at around 10,000 in 2002.

According to the study group for AIDS on Cipto Mangunkusumo Hospital there are around 300 patients currently receiving combination ARVT. The number of reported AIDS patients is 1058, 390 of whom have died. Of the 668 known AIDS patients around 50% have received ARVT.

5.3 National behaviour

5.3.1 Percentage of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention

A study in Jakarta among senior high school students (15-19 years old) in 2002 show that 38.4% of the respondents correctly identify ways of preventing sexual transmission and reject major misconceptions about transmission. An other study of young people (15-24 years old) in West Java, South Kalimantan and East Nusa Tenggara found that 93.3% know that HIV can be transmitted by sexual intercourse, but only 35% know that sharing needles can transmit HIV, while 15.2% still believe that normal social contact can transmit HIV.
5.3.2 Percentage of people aged 15 – 24 reporting the use of a condom during sexual Intercourse with a non regular partner

The BSS in 2002 revealed that consistent condom use in commercial sex is low. It is 18.4% among “indirect” female sex workers; 4.1% among “direct” female sex workers; 25.2% among transvestites or “waria”, 4.1% among sailors (clients) and 18.9% IDUs (clients). Over 90% of the sex workers and their clients know that condoms can prevent HIV/AIDS and STIs, but less than 10% use condoms consistently. But 41% used condoms at last sex with the client.

5.3.3 Percentage of injecting drug users who are reached with HIV/AIDS prevention services

The estimated number of IDUs is 160,000 in 2002.

The estimate for IDUs receiving some treatment is 2500. This includes 1300 IDUs treated in the Jakarta Drug Dependence Hospital, around 200 with methodone substitution therapy (in Jakarta & Bali) and around 1000 treated in mental hospitals and rehabilitation centers.

So the percentage is only approx. 1.5%

5.4 Impact

5.4.1 Percentage of young people aged 15-24 who are HIV infected

Available data from surveillance show that the 15-29 age group totals 48.2% of all HIV/AIDS reported cases.

The estimated number of people aged 15-29 who are HIV infected is around 50,000. This will give a percentage of 50,000 per 62.5 million or 8 per 10,000.

5.4.2 Percentage of HIV infected infants born to HIV infected mothers

As the estimate for HIV infected mothers is only 400 in 2002, only 120 HIV infected infants is expected to be born in 2002. This is not a meaningful indicator for a low prevalence country like Indonesia
6. MAJOR CHALLENGES AND ACTIONS NEEDED

The development of a new national AIDS strategy started in 2002 and launched on May 9 2003 was a significant step to ensure a multisectoral response. Central ministries/government agencies and local governments have to translate the national strategy into realistic strategic plans and annual action plans. The substantial resources from donor agencies like GFATM, USAID, AusAID and the UN Agencies have to be used in good coordination to implement the national strategy.

The main challenges of the implementation, relates to leadership development and capacity building at all spheres of society (government and NGOs/CBOs).

The process to revitalize the NAC needs to be continued. The recommendations of a consultant team for the reorganization of NAC need to be implemented as soon as possible.

Another challenge is to develop a coordinated process of monitoring and evaluation.

Special issues which are formidable challenges to a successful programme are:

- Inadequate outreach of high risk behaviour groups (injecting drug users, men who sex with men. Sex workers and their clients, partners of members of these groups)
- Low levels of condom use and resistance from certain religious groups against condom promotion
- High levels of needle sharing among IDUs
- Widespread stigma and discrimination of PWLHAs
- Limited testing, counseling for HIV and facilities for ARV treatment
- Limited facilities for STI management
- Legalization which constraints harm reduction among IDUs
- Low capacity of health personnel
- Limited government funding

Actions needed include:

