HIV/AIDS SITUATION
REPUBLIC OF INDONESIA

Multisectoral Approaches
In Combating HIV/AIDS

NATIONAL AIDS COMMISSION

United Nations General Assembly Special Session on HIV/AIDS
New York, 25-27 June 2001
Foreword

In assessing the epidemiological situation in Indonesia, one cannot deny that HIV/AIDS in Indonesia. The first AIDS case was identified in 1987. Cumulatively, AIDS reported cases in Indonesia from the month of April 1987 through 31 December 2000 are 452 AIDS cases. The total number of HIV/AIDS cases which have been reported in Indonesia may be considered small, one must be alert to the fast rate of transmission, the distribution throughout the population in 23 provinces. However, UNAIDS/WHO (1999) estimates the real number to be closer to around 35,000 to 50,000 cases, later the Indonesian Group from the Ministry of Health and Social Welfare and WHO/UNAIDS to Indonesia with the assistance of an expert from UCLA estimated that in 2001 there are around 80,000 - 120,000 people living with HIV.

The progression of the disease in Indonesia has followed the pattern of other countries appearing first in the homosexual, later, in particular in sub-population group with high risk behavior such as commercial sex workers and their clients who will ultimately spread the disease into the general population. Since two years ago, the progression of the disease has increased exponentially among the injecting drug users (IDU's).

The challenge of HIV/AIDS is not just a health problem, rather it has major political, economic, social and religious and legal consequences, which sooner or later will touch all aspects of human life. This threatens the national development efforts to improve the quality of life of our human resources.

Since June 1994, Indonesia has been promoting its national AIDS Strategy, through a national effort to control HIV/AIDS , carried out by the
government, non-government and private sector (multi-sectoral collaboration approach).

There are 10 programmes to be implemented, which include IEC (Information, Education, Communication), prevention, testing and counselling, treatment and care, education and training, research and development, monitoring and evaluation (surveillance), international Cooperation, program institutionalisation, and laws and regulation.

In relation to UNGASS and the plan to hold the 7th ASEAN Summit Special Session on HIV/AIDS with the signing of the ASEAN Joint Declaration on HIV/AIDS by the Heads of State/Government of ASEAN, in November 2001, we hope that this country report will be able to support the global, regional, as well as national issues, lessons learned, programs and actions involved in halting the spread of HIV/AIDS.

Jakarta, June 2001

Dr. Achmad Sujudi
Minister of Health and Social Welfare of the Republic of Indonesia/Executive Chairman of National AIDS Commission
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HIV/AIDS IN INDONESIA

1. INTRODUCTION

1.1. BACKGROUND

Indonesia is the largest archipelago in the world consisting of more than 17,000 islands, half of which are inhabited. The population of Indonesia is the fourth largest in the world after China, India, and the USA. Indonesia is a heterogeneous country consisting of over 250 ethnic groups each with its own language/dialect and customs. The country is still facing a multidimensional crisis that prevents full-scale implementation of National HIV/AIDS prevention and control programme. Indonesia is also in a transition from centralizes to decentralized administration.

The Government of Indonesia (GOI) has responded early to the challenge of HIV/AIDS. The first AIDS case (a foreign tourist) was reported from the Province of Bali in 1987. The case was a male homosexual. Subsequently, the reported HIV/AIDS cases increased to affect 23 out of 30 provinces. The GOI has intensified, expanded and accelerated the National AIDS Campaign based on HIV/AIDS epidemiological analysis because early intervention is more effective than late intervention. The Vice President took the leadership of the National HIV/AIDS programme to accelerate its activities, and the National AIDS Commission works under her supervision.

The National AIDS Strategy, the general guidelines for the prevention and control of HIV/AIDS in Indonesia, was enacted in June 1994 and has as its objectives: to prevent HIV/AIDS
infection, to minimize the impact of the virus, and to mobilize a unified national effort.

1.2. GLOBAL/NATIONAL COMMITMENT OF HIV/AIDS

Indonesia is strongly committed in doing its best to bridge the very deep and wide gap between the established rich countries and poor developing countries with respect to the prevention and response to HIV/AIDS.

