

# INDONESIA

## INDONESIA AT A GLANCE



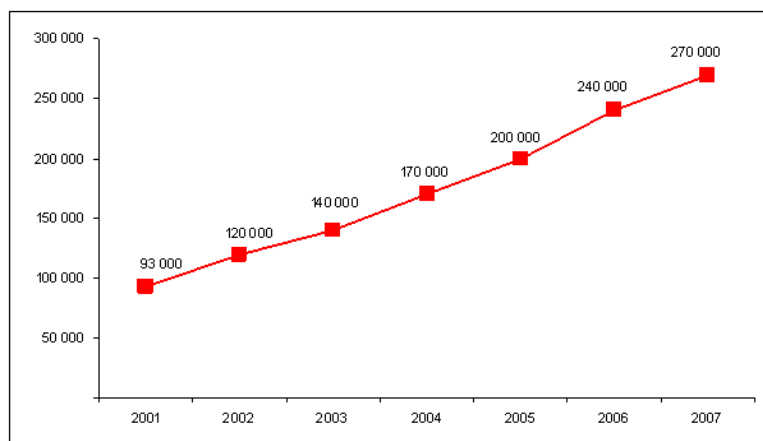
Total population (thousands)	240,271,522 (2009) [1a]
Annual population growth rate	1.136% (2009) [1a]
Population aged 15-29 (thousands)	158,467,890 (2009) [1a]
Percentage of population in urban areas	52% (2008) [1a]
Crude birth rate (births per 1,000 population)	18.84 (2009) [1a]
Under-5 mortality rate (per 1,000 live births)	29.97 (2009) [1a]
Human development Index (HDI) – Rank/Value	107/0.728 (2005) [1b]
Life expectancy at birth (years)	70.76 (2009) [1a]
Adult literacy rate	91% (2006) [1c]
Ratio of girls to boys in primary and secondary education (%)	98 (2006) [2]
GDP per capita (PPP, \$US)	3,900 (2008) [1a]
Per capita total health expenditure (Int. \$)	78 (2005) [3]

## HIV EPIDEMIOLOGY AND TRENDS

The first case of HIV was reported in 1987. Since then, the number of cases rose to approximately 270,000 people living with HIV & AIDS at the end of 2007 (figure 1) [4], with HIV prevalence estimated at 0.2% among adults (ages 15-49) [5]. The HIV & AIDS epidemic has changed from low to concentrated, with high HIV prevalence in some populations, namely

injecting drug users (up to 52%), transgender sex workers (up to 34%), female sex workers (up to 17%), and men who have sex with men (up to 8.1%). The HIV epidemic in the province of Papua is generalized, with current HIV prevalence at 2.9% in adult men and 1.9% in adult women, and higher in rural than urban areas [6]. In Papua, the prevalence in the general population is more than 20 times the national average [7]. The increasing number of new HIV infections in Indonesia makes the epidemic one of the fastest growing in Asia, with 20% of estimated HIV cases occurring among women by the end of 2007 [5].

Figure 1: Estimated number of people living with HIV, 2001-2007



Source: UNAIDS/WHO, 2008 Report on the global AIDS epidemic, July 2008

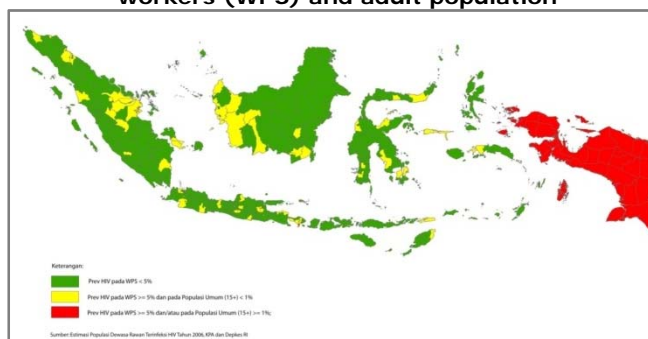
The epidemic is increasingly well entrenched in many parts of the country, especially amongst injecting drug users. In the near future HIV is predicted to be spread predominantly through sexual modes of infection. Thus, enhancing the STI clinics and promoting condom use will be necessary. While many initiatives have been taken to encourage safer sex practices, barriers to condom promotion remain. The main challenge is in persuading religious authorities to adopt public health perspectives in dealing with the epidemic.

## RISK BEHAVIORS

In late 2006, the Ministry of Health (MoH) conducted a size estimation of most-at-risk populations (MARPs) to map the AIDS epidemic for program development. The MoH sentinel surveillance showed that the increased HIV infection in many parts of Indonesia in early 2006 was triggered by the growing new infection among injecting drug users, but also by female sex workers and their clients (figure 2) [8].

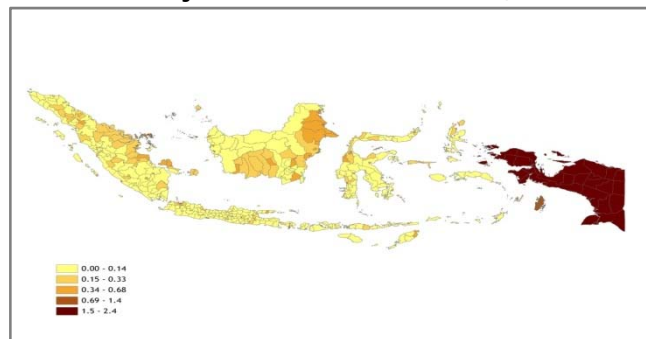
HIV distribution in Indonesia has a geographical pattern. New HIV infections occur mainly among behaviorally-linked most at-risk populations (MARPs): injecting drug users (IDUs), female sex workers (FSWs) and their clients. Locations with a high number of MARPs shows similarly high patterns of infection (figure 3). This correlation may explain the geographic spread of HIV seen in figure 3 [8].

**Figure 2: HIV Vulnerability Map, 2006**  
Based on HIV prevalence among female sex workers (WPS) and adult population



Source: Dr. Kemal N. Siregar, Indonesia's experience using geographical mapping tool: Programmatic implications of HIV geographical spread for local authorities, paper presented at The Second Global HIV/AIDS Surveillance Meeting in Bangkok, Thailand, 2-5 March 2009

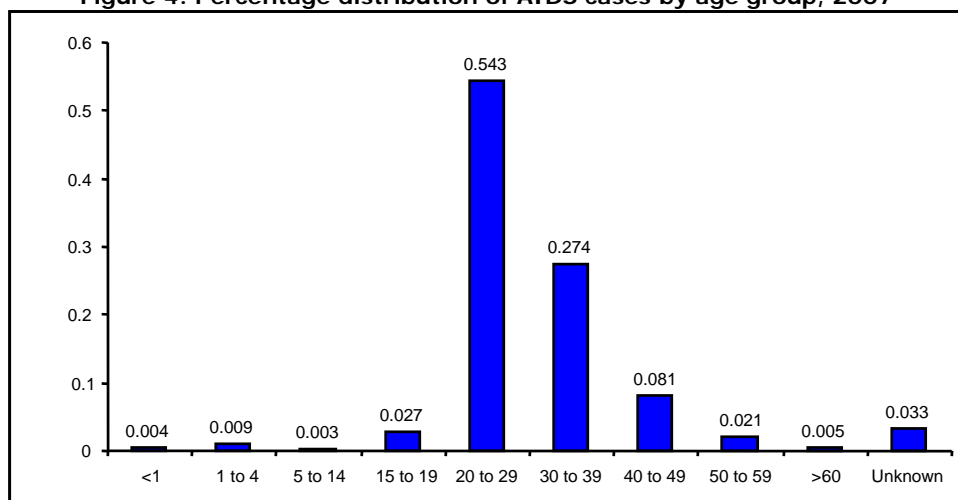
**Figure 3: Distribution of HIV infection in Banten, DKI Jaya and West Java Province, 2006**



Source: Dr. Kemal N. Siregar, Indonesia's experience using geographical mapping tool: Programmatic implications of HIV geographical spread for local authorities, paper presented at The Second Global HIV/AIDS Surveillance Meeting in Bangkok, Thailand, 2-5 March 2009

Young people also constitute an important high-risk group. By March 2007, young adults between the ages of 20-29 accounted for about 54% of cumulative AIDS cases, according to the Ministry of Health (figure 4). There are very few HIV infections in people below the age of 20.