- Strengthening capacity of AIDS Commissions at national, provincial and district/city levels, especially of provinces with concentrated epidemics like Papua, Jakarta, Riau, West Java, East Java & Bali.
- Capacity building of NGOs/CBOs
- Improvement of coordinating mechanism
- Develop conducive environment for harm reduction and increasing outreach of clean needles and condoms among high risk behaviour groups.
- Start life skills education for young people through schools and outside schools.
- Increasing role of private sector, especially for workplace based HIV prevention programmes.
- Developing voluntary counseling and testing facilities and better access to treatment.
- Developing laws and regulations to protect the rights of PLWHAs and promote HIV prevention.
- Additional training for health personnel.
- Developing a monitoring and evaluation system.
7. SUPPORT REQUIRED FROM DEVELOPMENT PARTNERS

The country requires around Rp.200 billion or US$22 million a year to take the actions and implement the activities to combat HIV/AIDS. In 2003, US$5.6 million can be provided by the government, and US$16.4 million will be provided by international donors. The country has not fully recovered from the economic, social and political crisis that prevents full scale implementation of the national HIV/AIDS prevention and control programme.

It is expected that the global fund, multilateral and bilateral donors will be able to support the Indonesian HIV/AIDS programme with around US$20 million a year in the next five years.
8. MONITORING & EVALUATION ENVIRONMENT

The National Strategy of 2003 stated the importance of monitoring and evaluation in order to take appropriate corrective measures and achieve high efficiency of programmes. Policies and guidelines for monitoring and evaluation will be formulated.

A working group on monitoring & evaluation and research will be established by the National AIDS Commission consisting of representatives from relevant stakeholders like the Ministry of Health, Ministry of Education, Ministry of Social Affairs, National Narcotics Board, Ministry of Defence, Ministry of Manpower & Transmigration, bilateral agencies (USAID, AusAID, etc), UN Agencies (WHO, UNAIDS, UNICEF, ILO) and relevant NGOs.

The Ministry of Health has made AIDS a reportable disease since 1989 and is implementing a sentinel surveillance programme in 16 provinces.

The Indonesian Red Cross collects data on the prevalence of HIV among blood donors.

Behavioural surveillance surveys were undertaken by MOH and NAC with the assistance of FHI/USAID (HAPP & ASA projects), the AusAID HIV/AIDS Prevention & Care Projects and BPS in 1996, 1998, 2000 and 2002.

Operational and epidemiological evaluation studies have been sponsored by UN agencies and bilateral donors.

The National Institute of Health Research & Development (NIHRD) and the Central Bureau of Statistics (BPS) are doing periodic national health and demographic surveys. Questions on HIV can be included in the surveys if necessary.

The two bilateral projects: ASA/USAIDS and Indonesia HIV Prevention & Care project /AusAID have both M&E components.

Many UN agencies and NGOs have weak M&E of their AIDS related activities and need strengthening of their M&E components.

According to the MOH strategic plan 2003-2007 the success of the responds to HIV/AIDS should be measured by developing indicators on:
- HIV prevalence and number of AIDS cases.
- Behaviours that put people at risk.
- The cost effectiveness of national programmes.
- Intersectoral collaboration
- Community participation
- Environmental factors which make communities vulnerable (social economic factors, discrimination, legislation etc).

The National AIDS Commission and UNAIDS are planning to organize a national workshop on M&E of AIDS programmes in the middle of 2003. It is expected that the workshop will decide on a set of relevant indicators and their method of collection. The constitution of a working group on M&E under NAC will also be one of the objectives of the workshop. Technical and financial assistance from UNAIDS will be required.
ANNEX 1
Preparation/consultation process for the National Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1. Which institutions/entities were responsible in filling out the indicators forms?
   - a. NAC or equivalent: Yes √, No
   - b. NAP: Yes √, No
   - c. Others: bilateral donors & UN agencies: Yes √, No
     (please specify)