1.3. POLICY, STRATEGY OF HIV/AIDS PREVENTION AND CONTROL

The GOI response to the AIDS epidemic started in 1986 with the establishment of a Working Group on AIDS within the National Institute of Health Research and Development, Ministry of Health. In 1988, activities for HIV/AIDS prevention and control were integrated into the STD control programme of the Directorate General of The Center for Diseases Control and Environmental Health, while still involving inter-sectoral units.

Basically, communicable disease control in Indonesia is under the jurisdiction of the Ministry of Health. This is also true for HIV/AIDS prevention and control. However, due to the epidemiological nature of the disease and its socio-economic impacts, many sectors share in the responsibility for combating the disease. For this reason, a National AIDS Commission was established by Presidential Decree Number 36 in 1994 to address inter-sectoral issues. There are four main approaches in Indonesia, i.e.: religious, socio-cultural, public health and family. AIDS control policies in Indonesia are formulated by the National AIDS Commission, which has already developed a National Strategy.
The National Strategy stated the basic principles of AIDS control in Indonesia, as follows:

- AIDS control is mainly implemented by the community participation, and the government should give directions, supervision and creates a conducive situation;
- AIDS control measures should reflect religious and culture values in Indonesia;
- Activities should be aimed at defending the family welfare and resilience;
- AIDS prevention should be aimed at educating the public in order to prevent HIV transmission and to change high risk behavior;
- Every individual has the right to get information on AIDS prevention;
- Policies, programmes, services and activities should respect the dignity of AIDS patients and their families;
- Counseling should be provided prior to diagnosis and testing of HIV/AIDS and confidentiality should be guaranteed;
- Law and regulations should be in-line with the principles of AIDS control;
- Public services must not discriminate HIV/AIDS patients.

According to the strategy, there are three concerns of AIDS control, namely to safeguard human resources from HIV/AIDS, to mobilize all individuals, families and community to prevent the transmission of AIDS, to provide treatment and support services for AIDS patients.

The National AIDS Commission has identified National Programme priorities for the prevention and control of AIDS. There are 10 priority programmes identified: IEC (Information,
Education, Communication), prevention, testing and counseling, treatment and care, education and training for health workers, research and development, monitoring and evaluation (surveillance), international cooperation, programme institutionalization, and laws and regulation.

2. CURRENTS SITUATION OF HIV/AIDS 2.1. MAGNITUDE OF THE PROBLEMS

The real magnitude of the HIV/AIDS problem in Indonesia is very difficult to measure and is still unknown, but the trend of HIV transmission can be monitored through a national HIV/AIDS surveillance system. The system has been designed so that it can be modified to reflect new inputs from the national and international scientific community, so as to be more effective and efficient. It is also periodically updated based on identified weaknesses and strengths, which results in an improved national surveillance system.

Indonesia is still a low prevalence country (HIV-infection rate is less than 5%), but there is considerable potential for spreading the HIV/AIDS epidemic in the future, because the number of risk factors in the country: a large and highly mobile prostitute population, domestic and international migration, urbanization, tourism, increasing poverty, proximity to high incidence areas, high-risk sexual behaviors among certain groups, and a small but growing population of Intravenous Drug Users (IDU).

Result of second-generation HIV/AIDS surveillance reveals that HIV sexual transmission is low and slow. Behavioral surveillance surveys also reveal that the numbers of sex partners for female prostitutes in Indonesia is less than two clients per day (between 7-14 partners per week), and considerably lower than in
many other ASIAN-Pacific Countries (18-33 partners per week). Only 8% of urban men in a survey in East Java reported ever having had commercial sex. In 1996 the government issued a regulation that condom use is compulsory for all (100%) clients of female prostitutes throughout Indonesia to help prevent transmission to the general population.

Although Indonesia started early and has worked to prepare a realistic National HIV/AIDS strategy, full implementation is constrained by many factors including budget and qualified manpower.

2.2. PRIORITIES AND RESULTS 2.2.

1. Prevention

2.2.1.1. Blood Donations Screening

Blood donations screening against HIV/AIDS has been done since 1992. At present 95% of blood donations can be screened. The remaining 5% are not properly screened because the transfusion is done in remote areas where blood-screening facilities are not available. The economic crisis is limiting Indonesia's ability to make enough test kits available for nationwide screening. (see Annex 1 - Figure 1).