**Figure 4: Percentage distribution of AIDS cases by age group, 2007**



Source: Ministry of Health. HIV/AIDS report, Directorate General of Disease Control and Environmental Health, March 2007

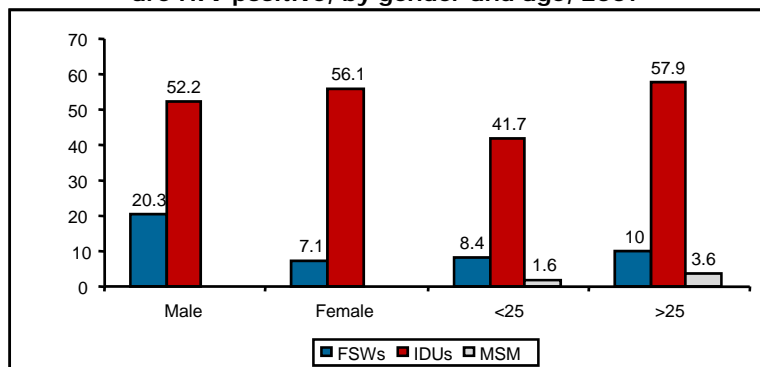
By traditional norms, premarital sex is uncommon. However, several studies show the propensity of young people to engage in this risk behaviour. One study indicates that 13% of adolescents approved of premarital relationship if they planned to marry the same person. The 2004-2005 Behaviour Surveillance Surveys (BSS) showed that approximately 1 in 10 high school students in Jakarta reported having had sex in the last year. Meanwhile, 2% of male high school students in both Jakarta and Surabaya said that they had sex with a female sex worker in the past year.

The 2004-2005 BSS also found that around 1% of students in Jakarta and Surabaya had ever injected drugs, while 23% of students in Jakarta and 9% of students in Surabaya had once experimented with drugs. Given the high rate of sharing injecting equipment amongst IDUs in Indonesia, there is a potential risk of being infected with HIV via injection.

The same BSS shows that female sex workers in Jakarta and Surabaya tend to be younger than elsewhere in the country. More than 40% of the reported AIDS cases amongst IDUs in Indonesia were in the 15-24 year age group. The young (aged <25 years) and high risk groups seem to engage in high risk behaviour with higher levels than the older (>25 years) groups.

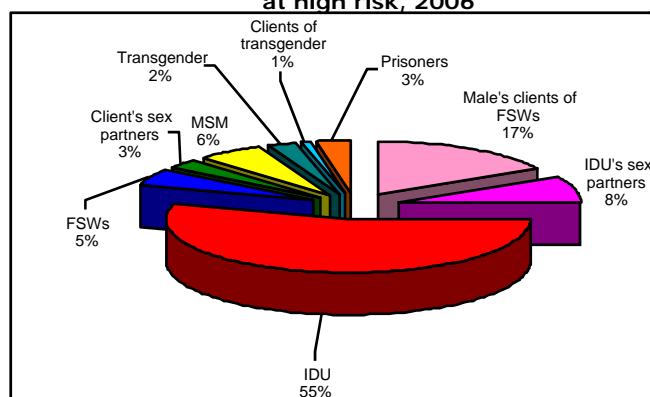
The above patterns among MARPs with regards to age and gender are represented in figure 5.

**Figure 5: Percentage of most-at-risk populations who are HIV positive, by gender and age, 2007**



Source: IBBS MARPs, FHI & CDC MoH, 2007 cited by the National AIDS Commission, in UNGASS Country Report (2006-2007)

**Figure 6: Estimated percent distribution of HIV amongst groups at high risk, 2006**



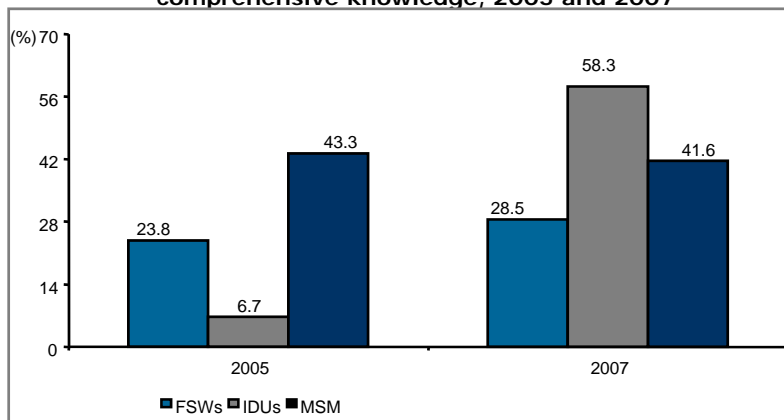
Source: Pandu Riono – FHI Indonesia. HIV Epidemic Modeling and Response in Indonesia, PowerPoint Presentation, 2007

For instance, HIV infections exist amongst 5 in 10 injecting drug users [9]. The primary mode of HIV transmission is through sharing of contaminated injecting equipment amongst drug users. High levels of injecting drug use have been recorded in Jakarta, West Java, East Java and Bali. Apart from injecting drug use, HIV is also transmitted through unprotected sex. These modes of transmission are well-represented by those groups having the highest HIV prevalence (figure 6).

### Knowledge of HIV and AIDS

Between 2005 and 2007, there was a significant increase (by 87%) in the proportion of IDUs who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission. Considering the rise in number of IDUs over the years, prevention efforts have been largely directed at this most-at-risk group. The number of FSWs who had a comprehensive HIV knowledge increased by 20%. Notably, comprehensive knowledge among MSM decreased by 4% during same period (figure 7).

**Figure 7: Percentage of most-at-risk populations with comprehensive knowledge, 2005 and 2007**



Source: UNGASS Country 2006 -2007; UNAIDS, Report on the Global AIDS Epidemic, 2006

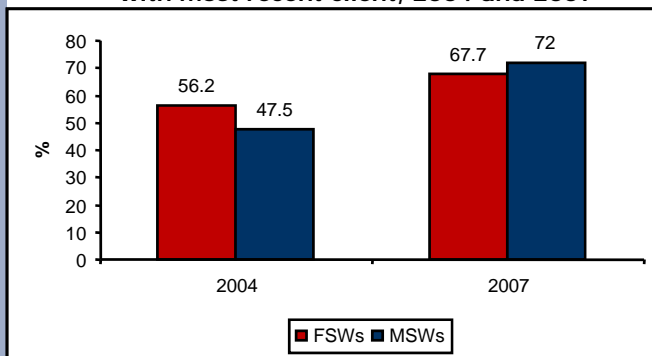
Amongst the general population, findings of the 2007 Indonesia Demographic and Health Survey (IDHS) show very low levels of comprehensive knowledge of HIV prevention and transmission among ever-married women (9%) and currently married men (13%) [7]. The same survey found that HIV & AIDS knowledge levels were higher amongst urban than rural dwellers, and amongst those with higher education and higher wealth quintiles.

