

COUNTRY REPORT:

INDONESIA

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Overview of the situation of children and HIV/AIDS in Indonesia.

While rates of infection in the Asia-Pacific region remain relatively low, millions of children in the region are already vulnerable, and this number will almost certainly rise as countries like Indonesia stand on the brink of a generalized epidemic. The data regarding the number of children directly or indirectly affected by HIV/AIDS are far from complete, but recent estimates for the Asia-Pacific countries indicate that by the end of 2004¹:

- 1.5 million children had been orphaned by AIDS
- 120,700 children were living with HIV/AIDS
- 46,900 children were newly infected in 2004
- 35,000 children needed antiretroviral therapy.

Those estimations are widely believed to underestimate the current situation. In Indonesia, data on children infected with, made vulnerable and/or orphaned by HIV/AIDS are limited. We do believe -that HIV/AIDS caused deep concern in this region.

Indonesia is on the brink of a rapidly worsening AIDS epidemic² that is already spreading into remote parts of the archipelago, the incidence is strongly related to injected drug users (IDUs). Sharing needles is common, and a high proportion of IDUs are sexually active, many of them are related to sex workers. In December 2005 the Ministry of Health reported a cumulative figure of 5,321 AIDS cases in 31 out of 33 provinces. The majority of that (54.07%) were in the age group of 20-29. Children under 14 years of age account for 1.23 percent. Almost half (48.9%) of the HIV cases were transmitted through injection drug use, with heterosexual transmission accounting for most of the rest (39.4%). The national AIDS case rate per 100,000 of the population is 2.65. Those figures above reveal just a fraction of the story. With a Total Fertility Rate (TFR) of 2.3 in 2003, it is thought that 2,250 to 3,250 new born are at risk of HIV infection each year. By 2010, it is estimated that 110,000 people will be suffering or will have died of AIDS and another million will be HIV-positive.

To date, the official estimate of people living with HIV/AIDS is 90,000-130,000. Since 2002, actions to fight HIV/AIDS have resulted in high commitments and have become one of the national priorities with periodic discussion of HIV/AIDS problems in cabinet meetings. Indonesia has also launched a national strategic plan of HIV/AIDS in 2004-2010 of which will be developed and implemented by all sectors in particular the health sector.

Women and adolescents form the majority of poor and vulnerable groups in any parts of the world. Although in most cases they are victimized, their involvement in planning and implementation of HIV/AIDS program has been indirect, mainly through information and data collection on reproductive health and HIV/AIDS. The HIV/AIDS epidemic in Indonesia may primarily driven by poverty. The main mode of transmission of HIV infection is shifting from sexual route to injecting drug user. Estimates used by the Directorate General of Communicable Disease Control and Environmental Health of the Ministry of Health (CDC and EH-MoH 2004, in UNGASS Country Report, NAC 2005) state that the total number of IDUs in Indonesia is approximately 111,894, with an overall HIV prevalence of 39%. The great majority of injectors are young men, over two-thirds of whom are sexually active.

The pattern of the epidemic in Papua is somewhat different from that in the rest of the country. Here the epidemic is becoming generalised, with HIV infections estimated at 8,000-14,000, or about 0.6-1% of the total adult population. Surveys of pregnant women in some selected areas (Mimika and Merauke) indicated a prevalence of over 1 percent.³ Unlike in other parts of the country, the epidemic in Papua is driven principally by sexual transmission and in a region where sexual activity tends to begin at an earlier age, young people in particular are at risk. For instance, around 10-15% of young men (aged 15-24) had sex and 50% have had sex before marriage. Premarital sex among young women (aged 15-19) is

¹ Reference Group on HIV/AIDS Surveillance, 2005. The estimates refer to children under the age of 18 and include all countries of Asia and the Pacific.