2.2.1.2. Condom promotion

In the past, condom promotion as a contraceptive device has been done without any objection from the public. But like in many other countries, condom promotion for prevention of STDs and HIV/AIDS is a sensitive issue. That is why condom promotion for STD and HIV/AIDS prevention has been done carefully and only among high-risk groups.

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As mentioned earlier, in 1996 the Ministry of Health (Director General of CDC and EH) issued a circular to all Provincial Health Office Chiefs in Indonesia to promote 100% condom use among high-risk groups in 1996. There has been no evaluation of the effects of the circular or changes in behaviors around commercial sex. It is difficult to persuade people to use condom. It is especially difficult in Indonesia because of a long history of promoting other family planning methods as more effective than the condom.

At present the GOI has decided to promote condom use for double protection -- prevention of pregnancy and STIs, including HIV/AIDS. Condom promotion through radio and television has had a wide reach, and has resulted in very little negative public reaction. The National Workshop of Ulemas (Islamic Religion Scholars) on HIV/AIDS Prevention and Control (1997) did not mention condom specifically, but did recommend that couples use "protective devices" to prevent the spread of HIV/AIDS. Training on syndromic management, including health education on condom use, has been tested in some provinces. A pilot project promoting 100% condom use in selected establishment where commercial sex is available is to be tested with the guidance from UNAIDS/WHO.

Behavioral Surveillance Survey data on condom use are included in Annex 1 - Figure 2 and 3.

2.2.1.3. Universal Precaution

Efforts to develop universal precautions for health workers have included training, orientations, and developing Standard Operating Procedures and guidelines. We continue to see problems in the field due to the attitude of health workers, a lack of supervision and quality control, and shortages of supplies, and equipment.
2.2.1.4. Prevention Activities Among IDUs (Harm reduction)

There are no GOI-administered prevention activities among IDUs. Some non-government organizations (NGOs) have started limited activities. Results of a sero-surveys at a hospital patients in Jakarta revealed a high prevalence of HIV/AIDS infected among IDUs (39 among 247 IDUs).

2.2.1.5. Mother to Child Transmission Prevention

One project has been initiated by a private foundation (Yayasan Pelita Ilmu), with planning assistance from WHO. Field implementation will begin soon in Irian Jaya and Riau Provinces.

2.2.2. Information, Education and Communication (IEC) Activities

A variety of IEC activities have been conducted utilizing grant and loan fund from the GOI. These activities have been conducted in various parts of the country, and have involved the public and private sectors as well as a number of NGOs. The IEC activities have included developing IEC materials, disseminating information, and peer education. World AIDS Days are usually a focal point for initiating IEC activities and are widely commemorated every year in Indonesia. The National AIDS Campaign was launched throughout the country on the World AIDS Day 1998 by the President. The national AIDS logo was also inaugurated that day. The Ministry of Education started in 1999 to implemented prevention education in all schools. The Ministry has also published and distributed educational materials on AIDS prevention for use junior and senior high schools and universities.
The Indonesia Demography and Health Survey of 1997, based on interviews with 8,117 urban and 20,693 rural women found that 51.5% of married women aged 15-49 years reported hearing about AIDS (reported source: 4.7% TV, 18% radio, 15% print media, 1% relatives). Among these same women 29% stated that AIDS could be prevented by having sex with only one partner, 23.7% stated that it could be prevented by not having sex with prostitutes.

The results of Behavioral Surveillance Survey in Jakarta, Surabaya, Manado in 1996 and 1997, indicate that the percentage of selected respondents who were able to mention single partner and avoid prostitutes to prevent AIDS are as follows:

- CSW: 71.4% (1996)
  77.5% (1997)
- High-risk males: 76.
  4% (1996) 79.0% (1997)
- High school students: 92.9% (male)
  84.4% (females)

2.2.3. Surveillance

Epidemiological surveillance of AIDS is an important role of the national programme of prevention and control of AIDS. Surveillance in Indonesia consists of both sentinel and ad hoc surveillance sites, behavior surveillance, and anti-microbiological resistance studies for STIs. Efforts have been made to improve HIV/AIDS surveillance as follows:

a. Developing standard operating procedures and guidelines of HIV and AIDS surveillance.

b. Conducting surveillance training for provincial staff.

c. Reviewing and improving the Decree of the Directorate General of The Center for Diseases Control and Environmental Health on the requirements to report AIDS cases.
d. Developing plans to enhance the laboratory facilities, laboratory staff capabilities, and internal and external quality controls for laboratories.