### Condom use

Condom promotion still faces constraints in Indonesia, given issues such as the lack of strong political support for the implementation of condom programs as well as the limited access to and availability of condoms. Only 17% of the Papua population reported that it is easy to get condoms. Pharmacies and clinics are the main sources of condoms [10].

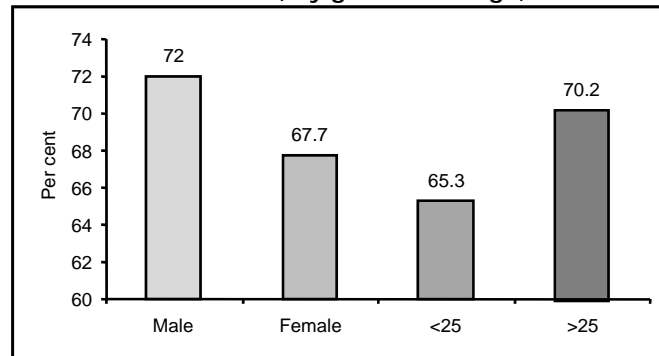
Of the most-at-risk populations, condom use was highest among sex workers and lowest among injecting drug users. Thirty-four percent of IDUs reported the use of a condom the last time they had sexual intercourse, compared to 68% of sex workers and 39% of MSM. There has been an overall increase in condom use at lat sex with a client among both female and male sex workers (from 56% in 2004 to 68% in 2007 and from 48% in 2004 to 72% in 2007, respectively) (figure 8). When disaggregated by age, the 2007 IBBS data shows that more older (70.2%) than younger (65.3%) sex workers report the use of a condom with their most recent client (figure 9).

**Figure 8: Percentage of female and male sex workers reporting the use of a condom during sex with most recent client, 2004 and 2007**



Source: Behavioral Surveillance Survey (BSS 2004-2005. MoH, Jakarta, 2005; UNGASS Country Report (2006 -2007)

**Figure 9: Percentage of male and female sex workers reporting the use of a condom with most recent client, by gender and age, 2007**

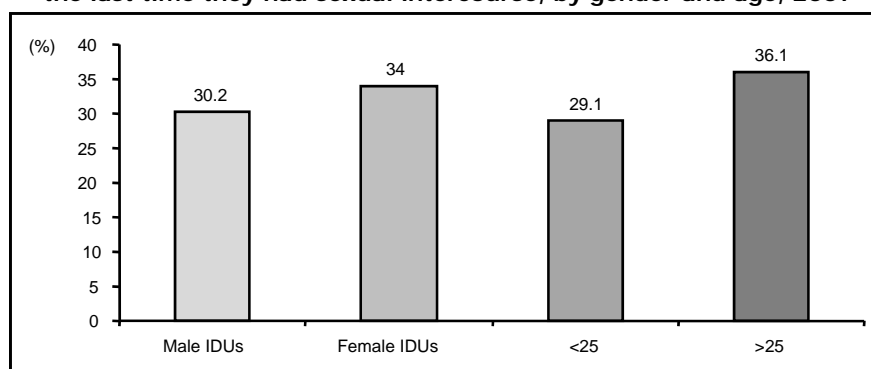


Source: IBBS MARPs, FHI & CDC MoH, 2007 cited by the National AIDS Commission, in UNGASS Country Report (2006-2007)

The BSS 2004-2005 data reveals that amongst transgenders, HIV prevalence was 22% - the second highest level of HIV prevalence amongst high risk groups (after IDUs). Moreover, some 40% of HIV positive transgender sex workers in Jakarta were infected with active syphilis. Unprotected sex was high amongst transgender (61%) and male sex workers (52%) [11]. However, the absolute number of transgender and male sex workers was relatively small; thus, their contribution to the HIV epidemic was not as prevalent as that of IDUs.

The 2007 IBBS compares risk behaviours taken by both young and adult IDUs (specifically with regards to levels of condom use) (figure 10). IDUs under 25 years were less likely to adopt safer behaviours than those over 25 years (29% against 36%). In addition, slightly more female than male IDUs had used a condom during their last sexual encounter.

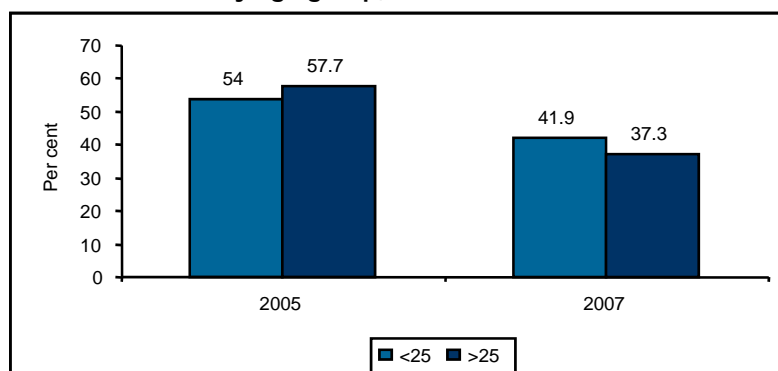
**Figure 10: Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse, by gender and age, 2007**



Source: IBBS MARPs, FHI & CDC MoH, 2007 cited by the National AIDS Commission, in UNGASS Country Report (2006-2007)

The 2004-2005 BSS reported high levels (63%) of unprotected sex between MSM and their commercial sex partners. Responses from sex workers pointed to the unwillingness of their clients (most likely including MSM) as the main reason for not using a condom [11]. Although condom use during the last anal sex between MSM and their sex partner reached 57% in 2005, figure 11 shows a slight decline in condom use from 2005 to 2007, particularly amongst older MSM.

**Figure 11: Percentage of men reporting the use of a condom the last time they had anal sex with a male partner by age group, 2005 and 2007**



Source: IBBS MARPs, FHI & CDC MoH, 2007 cited by the National AIDS Commission, in UNGASS Country Report (2006-2007)

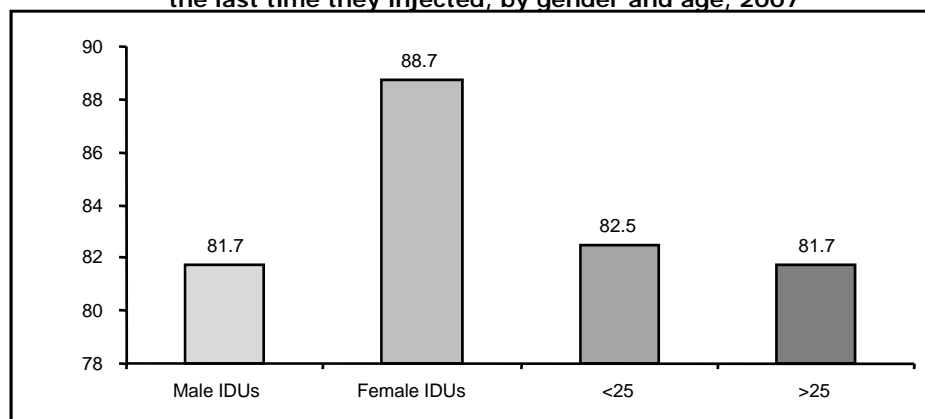
## WHO ARE AT RISK OF HIV IN INDONESIA?