2. With inputs from:
   - Ministries:
     - Education: Yes √, No
     - Health: Yes √, No
     - Labour: Yes √, No
     - Foreign Affairs: Yes √, No
     - Others BKKBN: Yes √, No
     (please specify)
   - Civil society organizations: Yes √, No
   - People living with HIV/AIDS: Yes √, No
   - Private sector: Yes √, No
   - UN organizations: Yes √, No
   - Bilaterals: Yes √, No
   - International NGOs: Yes √, No
   - Others: Yes, No
     (please specify)

3. Was the report discussed in a large forum? Yes √, No

4. Are the survey results stored centrally? Yes √, No

5. Is data available for public consultation? Yes √, No

Name/Title: Dr Farid W. Husain/Secretary of NAC
Date: 21 May 2003

Signature: _________________________________
ANNEX 2
NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

Strategic plan

1. Has your country developed multisectoral strategies to combat HIV/AIDS? (Multisectoral strategies should include, but not be limited to, the health, education, labour, and agriculture sectors)

<table>
<thead>
<tr>
<th>Yes√</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
</table>

Comments:
A multisectoral national strategy was launched in 1994. Consultations with civil society, the provinces, the private sector and government agencies to revise the strategy started in August 2002 and on 9 May 2003 the new national strategy for HIV/AIDS 2003-2007 was launched.

2. Has your country integrated HIV/AIDS into its general development plans (such as its National Development Plans, United Nations Development Assistance Framework, Poverty Reduction Strategy Papers and Common Country Assessments)?

<table>
<thead>
<tr>
<th>Yes√</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
</table>

Comments:
The cabinet special session on HIV/AIDS on March 2002 decided to put HIV/AIDS as priority in the national development plan. UNDAF has HIV/AIDS as a cross-cutting team in the projects of UN agencies in Indonesia.

3. Does your country have a functional national multisectoral HIV/AIDS management/coordination body? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

<table>
<thead>
<tr>
<th>Yes√</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
</table>

Comments:
A national multisectoral AIDS commission has been established by Presidential Decree in 1994.
4. Does your country have a functional national HIV/AIDS body that promotes interaction among government, the private sector and civil society? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
The NAC (at central as well as local levels) promote interaction among government, private sector and civil society.

5. Does your country have a functional HIV/AIDS body that assists in the coordination of civil society organizations? (Such a body must have terms of reference or equivalent, defined membership, action plans and staffing support, and should have met at least once in the last 12 months.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
A forum for NGOs active in AIDS prevention and care was established in 1996. It has not been active for almost a year since the death of the chair person (Susana Murni).

6. Has your country evaluated the impact of HIV/AIDS on its socioeconomic status for planning purposes?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
This has not been done since the epidemic is still in its early phase, but the national strategy stated that this should be done in the next 5 years and the World Bank will assist the study.

7. Does your country have a strategy that addresses HIV/AIDS issues among its national uniformed services, including armed forces and civil defence forces?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
The strategy is being formulated and will be finalized in 2003.
Prevention

1. Does your country have a general policy or strategy to promote information, education and communication (IEC) on HIV/AIDS?

<table>
<thead>
<tr>
<th>Yes√</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The NAC has issued a national strategy for IEC on HIV/AIDS in 1996</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Does your country have a policy or strategy promoting reproductive and sexual health education for young people?

<table>
<thead>
<tr>
<th>Yes√</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Ministry of Education and the National Family Planning Board (BKKBN) have developed policies and programmes with assistance from UNICEF, UNFPA and IPPF. The Indonesian Family Planning Association (PKBI) is very active in this field.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Does your country have a policy or strategy that promotes IEC and other health interventions for groups with high or increasing rates of HIV infection? (Such groups include, but are not limited to, IDUs, MSM, sex workers, youth, mobile populations and prison inmates.)