² UNAIDS December 2005: AIDS Epidemic Update

³ National AIDS Commission, 2006: UNGASS Country Report 2004-2005.

also high, 6% in Merauke, 90% in the Jayawijaya highlands, 30% in Biak and 20% in Jayapura.⁴

To date the prevalence of HIV/AIDS nationwide among people aged 15 to 29 is estimated at below 0.1 per cent⁵. Noting the figures above, this could be expected to increase rapidly. Nevertheless, the number of HIV-infected children is still low compared to that of some neighbouring countries. In a presentation made in 2005 by MoH, nine HIV/AIDS cases were reported among children below four years of age, eight in the 5-14 age group and 82 in the 15-19 age groups.⁶ It is likely that there are vastly more cases that remain unreported. Nearly 2.2 million children in Indonesia are sex workers, domestic workers or living and working on the streets. That situation, increase the risk of exposure to HIV along with the alarming fact that 30% of sex workers are under the age of 18.⁷ The circumstances of a further 3.5 million neglected children and 193,000 delinquent children⁸ multiply the increase risk factors that make children highly vulnerable to such infection.



Source: Indonesia, Ministry of Health, 2005

It is also a problem that limited data are available on the number of cases of HIV among pregnant women and infants. Some behavioural surveillance data indicate that married men commonly have extramarital sex with sex workers while very few of them use condoms, thereby putting their wives at risk. As the consequences, more infections among women of childbearing age will lead to more infections among newborns and infants. Data on children made vulnerable and/or orphaned by HIV/AIDS are limited. Clearly, if—as noted in the 2004 *Children on the Brink* report (UNAIDS, UNICEF, USAID)—the epidemic in Indonesia expands to the levels of countries such as Thailand and Cambodia, the number of children orphaned by AIDS could grow dramatically.

Indonesia's relatively low prevalence provides a window of opportunity to act and prevent more children and adolescents from getting infected. Evidence from several countries in the region shows that young people participation in a comprehensive HIV/AIDS strategy may reverse trends. As a result of prevention initiatives specifically targeting young people such as male adolescents in Cambodia are more likely to use condoms than adult men, and male youth in Thailand are less likely to visit sex workers⁹. In Indonesia, interventions to reach children and young people at risk prevent mother-to-child transmission (MTCT). Therefore, expand access to information, education and services would have to be rapidly scaled up from current levels otherwise the opportunity would have been lost.

Progress and Achievements

The response to HIV/AIDS in Indonesia has so far focused principally on combating the epidemic and preventing further infections among the most at-risk groups, that is, female sex

⁴ Ibid.

⁵ National AIDS Commission. 2003 HIV/AIDS Country Progress Report.

⁶ Rachmat, Haikin, 2003. "HIV/AIDS Prevention Strategy for Children and Young People". Presentation at IFPPD Meeting, Ministry of Health, Indonesia, November 2003.

⁷ Save the Children UK: Children and HIV/AIDS in Indonesia, October 2004. *In: UNICEF: East Asia: Children and HIV/AIDS: A call to action, 2005.*

⁸ Ministry of Social Affairs, Republic of Indonesia. 2005. Report on the Progress of the Ministry of Social Affairs on Preventing HIV/AIDS, 1 Year After the Sentani Commitment

⁹ UNICEF: East Asia: Children and HIV/AIDS: A call to action, 2005.

workers and their clients, men who have sex with men, *waria* (transgenders), and the IDUs. Many among those group of population are young. The figure above shows that 30% of female sex workers are less than 18 years old, and some 60-80% of IDUs are between the ages of 16 and 25.¹⁰ Efforts specifically targeted to the needs of vulnerable children and preventing mother-to-child transmission, unfortunately, have only recently begun.

Indonesia is making progress towards key UNGASS targets. The national commitment to combating HIV/AIDS is growing. It is documented that 106% increase in the government funding allocation from US\$ 6.3 million in 2003 to US\$ 13.0 million in 2005 (US\$ 11.4 million by the central government and US\$ 1.6 million by local governments). In addition to that, HIV/AIDS is a component in the Short Term National Development Plan for 2004–2009. In 2004, six cabinet ministers, together with the governors of six high-prevalence provinces, made a commitment to collaborate on strengthening and expanding the response to the epidemic. In 2006, the National AIDS Commission plans to roll out the HIV/AIDS prevention, care and treatment program to a total of 100 districts in 21 provinces.