### *Injecting drug users & female sex workers*

It is estimated that there are 219,000 IDUs in all parts of the country. In 2007, the IDU prevalence was 0.14% amongst the 15-64 year old population [10]. IDUs comprised 52% of the total registered HIV cases, of whom more were women (56%) than men (52%) [9].

More female than male IDUs have reported the use of sterile injecting equipment the last time they injected. Furthermore, the number of younger IDUs who practice safe injection practice is higher than that of older IDUs (figure 12).

**Figure 12: Percentage of injecting drug users reporting the use of sterile equipment the last time they injected, by gender and age, 2007**

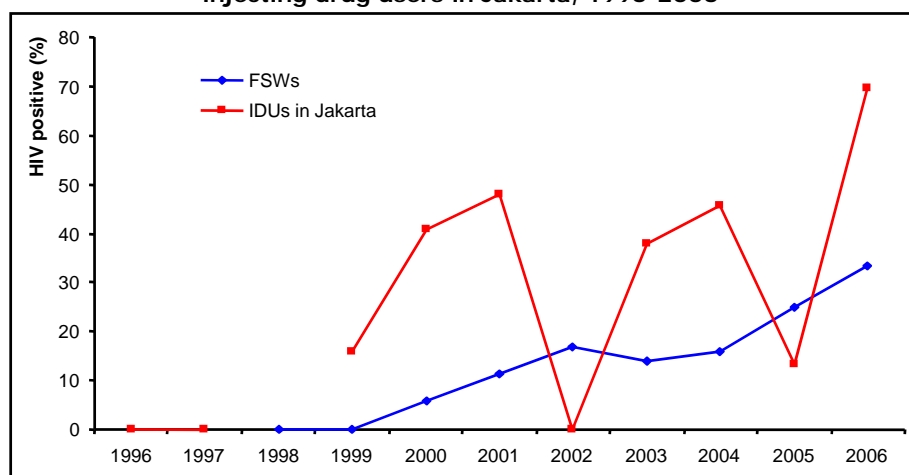


Source: IBBS MARPs, FHI & CDC MoH, 2007 cited by the National AIDS Commission, in UNGASS Country Report (2006-2007)

In the BSS 2004-2005, 12% of IDUs reported that they had been jailed. The HIV prevalence amongst prisoners in Jakarta rose steeply, from zero in 1997 to 47% in 2001 and to 22% in 2005. There is also evidence from the 2004-2005 BSS that many prisoners continue injecting drugs while in prison [11]. This evidence challenges the assumption that the rise of HIV prevalence is only due to the injecting practices prior to entering prison. It also supports lessons from neighbouring countries that show that jailing injectors clearly increases their likelihood of becoming infected with HIV.

Estimates from 2005 showed that sex workers in Jakarta could generate 850 billion Rupiah per year (or around \$US 100 million) [11]. This amount was around 850 times the budget that Jakarta had allocated for HIV prevention programmes. Thus, the high financial prospect from sex work could account for the increasing trend in HIV prevalence amongst sex workers. On the other hand, HIV prevalence amongst IDUs in Jakarta has been fluctuating over the years, reaching its peak in 2006 (figure 13).

**Figure 13: Trends of HIV prevalence amongst female sex workers and injecting drug users in Jakarta, 1996-2006**



Source: Ministry of Health, Sentinel Surveillance data, 2007

The most numbers of female sex workers came from East Java (42%), followed by West Java (18%), Central Java (14%) and North Sulawesi (6%) [11]. A similar pattern is observed among transgender and male sex workers. Transgender sex workers stay in sex work for an average of 12 years. From the supply side, sex workers move between provinces and islands to sell sex. From the demand side, clients of sex workers also move around to buy sex. This level of mobility coupled with unprotected sex could be compounding risk factors in the spread of HIV across the country.

### Men who have sex with men

<b>HIV prevalence</b> [10, 12]	<ul style="list-style-type: none"> <li>The number of MSM is estimated to be 760,000;</li> <li>HIV prevalence increased from 3.5-4.5% in 2006 to 5.2% in 2007;</li> <li>HIV prevalence was 2% in Ban dung, 6% in Surabaya and 8% in Jakarta (in 2002-2004);</li> <li>In 2005 in Jakarta, there was a prevalence of 36% of at least one sexually transmitted infection.</li> </ul>
<b>Selected behaviors</b> [11, 12, 15]	<ul style="list-style-type: none"> <li>In 2002, 53% of MSM reported unprotected anal intercourse with their male partner;</li> <li>In 2004-05, 63% of MSM reported unprotected sex with their commercial sex partners;</li> <li>9% of MSM reported sex with both men and women;</li> <li>In 2007, 42% of MSM had comprehensive HIV knowledge;</li> <li>39% of condom use was reported by men the last time they had anal sex with a male partner (in 2007);</li> <li>The percentage of condom use in most recent anal sex went up from 31% in 2002 to 63% in 2004; in 2007, only 39% had used a condom during last anal sex contact.</li> </ul>
<b>National response</b> [17, 18]	<ul style="list-style-type: none"> <li>In 2007, 40% of MSM were reached by HIV prevention programmes as compared to 1% in 2005;</li> <li>In 2007, 40% of 998 MSM reported ever being tested for HIV and were informed of their results;</li> <li>In 2008, 824,000 received outreach and peer education for prevention of sexual transmission of HIV and condom use; out of this total, 32,000 were MSM;</li> <li>MSM are explicitly mentioned in the National response strategy (2007-10); activities for MSM are explicitly funded through the Global Fund Round 8 as well as USAID.</li> </ul>

HIV prevalence amongst 15-64 year olds men who have sex with men ranges from 3.5 to 4.5 [10]. In 2006, the estimated number of MSM was 766,450 [12].

In 2002, a cross-sectional survey was conducted amongst Waria (Indonesian category of Transgender – men who accept their gender and identity as a woman) (n=241), male sex workers (MSW) (n=250) and men who have sex with men (n=279) in Jakarta. HIV prevalence was 22%, 3.6% and 2.5% respectively; syphilis prevalence was 19.3%, 2% and 1.1% [13]. No other recent HIV and STI data were found.

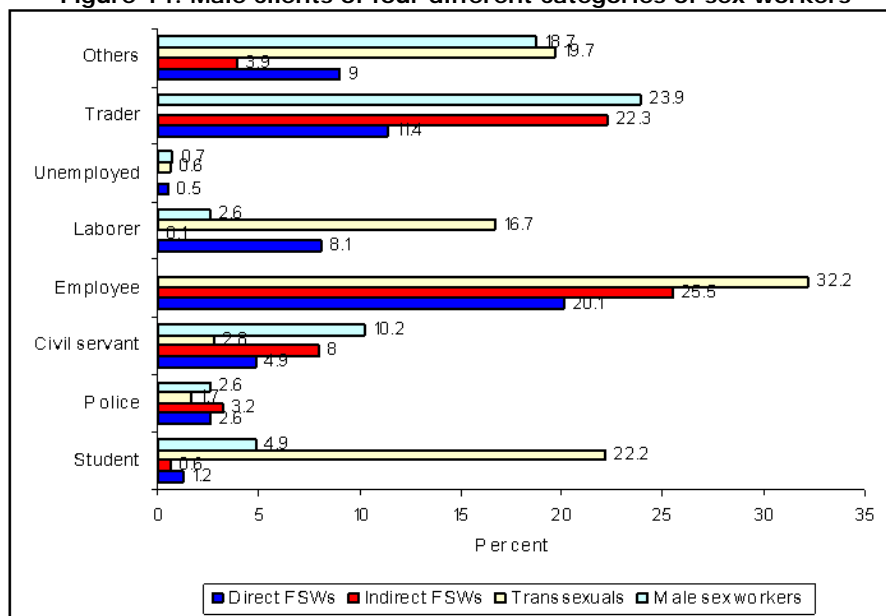
During the 2002 cross-sectional survey in Jakarta, 59% of Waria sex workers and 65% of MSW reported unprotected anal intercourse with clients in the preceding month, and 53% of other MSM reported unprotected anal intercourse with men in the previous month. Fifty-four percent of MSW and 18% of other MSM reported sex with both men and women in the past year; 38% of MSW and 9.3% of MSM reported sex with both men and women in the past month [13].