<table>
<thead>
<tr>
<th>Yes√</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ASA project and AusAID Indonesia HIV/AIDS prevention and care project have initiated interventions for IDUs, MSM, sex workers, youth. These are pilot projects which will be integrated into a national programme if they are successful.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Does your country have a policy or strategy that promotes IEC and other health interventions for cross-border migrants?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No√</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The problem is being studied and a policy is in the process of finalization, however several NGOs have initiated projects to promote IEC for migrant workers.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5. Does your country have a policy or strategy to expand access, including among vulnerable groups, to essential preventative commodities? (These commodities include, but are not limited to, condoms, sterile needles and HIV tests.)

<table>
<thead>
<tr>
<th>Yes ✓</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, please list</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groups:</td>
<td>Commodities:</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
Condom promotion, provision of sterile needles and HIV test are included in the national strategy. Pilot projects are being undertaken. Implementation is still facing many obstacles.

6. Does your country have a policy or strategy to reduce mother-to-child HIV transmission?

<table>
<thead>
<tr>
<th>Yes ✓</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>According to the national strategy MTCT should be prevented. MTCT prevention is included in the proposal to GFATM. An NGO (YPI) has initiated MCTC prevention in Jakarta and Papua.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Human rights

1. Does your country have laws and regulations that protect against discrimination of people living with HIV/AIDS (such as general non-discrimination provisions and those that focus on schooling, housing, employment, etc.)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>√</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Comments:
The national strategy prohibits discrimination of PLWHAs. A tripartite declaration on HIV/AIDS in the world of work signed in February 2003 prohibits discrimination in the workplace.

2. Does your country have laws and regulations that protect against discrimination of groups of people identified as being especially vulnerable to HIV/AIDS discrimination (i.e., groups such as IDUs, MSM, sex workers, youth, mobile populations, and prison inmates)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

If yes, please list groups:

Comments:
No laws or regulations have been enacted so far, but the national strategy prohibits discrimination against those groups.

3. Does your country have a policy to ensure equal access, for men and women, to prevention and care, with emphasis on vulnerable populations?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td></td>
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<td>N/A</td>
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</table>

Comments:
This is stated in the national strategy, but requires operational guidelines to be effective.

4. Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by an ethics committee?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>√</td>
<td></td>
<td>N/A</td>
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</tbody>
</table>

Comments:
The National of Health Research & Development, medical schools and other research institutions have institutional ethics review committees. The MOH has formed a national commission on health research ethics for oversight.
# Care and support

## 1. Does your country have a policy or strategy to promote comprehensive HIV/AIDS care and support, with emphasis on vulnerable groups?

(Comprehensive care includes, but is not limited to, VCT, psychosocial care, access to medicines, and home and community-based care.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Yes √</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes, please list

- **Groups:**

- **Commodities:**

**Comments:**
The issues of comprehensive care and support are dealt in the national strategy and operational guidelines are in process of formulation.

## 2. Does your country have a policy or strategy to ensure or improve access to HIV/AIDS-related medicines, with emphasis on vulnerable groups?

(HIV/AIDS-related medicines include antiretrovirals and drugs for the prevention and treatment of opportunistic infections and palliative care.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
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</tr>
</tbody>
</table>

If yes, please list

- **Groups:**

- **Commodities:**

**Comments:**
A special arrangement to import generic ARV drugs tax free from India and Thailand through the special study group on AIDS of Cipto Mangunkusumo Hospital is in operation since 2001. FDA and MOH are working on a national strategy to produce affordable drugs for AIDS treatment.
3. Does your country have a policy or strategy to address the additional needs of orphans and other vulnerable children?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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</tbody>
</table>

Comments:
This has not yet become an important problem but will be given attention in the next five years. NGOs have initiated projects to support known AIDS orphans.

Annex 3

Annex 4

LIST OF REFERENCES

5. BPS-Depkes-ASA. Survey surveillance prilaku (Behaviour surveillance survey) in 10 provinces /12 locations. Power point presentation 19 May 2003.
8. MOH. Profil Kesehatan Indonesia (Health Profile of Indonesia) 2001. Centre for Health Data, Jakarta 2002


23. UNAIDS. UNGASS on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. August 2002