Despite those efforts above, coverage is still far from adequate. Data on the targets of a 2005 projects revealed that only 20% of transgenders and just 15% of IDUs¹¹ -- two of the groups at the highest risk of exposure to HIV/AIDS -- were reached by prevention programmes. Coverage of female sex workers and people living with HIV/AIDS (PLWHA) was slightly better, at 37% and 40% respectively, but only 14% of sex workers and 3% of clients had been tested for HIV and knew the result.¹² Clearly not enough people are getting access to the prevention services they need.

It is noted that the most at-risk groups are becoming better informed. In 2004, 23.8% of sex workers correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions concerning the issues, as compared to just below 14% in 2002; knowledge among clients increased to similar levels. Men who have sex with men (MSM) were more aware since just over 40% responded correctly. However, the implication tells that almost 60% of a highly vulnerable subpopulation does not know how HIV is transmitted.

The lack of information contributes to low levels of condom use. Condoms can be a highly effective method of preventing HIV transmission, but only if they are used consistently and correctly. Behavioural surveillance in 2004 indicated that only just over half of female sex workers used a condom with their most recent client (this generally reflects the trend in consistent condom use).¹³ A similar percentage of men (56.46) reported using a condom the last time they had anal sex with a male partner. Consistent condom use, indeed, was very low (10%).

Important steps towards strengthening health-care systems to support people living with HIV/AIDS has been initiated by staff training at 75 ARV referral hospitals across the country and providing subsidized antiretroviral drugs and expanded VCT services within those hospitals, as well as providing reagents for HIV testing.

Two positive results in 2005 that target children are the development of policy on the prevention of mother-to-child transmission of HIV (PMTCT) and the introduction of life skills education for HIV/AIDS into the school curriculum. Students at a total of 533 high schools in 20 provinces in Indonesia received life skills-based HIV/AIDS education during the last academic year. Two teachers from each school were trained to teach the subject, and they were supported by an additional 3,318 peer educators spread among the schools. This is a start, but with a total of 8,036 high schools nationwide, so far only 7% of them are providing life skills education.¹⁴ Many challenges remain, including stigma and discrimination against people living with HIV/AIDS, which seriously hampers all efforts to prevent HIV/AIDS and to provide care, support and treatment for people affected by the virus.

¹⁰ Center for Harm Reduction, 2001: Revisiting 'The Hidden Epidemic' – a situation assessment of drug use in Asia in the context of HIV/AIDS

¹¹ National AIDS Commission, 2006: UNGASS Country Report 2004–2005.

¹² Ibid

¹³ Ibid

¹⁴ Ibid

It can be concluded that another priority to be addressed is the critical weaknesses in the national surveillance system. Sentinel surveillance efforts by the Ministry of Health suffered a setback after the process of administrative decentralization began in 2001, because local health services were not reporting activities of which are considered as the responsibility of the central government. The Ministry of Health continued to support the provision of equipment and reagents for surveillance in all provinces. However, to ensure that children and young people can be effectively covered by HIV/AIDS programmes, surveillance and data collection systems will have to be further designed to track vulnerable children and young people as well as other at-risk groups of population.

In 2002, the Ministry of Health, with support from international experts, created a national estimation method for HIV infection in Indonesia. The method bases estimates on available sentinel surveillance and behavioural surveillance data, focusing on high-risk populations and on their total population sizes in each province. In 2004 and 2005 the estimation process was carried out in eight provinces using more province-specific data. The National AIDS Commission (NAC) has formed a technical working group to review the resulting estimates.

Good Practices and Lessons Learned

The impact of HIV/AIDS on children can be considered as an emerging issue in Indonesia, and while accurate data on the number of children affected are unavailable, the factors that put them at risk are very clear. Some examples of good practices of providing support for children at risk or affected by HIV/AIDS which are already beginning to emerge are described below.

That includes the partnership effort in prevention, care, treatment and support for children at Jakarta's biggest state hospital and peer education for prevention of HIV/AIDS and drug use by government and a local Non-Governmental Organisation. Through these interventions both parties have learned that quality communication and counseling skills are essential to successful outreach interventions in the communities. Also, sustained capacity development for service providers on new development in HIV/AIDS prevention and care is crucial for effective response to the HIV/AIDS epidemic. In relation to that, youth prefer to receive education and information about reproductive health and HIV/AIDS from their peers and that multi-sectoral approach is the key to the prevention of HIV/AIDS.