After the first two years of HIV prevention interventions, the frequency of unprotected sex had decreased – providing evidence of the possible effect of HIV intervention work on reducing risk behaviors, especially among Waria. Condom use with commercial and non-commercial partners increased in all groups; in 2004, MSW reported 83% condom use in most recent anal sex with clients. Among MSM, the percentage of condom use in most recent anal sex went up from 31% in 2002 to 63% in 2004. Moreover, this figure increased among Waria from 43% to 80% [14]. However, the use of condoms was inconsistent across partner types, and water-based lubricant use remained low. Between 2002 and 2004, a huge increase across the three groups was found in the uptake of HIV testing [15].

### Clients of sex workers

Results of the 2004-2005 BSS showed that clients of sex workers in Indonesia come from a wide range of occupations. Employees tend to be clients of transgender and female sex workers whereas traders tend to buy sex from FSWs and MSWs. More students (22%) are clients of transgenders, probably owing to the lower service fees they charge compared with other types of sex workers (figure 14).

Figure 14: Male clients of four different categories of sex workers

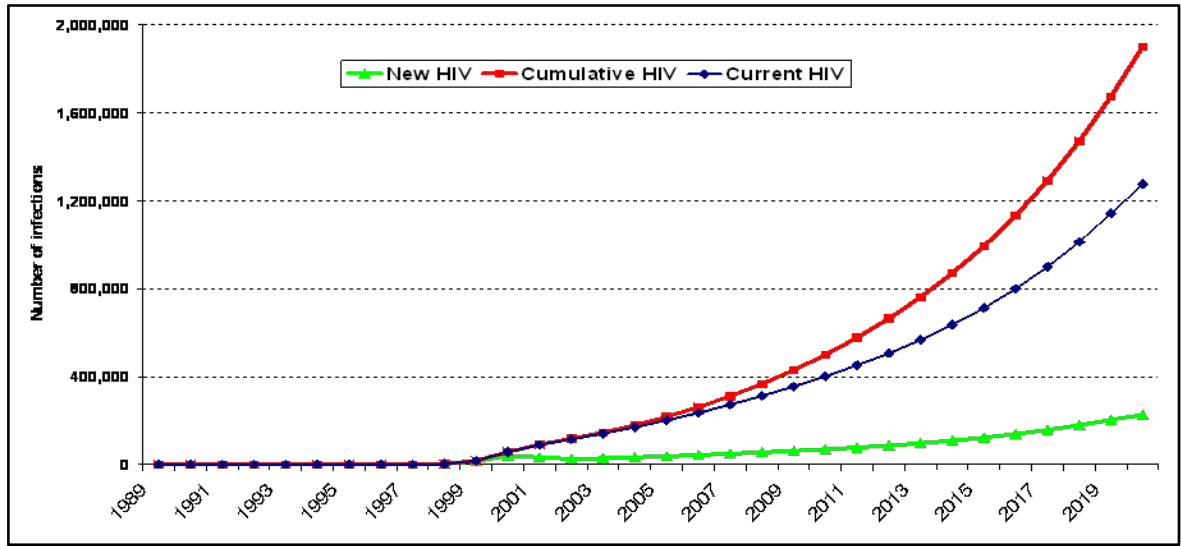


Source: Ministry of Health, BSS 2004-2005, 2005

### HOW MIGHT HIV AFFECT INDONESIA IN THE FUTURE?

In the absence of comprehensive intervention programmes, it is estimated that there will be more than 420,000 people living with HIV & AIDS, cumulatively, by 2010 (figure 15). HIV transmission through injecting drug use will progressively be overcome by the sexual route of transmission involving other risk groups. High risk groups currently influence and/or dominate the trend of the HIV epidemic, but the trend in the future may significantly involve lower-risk groups such as clients of sex workers and their female partners.

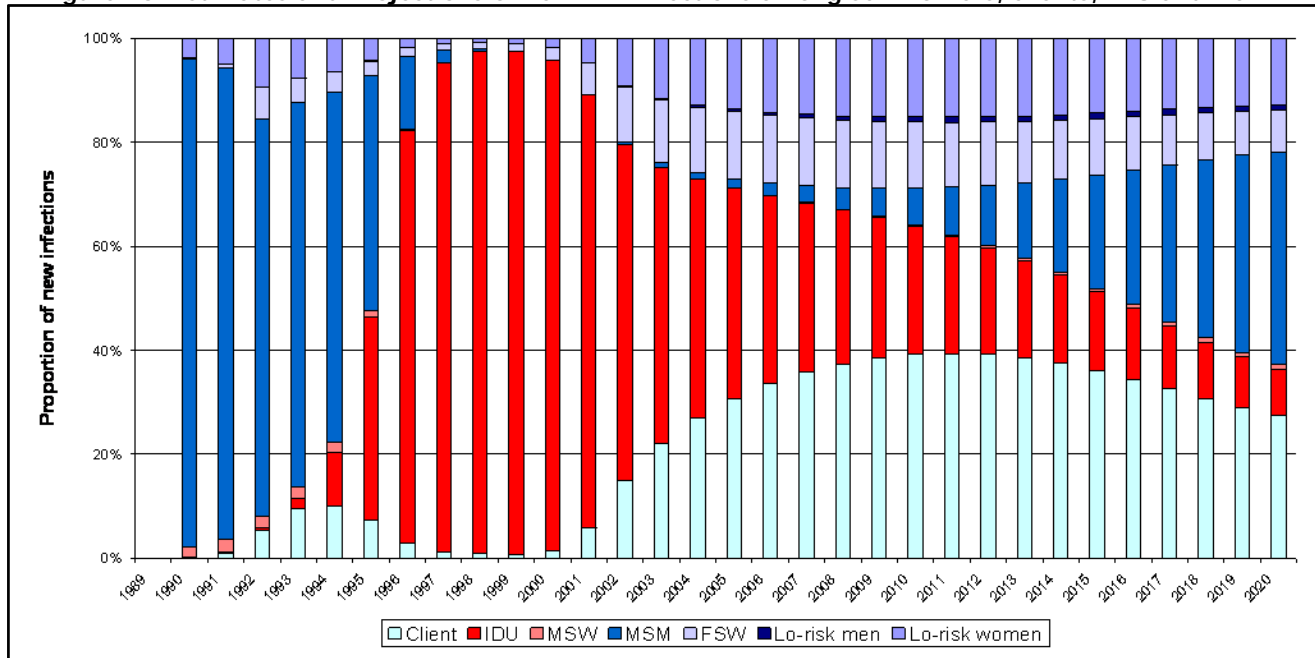
Figure 15: Estimated and projected trend of the HIV epidemic, 1989-2019



Source: Pandu Riono-Family Health International. Pemodelan Matematik Tren Epidemii HIV-AIDS Indonesia Sampai 2020. 2006

The escalating trend in HIV transmission amongst men who have sex with men (both commercial and non-commercial) in the projections is not surprising due to the prevailing stigma and discrimination against them, as well as their lack of access to HIV intervention programmes and services (figure 16).