Selected HIV and AIDS surveillance are presented in Annex 1 - Figure 4-13.

2.2.4. Treatment and care

A limited number of Indonesian hospitals have staff trained in HIV/AIDS care. Some NGOs have been providing care for AIDS patients, but only a limited amount of training on HIV/AIDS case management have been conducted. Guidelines on AIDS case management have been developed, which include AIDS clinical case management, tuberculosis with HIV infection case management, and community-based AIDS care. Some NGO's have set up shelters for people living with HIV/AIDS, and there are limited number of home-care projects.

The drugs for STIs, opportunistic infection, and for HAART (Highly Active Anti Retroviral Therapy) are rarely available due to limited budgets. While increasing, donor funding has been limited. Also donors often place restrictions on the use of funds to purchase consumable items.

2.2.5. Testing and Counseling

Testing and counseling facilities are still very limited in Indonesia. At present all provincial health laboratories are capable of doing HIV testing, but they do not have counseling facilities. Most of the blood transfusion services of the Indonesian Red Cross can conduct HIV testing, but only a small number of centers can provides counseling.
2.2.6. National Capacity (Capacity Building)

Capacity building, both medical and management/administration has been conducted for health professionals. Training has also been directed to decision-makers, NGOs and National AIDS Committee members at the central, provincial, and district levels. Recent laws on decentralization focus capacity building funding on improved management and organization structure for local AIDS Commissions.

2.2.7. Monitoring and Evaluation

Activities on monitoring and evaluation have been conducted not only by the GOI, but also by the donor agencies. Considerable progress has been made in the tools used to track AIDS in Indonesia. These tools include project evaluations, biological and behavior monitoring, and behavior surveillance surveys.

2.2.8. International Cooperation

Indonesia has developed international cooperation at both global and regional levels. Through this cooperation, Indonesia has not only received technical and financial assistance, but also exchanged views, learned from the experiences of others, and established networks.

3. LESSON LEARNED/ISSUES/PROBLEMS

3.1 HIV/AIDS PROBLEMS

The problems encountered are as follows:
• Coordinated efforts for the AIDS Prevention and Control Programme are very much needed.
• Due to the diversity of the Indonesian language and culture, different IEC approaches should be developed for specific groups and behaviors.
• Condom promotion for STI/HV/AIDS control is still a sensitive issue, but for high-risk groups may be better accepted.
• Concentrations of brothels are no longer accepted by some communities. This may effect IEC coverage and testing and treatment of STIs.
• Inter-sectoral activities for the prevention and control of AIDS are still limited.
• Numbers of involved non-governmental organization are still limited.
• The prices of antiretroviral drugs are unaffordable for most of HIV/AIDS patients.

3.2. SOCIO-ECONOMIC IMPACT OF HIV/AIDS EPIDEMIC

Socio-economic impacts depend on the stages of HIV/AIDS epidemic. Indonesia is still a low prevalence country, with emerging concentrations of infection in some high-risk sub-populations (e.g. commercial sex workers Merauke, Irian Jaya; transvestites in Batam, Riau; and transvestites and IDUs in Jakarta. Recent studies suggest that the economic loss due to an HIV/AIDS in Indonesia was US $39,700 per case. With the current estimated case load of 52,000 (UNAIDS) infected individuals the cost of the disease to Indonesia US$ 2 Billion and considerable human suffering. The increasing case load of the disease and the declining strength of the Indonesian economy ensures that the economic burden of AIDS in Indonesia is increasing.
3.3. HUMAN RIGHTS/LAW

Indonesia has made some progress in the effort to abolish discrimination, isolation and stigmatization of patients living with HIV/AIDS, based on the nine basic principles of the Indonesia National AIDS Strategy.