Prevention, Care, Treatment and Support for Children

Physicians at Jakarta's biggest state-owned hospital (Cipto Mangunkusumo) are providing services that span a continuum from prevention to care, with currently some 2,000 registered ARV patients.¹⁵ In this hospital, a pilot program on the PMTCT began in 2002, using the PACTG 076 protocol. This protocol was evaluated in 2004 in order to incorporate new data from other countries. The evaluation was further conducted in early 2006 in order to accommodate the best practices available in the hospital. There are now 49 mother-baby pairs in the program, with three (6.12%) positively infected.¹⁶ In most cases, the paediatrician makes the first contact with the pair in the nursery after delivery, where data is obtained and ARV given to the baby. During follow-up visits, the mother-baby pairs usually see an obstetric-gynaecologist, a paediatrician, an internist and the lab on the same day, a package known as PMTCT Plus.

Care, Support and Treatment

One of the biggest challenges in managing HIV infection in children is diagnosis. This has become easier now that PCR RNA is used in the PMTCT Program to diagnose infants below

¹⁵ Working Group on AIDS, Cipto Mangunkusumo Hospital, Jakarta (2006) Draft report on Good Practices, Lessons Learned in Providing Prevention, Treatment, Care, Protection and Support Services to Children at Risk, Infected and Affected by HIV/AIDS

¹⁶ Ibid

18 months exposed to HIV. For children over 18 months, ELISA is usually used. The CD4+ count is used as a guideline for starting ARV therapy, since PCR is too expensive for most of the parents. A complete blood evaluation and liver function test is also taken before starting ARV, and these data are re-evaluated every 3 months. The procedure also involves identifying any opportunistic infections that need to be treated before ARV, identifying the child carer who will be responsible for drug delivery, counselling and evaluating whether they will be able to adhere to every step of the therapy. If appropriate, ARV is started, with bi-weekly monitoring for the first 3 months and monthly monitoring thereafter. If the patient fails to appear on the specified day, one of the doctors will make a call to the carer, to see whether more attention and support is needed. The common reason for postponing a clinical visit is lack of money.

Patient care is organised into entry point, clinic, drug dispensing and consultation. There are separate clinics for adult patients and child patients. In the child clinic, there is a paediatrician, an internist, a dermatologist, and a neurologist every weekday, as well as a nutritionist. There is a duty doctor at weekends, and where necessary, arrangements can be made for consultations with dentists, surgeons, eye specialists, parasitologists, and psychiatrists. Support is provided by an office-based counsellor. There are currently no PLWHA support groups for children. This matter is being explored with existing PLWHA support groups to attract them into extending their services to children and care-givers. Drug dispensing for adults and children is managed by the same unit. There is no paediatric formulation available in the form of tablets, capsules or syrup, thus, the children's dose is made by breaking down the adult preparation.

Managed Care/Psychosocial Challenges in Paediatric HIV Infection

According to a physician at the Cipto Mangunkusumo hospital, one third of the children affected, infected or exposed, is orphaned or has only one parent. This increases the burden on the family's economic situation. Financial support usually comes from the extended family (grandparents, aunts/uncles) or adoptive family, or an orphanage. Although various government social supports are available the ARV drugs and HIV testing are free and fully subsidized by the government, the family has to pay for other laboratory examinations and drug preparation.

On the issues above, the oldest child in the program is 9 years old. Those children have not been informed that they have the virus nor did the schools they attended. This is due to stigma and discrimination against PLWHA. It is imperative that community education be intensified to address stigma.