Figure 16: Estimates and Projections of new HIV infections among sex workers, clients, IDU and MSM



Source: Pandu Riono-Family Health International. Pemodelan Matematik Tren Epidemii HIV-AIDS Indonesia Sampai 2020. 2006

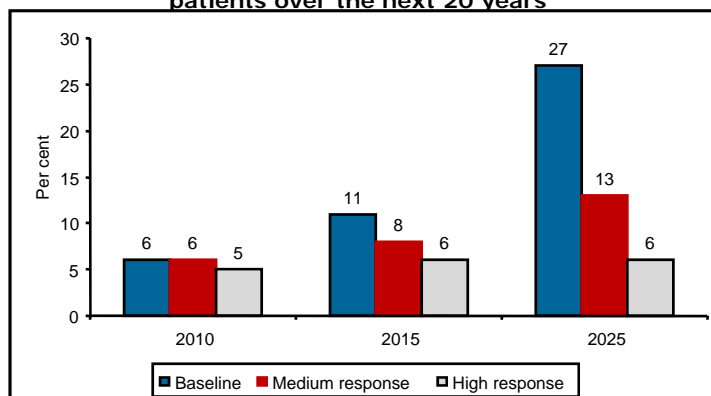
### Socio-economic impacts

Recent (2007) research showed that while there was no change in both life expectancy and crude death rates in 2005 in Indonesia due to AIDS, there are projected changes for 2015 under the baseline scenario (no scaling up of interventions). Specifically, the life expectancy of Indonesians will reduce by 0.5 year and the crude death rates may increase by 0.2% by 2015 [16].

Even though there is an unclear association between HIV prevalence and national economic growth, many attempts have been made to understand the impact of HIV and AIDS on a country's economy. The Oxford Economics Model was used to calculate the effects of AIDS on real wage rates, exports and consumption. Results showed that, in 2005, Indonesia had lost \$55 million because of the epidemic [16].

As growing numbers of people living with HIV require treatment for AIDS, the budgetary implications are daunting. In 2025, an estimated 27% of public medical beds will be filled with people living with AIDS – a figure that would be much less under the high response scenario (figure 17). The treatment costs are predicted to reach 3,210 billion Indonesia Rupiah (or about USD350,000).

**Figure 17: Percentage of hospital beds take by AIDS patients over the next 20 years**



Source: AusAID. Impacts of HIV/AIDS 2005-2025 in Papua New Guinea, Indonesia and East Timor: Synopsis Report of the HIV/AIDS Epidemiology Modeling and Impact Study. February 2006

## NATIONAL RESPONSE

### Law and policy implementation

Over the years, the Government of Indonesia through the Ministry of Health has mounted a broad range of policy and programme responses to HIV & AIDS, among which include:

- Establishment of a Study Group on AIDS and a Working Group on AIDS (1985);
- Establishment of the National AIDS Committee (1987);
- Formulation of the first National AIDS Strategy in 1995 and the second National AIDS Strategy (2003-2007) in 2003;
- Reorganization and expansion of the National AIDS Commission to encompass 5 non-government organizations in addition to the 21 government ministries and agencies (2006);
- Launching of the new National AIDS Strategy and formulation of the National HIV and AIDS Action Plan 2007-2010, which serves as a national guideline for HIV programs (2007).

The 2007-2010 National HIV/AIDS Strategy focuses on [10]:

- Programs to move towards achieving Universal Access;
- Establishing evidence-based priorities and targets;
- Providing a comprehensive-services approach to those who are in need;
- Building partnership between national and local governments, and with support from international funding agencies;
- Allocating funding from the national and provincial government budgets;
- Improving human resource capability and technical assistance;
- Conducting policy and intervention-oriented research;
- Strengthening the monitoring and evaluation system.

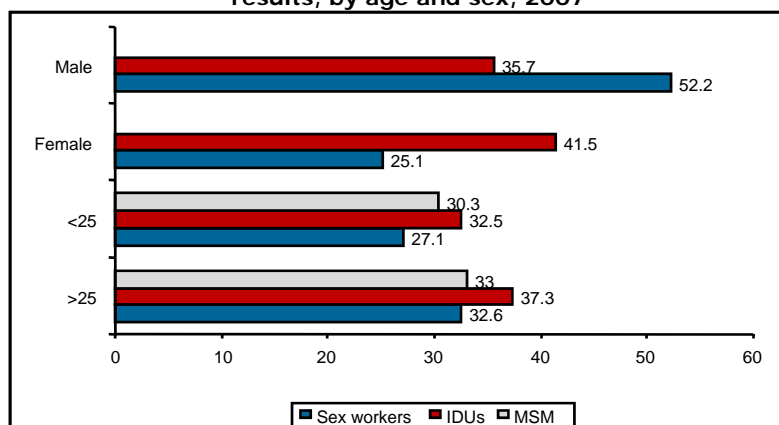
### Governance

By virtue of Presidential Decree No. 36/1994, the National AIDS Commission (NAC) and Regional AIDS Commissions were established to coordinate the fight against AIDS. The NAC has 12 working groups that help formulate policies with each working group responsible for a specific aspect of the HIV response. These working groups are focused respectively on: Papua; women; children and youth; harm reduction; communications and promotion; care, support and treatment; monitoring and evaluation; estimation and surveillance; world of work; migrant populations; law and human rights; and research and operational studies [10].

### HIV Prevention programmes

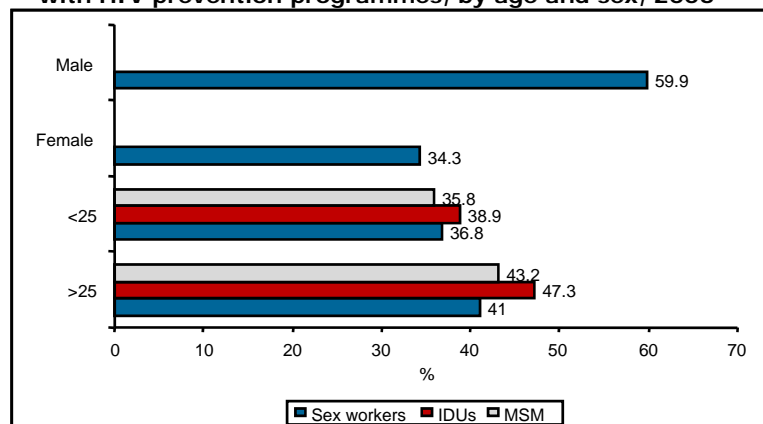
In 2007, approximately 3 in 10 individuals from most-at-risk populations (sex workers – 30.8%; IDUs – 35.9%; and MSM – 31.9%) received an HIV test in the last 12 months and knew the results. Amongst those tested, higher numbers were found amongst older groups and amongst male sex workers and female IDUs. Although there has been a noted increase in HIV testing uptake from 2004-2005 to 2006-2007, it is not conclusive as survey methods and sample size differed between these periods (figure 18).