The Empowered Youth programme managed by a local NGO (YAKITA, a drug rehabilitation centre based in Bogor, West Java province) is another best practice which targets young people with information and skills through peer education on the prevention of HIV/AIDS and drug use. Most of the young people at the program are no strangers to drugs by the age of 15. The youngest reported case of smoking was 4 years old and alcohol by the age of 8. By the age of 15 or 16, many have already begun using heroin, or had their first experience with heroin through injection. It is documented that the use of alcohol and drugs is a major contributing factor to unsafe sex. In Pematang, North Sumatra, nine out of 12 boys aged 15 to 18 said that they had used heroin and had shared needles on more than one occasion. All of them had had sex, some as early as age 12, and none had ever used a condom.¹⁷

Empowering Youth to Fight HIV/AIDS and Drug Use

Indonesia is running towards a delicate and dangerous situation of high infection of HIV among young people that may not be reversed if no action is taken timely and sensibly. The country may not be ready to face a full-blown HIV epidemic on top of its other political and development challenges- poverty, terrorism, natural disasters and regional conflicts. Anyhow, Indonesia can rise to the challenge of HIV/AIDS, if timely, concerted and appropriate actions are taken to avert the emerging crisis. The program mentioned above, may be considered as one strategy that offers Indonesia an opportunity to reach a critical mass of children and

¹⁷ A report by YAKITA/Unicef, 2003

young people with prevention education about HIV/AIDS, reproductive health and drug use.

Children and young people often find it easier to accept and discuss sensitive topics like sex and drugs with their peer group, rather than with their teachers or parents. That is the bases of the Empowered Youth initiative program mentioned above when undertaking a programme to train young people to reach out to their peers on issues related to HIV/AIDS and how it is transmitted including prevention of drug use among youth in Indonesia. The initiative has been developed and implemented with full participation of young people in four HIV hotspots provinces: Jakarta, West Java, South Sulawesi and Bali.

The programme provides a one-month in-depth training to equip young people with communication skills and knowledge about HIV/AIDS and drug abuse. These young people then return to their home towns and work with their peers in youth groups, schools, campuses, hospitals, on the street and even in military barracks. Many have been sought out by local government agencies to collaborate on training. So far, four Empowered Youth groups of 25 participants each have been trained, and they themselves have reached over 6,000 other young people. The sense of local ownership is strong, and the peer educators Empowered Youth groups are as follows: 25 Messengers (West Java), We are Youth (WAY, Bali), KIPAS (Makassar), s.t.i.c.k.e.r (Greater Jakarta), and Viva Education on Drugs, Hepatitis, AIDS (VEDHA), to name a few. Many have already begun training other peer educators in how to spread the message further.

The expertise of the program management in running a successful youth peer education programme has recently been sought beyond Indonesia. In December 2005 the programme has been applied in Maldives in the form of technical assistance (given by YAKITA) in initiating a peer education training on and rehabilitation programme for young injecting drug users. This is expected to translate into several follow-ups including peer counselors training, technical support in conducting a situation assessment on drug abuse by recovering addicts themselves, and a possible host to a study tour by youth from the Maldives to Indonesia.

Children participation

While children and HIV/AIDS may not be very explicitly seen in the current national legislation, policies and HIV/AIDS strategies, it is worth noting that within the National HIV/AIDS Strategy 2003–2007 which outlines seven priority areas for Indonesia's response with reference to opportunities and entry points to addressing the needs of children are made. The strategy priority areas include HIV/AIDS prevention, care, treatment and support for PLWHA, HIV/AIDS and STI surveillance, operational studies and research, enabling environments, multisectoral coordination and a sustainable response.

Although the above priority area caters for prevention, care, treatment and support, such services for children do not explicitly expressed. This has translated into limited focus on attention to the needs of children. The National Strategy also identifies the Ministry of National Education as a key partner in multisectoral response, outlining its responsibility to provide health education and HIV/AIDS prevention education in both school and out-of-school settings. Apart from this, however, strategies to address the AIDS-related issues that most affect children are not explicitly described. In addition the NAC is in the process of drafting a Presidential Decree on Children and HIV/AIDS. This will need to be backed up by strong implementing guidelines and actively supported at provincial and district levels. To operationalise prevention, care, and support activities financial support will be required. The NAC has recently constituted a task force on children and women to provide technical guidance on policy development, coordination and advocacy.

The Law No. 23 on Child Protection, enacted in 2002, makes no explicit mention of HIV/AIDS, but it does provide that the state, the government, the family and the parents are responsible for ensuring that a child is born free of life-threatening or incapacitating diseases (Article 46) and that comprehensive healthcare facilities shall be provided free of charge for families of limited means (Article 45). In addition the law provides for special protection for children in a range of circumstances, including those who have been neglected or abandoned, sexually

exploited, or have become victims of the misuse of drugs, alcohol and other additive substances. It also makes exposing children to such situations a criminal offence.

The Ministry of Health developed a national policy on PMTCT in 2005. This policy and the related national guidelines articulate issues on management of paediatric AIDS, infant feeding and HIV/AIDS including continuum of care for both baby and mother. The policy recommends integration of PMTCT into maternal child health interventions. The guidelines are also being integrated into the ART programs currently delivered in 25 hospitals and will serve to increase the VCT service level in 825 primary health centres in 26 districts in 14 high-prevalence provinces.

The HIV/AIDS was incorporated in Indonesia Medium-term National Development Plan (2004–2009), the various activities was carried out by various sectors/ministries, and civil societies. In line to that, the National AIDS Commission endorsed a range of strategies in line with the UNGASS Declaration of Commitment.

In the area of Adolescent Reproductive Health (ARH), National Family Planning Coordinating Board (NFPCB/BKKBN) addresses three issues namely sexuality, HIV/AIDS and drug abuse. The main focus of activity is on prevention of those issues by providing information and counselling to adolescent (aged 10-19). The ARH programme is a nation wide activity since the year 2000 with budget of around US\$ 1 million per year. The main activities are on building commitment, promotion and IEC, establishing centres for information and counseling on ARH and capacity building for programme implementers. While these are positive efforts worth scaling up there is urgent need to review existing policy on youth reproductive health with regard to making reproductive health services available in a public health centres. Currently, interventions are IEC and counseling materials, training modules on ARH for peer educators, peer counsellor and master trainers on ARH at national and selected provincial level. The strategy is to reach the adolescent through peer approach. In the next five years, activities through empowering Indonesia Scout Organization and Faith Based Organizations will be developed. The initiative targeting adolescent through Scout Organization will focus on adolescent aged 10-14 in school.

Plans, Initiatives, Gaps and Resources

In response to the challenges posed by HIV/AIDS to national development, local and international resources (including UNAIDS, UNICEF, and Global Fund) was mobilized to the increasing threat of HIV/AIDS. In 2004, initiated activities in care, support and treatment of PLWHA, prevention, capacity building, community education and research were conducted as reported below. While these plans are on-going it is pertinent to recognize the need for additional resources to address the HIV/AIDS problem in Indonesia.

Facilitating comprehensive trainings for care and support treatment (CST) for PLWHA and VCT in all provinces and covering 106 hospitals in Indonesia. Seventy five out of those hospitals are appointed as referral hospitals to provide Anti Retroviral Therapy (ART). These programs have reached almost 4,000 PLWHA and benefiting many. The CST for youth or adolescent is still very limited due to limited government resources as well as the private sectors in providing services (youth friendly), manpower (pediatrics care and drugs for children) and financing (the available funding is targeting high risk groups). It is plan to arrange easy access to facility, equipment and drugs for HIV/AIDS amongst children and youth. Both human and organizational capacity and resources are needed to reach a critical mass of young people with prevention education.

The current response to HIV/AIDS targeting children and young people is heavily prevention oriented. It emphasizes knowledge and skills to prevent risky behaviour such as pre-marital sex, unprotected sex, and injecting drug use. Various programs are being implemented such as training for peer educator and outreach program has reach 400 targets in 15 provinces (Life-Skill Education and Behaviour Change Communication program). Most of these programs are carried-out by the NGOs and civil societies. These programs should be expanded into more comprehensive program which includes the care, support and treatment

for children and youth in the near future due to the rapid increase of HIV/AIDS amongst IDUs, particularly among young age population groups.

Every PLWHA has a right to get treatment, care and support without discrimination. In this regard a community based VCT has been initiated to increase access to these services while encouraging integration of health service, treatment and care for PLWHA into the existing primary health services network. The availability of drugs for HIV/AIDS was also ensured. So far, the Ministry of Health has trained 206 basic counselors for community based VCT. There is need to expand these services in all provinces. The challenges to do so include stigma about HIV/AIDS, organizational capacity of CBOs, limited trained counselors and financial support.