**Figure 18: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results, by age and sex, 2007**



Source: IBBS MARPs, FHI & CDC MoH, 2007 cited by the National AIDS Commission, in UNGASS Country Report (2006-2007)

**Figure 19: Percentage of most-at-risk populations reached with HIV prevention programmes, by age and sex, 2006**



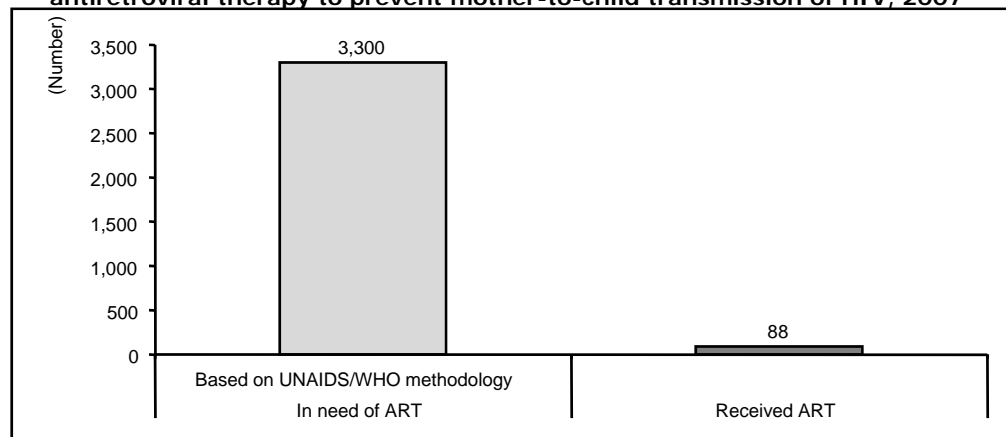
Source: IBBS MARPs, FHI & CDC MoH, 2007 cited by the National AIDS Commission, in UNGASS Country Report (2006-2007)

Of a sample of 1,404 IDUs, 36% underwent HIV testing, of whom 42% are female and 36% male; 45% were covered by HIV prevention programs, 34% had used condom at last sex, and 82% were engaged in safe injecting practices [10].

Prevention programmes have achieved the overall national targets for most-at-risk populations: 34% FSWs reached as against the 30% target; 40% MSM as against the 5% target; and 45% IDUs as against the 15% target (figure 19).

At the end of 2007, there were 296 VCT clinics throughout Indonesia, 153 hospitals providing free ART and 19 hospitals where PMTCT programs were in effect [10]. In spite of these, however, only 2.7% of 3,300 HIV-positive pregnant mothers who were in need of ART received antiretrovirals to reduce the risk of mother-to-child HIV transmission (figure 20).

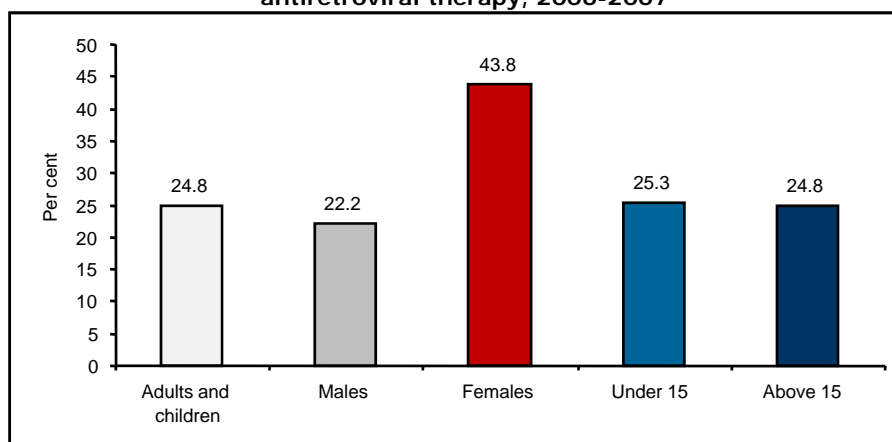
**Figure 20: Number of HIV+ pregnant women who are in need of and who received antiretroviral therapy to prevent mother-to-child transmission of HIV, 2007**



Source: WHO\_UNAIDS\_UNICEF\_Towards Universal Access – Scaling up priority HIV/AIDS interventions in the health sector, 2008

Furthermore, December 2006 data showed an estimated 20,577 people had advanced HIV infection. Of this number, 5,100 (or 24.8%) were receiving ART. This included more females than males because they more often attend medical services. Around 25% of those both under and above the age of 15 were on ART (figure 21). Whilst ART can be accessed free of charge, its distribution and availability remain challenges.

**Figure 21: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy, 2006-2007**



Source: ART Monitoring, CDC MoH, 2007 cited by the National AIDS Commission, in UNGASS Country Report (2006-2007)

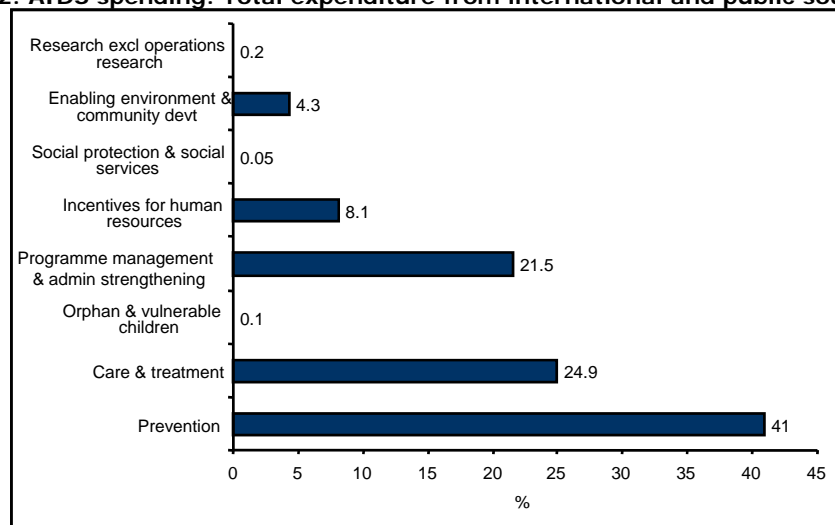
## HIV FINANCING AND EXPENDITURE

In the 2006-2007 biennium, total AIDS expenditure was USD 58.7 million of which 74% was financed by international sources and 26% by the public sector (central and local governments). The Government had allocated USD 1.6 million in 2006 for AIDS programs, an increase of 100% from the 2004 budget. The President of Indonesia has expressed interest in tackling the HIV epidemic by making a 250% increase to the health sector budget in 2007.

In 2006, the Global Fund was the largest sources of funding from multilateral sources in Indonesia, providing USD 10,465,000 or 78% of the total multilateral contributions. Meanwhile, UN development partners, funds and programs provided USD 2,897,137 or 21.7% of the total multilateral funding, and the remaining funds were provided by other international sources [10].

In 2006-7, the majority of funding was used in prevention programs (41%), followed by care and treatment (25%), and program management (22%) (figure 22).

**Figure 22: AIDS spending: Total expenditure from international and public sources, 2006**



Source: National AIDS Commission, Country report on the Follow up to the Declaration of Commitment on HIV/AIDS (UNGASS), 2006-2007

## ISSUES AND CHALLENGES FOR HIV & AIDS PREVENTION PROGRAMMES [10]

### *Key facilitating factors*

- Implementation of the 'Acceleration Program' that provides comprehensive services to MARPs in several districts of the country;
- The Memorandum of Understanding between the National Narcotics Agency and the NAC, followed by the Decision of the Coordinating Minister for People's Welfare regarding the Reduction of Harm Caused by Drug Use;
- Restructuring of the NAC in order to promote a more intensive, comprehensive, integrated and coordinated response;
- Strengthened role of civil society in the AIDS response such as in policy development and program implementation.

### *Key inhibitory factors*

- Indonesia being the largest archipelagic country (with over 17000 islands) and having a population of over 220 million people with very diverse cultural background make communication and resource distribution very difficult;
- Limited outreach to high-risk behaviour groups such as injecting drug users, men who have sex with men, sex workers and their clients, and partners of people in these groups;
- Low levels of condom use and resistance from men and as some religious groups to condom promotion;
- High levels of needle sharing among IDUs;
- Widespread stigma and discrimination against people living with HIV and AIDS;
- Limited availability of testing and counselling related to HIV, and facilities for ARV treatment;
- Limited facilities for STI management;
- Legal issues which constrain the implementation of a full harm reduction strategy among IDUs;
- Limited capacity of health personnel and distribution of appropriate health care facilities;
- Limited government funding and high dependence on foreign donors;
- A large gap between the national estimates of the number of PLHIV and the number of reported cases, which indicates weakness in national surveillance and outreach to MARPs.

## REFERENCES & FOOTNOTES

- [1a] CIA World Factbook, <https://www.cia.gov/library/publications/the-world-factbook/geos/ID.html>.
- [1b] UNDP, Human Development Report, 2007/2008.
- [1c] UNESCO 2006, cited in WHO, UNAIDS and UNICEF, Epidemiological Fact Sheet on HIV and AIDS: Indonesia, July 2008.
- [2] World Development Indicators database. September 2008; <http://ddp-ext.worldbank.org/>. Data refers to the percentage of girls to boys enrolled at primary and secondary levels in public and private schools. UNESCO Institute for Statistics.
- [3] World Health Statistics 2008, cited in WHO, UNAIDS and UNICEF, Epidemiological Fact Sheet on HIV and AIDS: Indonesia, July 2008.
- [4] WHO, UNAIDS and UNICEF, Epidemiological Fact Sheet on HIV and AIDS: Indonesia, July 2008.
- [5] UNAIDS 2008 Report on the Global AIDS Epidemic. July 2008.
- [6] Paul Janssen, Georg Peterson and Vidia Darmawi, UNAIDS Second Independent Evaluation, 2002-2008, Country visit to Indonesia: Summary Report, November 2008.
- [7] Ministry of Health, Statistics Indonesia, National Family Planning Coordinating Board, Macro International, Indonesia Demographic and Health Survey 2007, December 2008.
- [8] Kemal N. Siregar, Indonesia's experience using geographical mapping tool: Programmatic implications of HIV geographical spread for local authorities, paper presented at The Second Global HIV/AIDS Surveillance Meeting in Bangkok, Thailand, 2-5 March 2009.
- [9] Indonesia\_UNAIDS, UNGASS Country Report 2008 citing IBBS MARPs 2007 by FHI and CDC Ministry of Health.
- [10] National AIDS Commission, Republic of Indonesia, Country report on the Follow up to the Declaration of Commitment on HIV/AIDS (UNGASS) Reporting period 2006-2007.
- [11] Ministry of Health, Indonesia, Behavioural Surveillance Survey in Indonesia, 2004-2005, 2005.
- [12] Indonesia, CDC-EH WHO briefing document prepared for External review of the health sector response to the HIV/AIDS epidemic in Indonesia, 5-17 February .
- [13] Pisani E, Girault P, Gultom M, et al. HIV, syphilis infection and sexual practices among transgenders, male sex workers, and other men who have sex with men in Jakarta, Indonesia. *Sex Transm Infect* 2004; 80:536-40 cited by UNAIDS and Asia Pacific Coalition on Male Sexual Health. HIV and associated risk behaviors among men who have sex with men in the Asia and Pacific region (working draft), August 2008.
- [14] UNAIDS and Asia Pacific Coalition on Male Sexual Health. HIV and associated risk behaviors among men who have sex with men in the Asia and Pacific region (working draft), August 2008.
- [15] Ministry of Health Indonesia. Unpublished data of the HIV/STI behavioral surveys in Jakarta and Surabaya. Jakarta: Ministry of Health; 2002 and 2004 cited by UNAIDS and Asia Pacific Coalition on Male Sexual Health. HIV and associated risk behaviors among men who have sex with men in the Asia and Pacific region (working draft), August 2008.
- [16] McLeod R. The economic costs of inaction – Curbing the Asian HIV/AIDS epidemic, Draft version. Asian Development Bank/UNAIDS, February 2007.
- [17] UNAIDS. Report on the Global AIDS Epidemic, 2006.
- [18] Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) at <http://www.theglobalfund.org/en/>.

## OTHER SOURCES

- AusAID. Impacts of HIV/AIDS 2005-2025 in Papua New Guinea, Indonesia and East Timor. Synopsis Report of the HIV/AIDS Epidemiology Modeling and Impact Study. February 2006.
- CIA World Factbook, <https://www.cia.gov/library/publications/the-world-factbook/geos/ID.html>.
- International Harm Reduction Development Program (IHRD) and Open Society Institute, Public Health Program in Harm Reduction Developments 2008: Countries with injection-driven HIV epidemics, 2008.
- Janssen Paul, Georg Peterson and Vidia Darmawi, UNAIDS Second Independent Evaluation, 2002-2008, Country visit to Indonesia: Summary Report, November 2008.
- McLeod R. The economic costs of inaction – Curbing the Asian HIV/AIDS epidemic, Draft version. Asian Development Bank/UNAIDS, February 2007.

- Ministry of Health, Statistics Indonesia, National Family Planning Coordinating Board, Macro International, Indonesia Demographic and Health Survey 2007, December 2008.
- Ministry of Health. Indonesia. HIV/AIDS report, Directorate General of Disease Control and Environmental Health, March 2007.
- Ministry of Health. Indonesia. Results from the Behavioural Surveillance Survey (BSS) in Indonesia 2004-2005. 2005.
- National AIDS Commission, Republic of Indonesia. Country report on the Follow up to the Declaration of Commitment on HIV/AIDS (UNGASS) Reporting period 2006-2007.
- Riono P. HIV Epidemic Modeling & Response in Indonesia . Family Health International-Indonesia. February, 2007.
- Riono P -Family Health International. Pemodelan Matematik Tren Epidemi HIV-AIDS Indonesia Sampai 2020. 2006.
- Siregar, Kemal. Indonesia's experience using geographical mapping tool: Programmatic implications of HIV geographical spread for local authorities, paper presented at The Second Global HIV/AIDS Surveillance Meeting in Bangkok, Thailand, 2-5 March 2009.
- UNAIDS and Asia Pacific Coalition on Male Sexual Health. HIV and associated risk behaviors among men who have sex with men in the Asia and Pacific region (working draft), August 2008.
- UNDP. Human Development Report, 2007/2008.
- World Development Indicators database. September 2008; <http://ddp-ext.worldbank.org/>.
- WHO, UNAIDS and UNICEF. Epidemiological Fact Sheet on HIV and AIDS: Indonesia, July 2008.
- WHO\_UNAIDS\_UNICEF.\_Towards Universal Access – Scaling up priority HIV/AIDS interventions in the health sector, 2008.