In 2005, the program was started by facilitating the PMTCT training in 5 provinces in Indonesia (Jakarta, Riau, Bali, Kepulauan Riau, Papua) and trained 91 persons from 11 hospitals and 2 PHC with various background (specialist doctors, pediatricians, counselors, nurses, etc.). The number of HIV-positive babies being treated at the Cipto Mangunkusumo hospital in Jakarta has been increasing (1 in 1996 and 44 in 2004). The problem of mother-to-child transmission of HIV is predicted to worsen in Indonesia due to increasing spread of HIV among women of reproductive age. Without effective and comprehensive PMTCT programme, infection in children is likely to increase. This program should be expanded to enhance the accessibility to reach more women in all high prevalence provinces. In relation to that a national plan of action for PMTCT based on the PMTCT policy and accompanied guidelines has been finalized. Key areas of focus are to integrate PMTCT into the existing MCH services in hospitals and Community Health Services, to promote community education and to strengthen referral system between community based and health services.

The effort to achieve those objectives calls for intensified community education on HIV/AIDS and in particular women of reproductive age and their partners by accelerated training of various cadres of health workers, resource mobilization and development of legislation on children and HIV/AIDS. However, shortage of technical qualified personnel and adequately equipped health facilities may inhibit expansion and sustainability this program. The NAC has so far allocated funds for PMTCT in six priority provinces. Despite the modest amount, these allocations indicate a commitment to addressing PMTCT and Paediatric treatment. Support to scaling up these initiatives by providing technical assistance and financial support will go along way in promoting and ensuring universal access to prevention, treatment and care for children and their families. A local NGO (Yayasan Pelita Ilmu) has been implementing a community-based PMTCT intervention in the slums areas of Jakarta. Lessons learned from this project have been useful in designing community-based PMTCT interventions in other parts of Indonesia. The programme is experiencing difficulties in scaling its experiences due to limited trained personnel on PMTCT.

Harm reduction activities such as Needle Syringe Program (NSP) have been carried out by government agencies, NGOs, FBOs and Positive Support Groups. This program will also be expanded by providing Methadone substitution program (MMT) including HIV prevention, care, and support and treatment activities in every province in Indonesia. The MMT program have been implemented in two Drug Dependency Hospitals, Fatmawati in Jakarta and Sanglah in Bali, with satisfactory results and will be expanded to other hospitals, Sutomo in Surabaya and Hasan Sadikin in Bandung.

Prevention among Children and Young People

As part of the prevention effort the Ministry of National Education (MoNE) is undertaking school-based HIV/AIDS prevention education through Life Skills Education and Peer Education for students of Senior High School. An assessment of HIV/AIDS in the education sector was also conducted (support from UNESCO) in order to identify barriers to HIV/AIDS and reproductive health education and plan prevention programmes for children and youth in and out of school, across the country. An HIV/AIDS component has been developed and will be introduced into all pre-service training for secondary school teachers in 2006-2007 in two high priority areas. Life Skills Education has already been rolled to more than 500 senior high schools in 20 provinces across the country.

Focusing Resource for Effective School Health (FRESH) is another program noted to combat HIV/AIDS, particularly among the very young age. The FRESH initiative comprises four components: Strengthening health related school policy particularly in HIV/AIDS, strengthening skill based education in HIV/AIDS, strengthening water, sanitation and the conducive environment for implementing healthy life-style and strengthening health and nutrition services. It is expected, that in 2006, the program will be piloted in at least four provinces and will be expanded to more provinces within the next five years.

Other HIV/AIDS prevention programmes run by the Ministry of National Education includes Life Skills Education (LSE) with support from UNICEF. This programme uses a combined school-based and peer education approach to HIV/AIDS prevention and care. The programme has been implemented in Papua province since late 2002 and targets students in junior high school (13-15 years of age). A baseline KAP survey among junior secondary schoolchildren guided the design and implementation of the programme. The survey noted that high levels of misconceptions and ignorance on HIV/AIDS, a problem compounded by multiple sexual partners and an early age of first sexual intercourse, at times as young as 12 years. The results guided the implementers in programming and were used to advocate 13-15 years students.

That program enjoys strong link with communities. In the school based Life Skills Education (LSE) the establishment of teacher-parent association or school committee regular consultations between schools and members of the committee. The committee members were sensitized on HIV/AIDS and reproductive health and their role in supporting school HIV/AIDS prevention activities within schools. School AIDS clubs have been established to enable students interact on their own by organising events such as essay, poem and music competitions, wall display and debates. Sustained advocacy with political, religious and tribal leaders; government officials and donors is another approach of mobilising support for the activities in Papua.

Support to Children Affected and Made Vulnerable by HIV/AIDS

While stigma and discrimination against PLWHA and those affected remain high in Indonesia, the government and PLWHA organisations have recently increased agenda on children affected and infected with HIV/AIDS into their advocacy activities. Nevertheless, the challenge to educate the public about HIV/AIDS and to fight stigma remains. The Ministry of Social Affairs (MOSA) has activity focus on children and their welfare. It caters for care arrangements for separated, unaccompanied and single parent children. It encourages positive approaches to child protection. The activities characterised by the emphases on the importance of keeping children with their family (including siblings) in order to prevent possible separation of children from their families. Reunification of children with their families and the promotion of family-based care for children are paramount. It also encourages communities to avoid placing children in institutional care. Advocating for assessment of the best interests of each individual child is taken into account as well as the continuity of care for the children. Provision of basic needs of the children, including food, shelter, health care, psychosocial support and education; support the psychosocial recovery and development of the children, protect the children from potential abuse and exploitation are also supported.

To date, the specific needs of children orphaned and made vulnerable by HIV/AIDS have not been seen as a priority. As the epidemic spreads, it will have far-reaching impact, not just on the rights and lives of such children, but on the country as a whole. When one or both parents fall sick, the economic burdens often force children out of school—fees can no longer be paid, children have to care for sick family members or earn money to support them. Such children will often be driven into poverty, and without education, have little means to escape from. If this is to be averted, Indonesia will need to address the strategies outlined in the Framework for the Protection, care and Support of Vulnerable Children Living in a World with

HIV and AIDS.¹⁸ A national situation analysis of children and families affected by HIV/AIDS and other vulnerable children in Indonesia will be undertaken with technical and financial support from UNICEF. The analysis is expected to provide necessary information and data to facilitate the implementation of the framework in Indonesia.

To scale up the response for children while addressing other challenges posed by HIV/AIDS in Indonesia, the Government urgently requires technical and financial support in primary prevention among young people, prevention of mother-to-child transmission of HIV, provision of paediatric treatment and protection of children affected by HIV/AIDS. Critical to these is high level advocacy to all leaders and capacity development of all cadres of various sectors (health, education, etc) in HIV/AIDS prevention, care and support. Aggressive and comprehensive community mobilization through NGOs, FBO organizations, youth groups, media, private sector and professional association must also be scaled up. Genuine youth participation and involvement will be supported if they are to contribute to the solutions or problems affecting them.

Based on a model developed by the UNAIDS, it is estimated that a total of around **US\$ 100 million** is required to respond to the challenges facing the children and young people (population below 19 years of age) discussed in this report within the **next 7 years** including VCT and PMTCT, or around US\$ 14 million yearly. The estimation was calculated based on the assumption that the unit cost per children is around US\$ 62.9; for VCT around US\$ 61.0 and for PMTCT around US\$ 46.0. For the last three years, for the prevention of HIV/AIDS¹⁹ the government (with support from international agencies) has allocated around US\$ 24.8 million in 2003, US\$ 30.4 million in 2004, and US\$ 64.9 million in 2005. With reference to the age distribution, it is simulated that the funds for children below 19 years of age is around one-third of the total budget for HIV/AIDS prevention. The funds allocated was around US\$ 8.3 million in 2003, around US\$ 10.1 million in 2004, and around US\$ 21.6 in 2005, consistent with the above assumption.

¹⁸ UNAIDS, UNICEF, July 2004: Framework for the Protection, care and Support of Vulnerable Children
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¹⁹ UNGASS Indicators Country Report, 2006