3.4. ACCESS TO TREATMENT AND CARE

The country is not yet successful in preventing and controlling increasing incidence of HIV/AIDS and needed support to provide adequate treatment for STIs, and opportunistic infections for all AIDS victims.

3.5. RESEARCH AND DEVELOPMENTS

Many research institutes and NGOs carry out researches on HIV/AIDS. There is a wide spectrum of research carried out but none of them research on vaccine, because Indonesia is still a low HIV prevalence country. It is very difficult to have sufficient samples to carry out a research on vaccine. The research conducted so far is to enhance the quality of research, but NIHRD in collaboration with NAMRU (Naval And Medical Research Unit) has given the sero-typing of AIDS cases in Irian Jaya.

3.6. PARTNERSHIP WITH CIVIL SOCIETY

Indonesia has successfully established collaboration with civil society in preventing and controlling HIV/AIDS. Fund from international donor agencies is mainly provided for NGOs.
4. FUTURE ACTIONS

In the present crisis in Indonesia, it will be very difficult to increase the coverage and content of the HIV/AIDS program. The speed and coverage of future actions will depend on the availability of resources.

- Strengthening provincial and district AIDS commissions.
- Strengthening capacity of health related NGOs.
- Pilot test 100% condom use in brothels and similar facilities.
- Strengthening community participation in prevention, surveillance, and care.
- Targeted Advocacy for policy makers, including parliamentarians.
- Developing laws and regulation to protect the rights of HIV infected individuals.
- Empowering women.
- Developing pilot projects for mother-to-child transmission prevention in areas that have high prevalence of HIV to serve as a model for related interventions.
Annex -1

Figure 1. HIV-infection in Blood Donation
National Data, 1992-2000

![Graph showing HIV infection in blood donation from 1992 to 2000 with data points and trend line.]

as of March 2000

Figure 2. Reported condom use in last commercial sex act in the past year in 6 cities in Indonesia

![Graph showing condom use percentages in 6 cities with data points for 1997 and 1998.]

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Figure 3. Reported condom use in last CSW contact in the past year among seamen in 6 cities in Indonesia.

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Jakarta</td>
<td>15.8</td>
<td>10.9</td>
<td></td>
</tr>
<tr>
<td>Surabaya</td>
<td>11</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Manado</td>
<td>16.4</td>
<td>12</td>
<td>13.8</td>
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<tr>
<td>Denpasar</td>
<td></td>
<td></td>
<td>22.5</td>
</tr>
<tr>
<td>Kupang</td>
<td></td>
<td></td>
<td>10.8</td>
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<tr>
<td>Uj. Pandang</td>
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Figure 4. MI prevalence [range] in HRG at some Sentinel Site by province in Indonesia, 19941995-199912000.
Figure 5. HIV-infection in some sentinel sites in some provinces in Indonesia, 1994-2000

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<td>Sumatera Selatan</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Jakarta</td>
<td>0.16</td>
<td>0.08</td>
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<td>3.5</td>
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<td>Irian Jaya</td>
<td>0.48</td>
<td>1.31</td>
<td>0</td>
<td>0.99</td>
<td>0.5</td>
<td>6.69</td>
<td>6.38</td>
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<td>Riau</td>
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Note: Sumatera Selatan: Bangka, Jakarta: Jakarta Utara, Irian Jaya: Sorong, Riau: Kepri.

Figure 6. HIV-Infection in military recruit 1991-1998

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Figure 7. HIV-infection in Transvestites in Jakarta
1993-1997

<table>
<thead>
<tr>
<th>Year</th>
<th>Sample tested</th>
<th>HIV+</th>
</tr>
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<tbody>
<tr>
<td>1993</td>
<td>660</td>
<td>0</td>
</tr>
<tr>
<td>1994</td>
<td>619</td>
<td>1</td>
</tr>
<tr>
<td>1995</td>
<td>638</td>
<td>2</td>
</tr>
<tr>
<td>1996</td>
<td>347</td>
<td>11</td>
</tr>
<tr>
<td>1997</td>
<td>199</td>
<td>12</td>
</tr>
</tbody>
</table>

Figure 8. AIDS cases in Indonesia
1987-2000

as of 31 December 2000
Figure 9. Mode of transmission of HIV Infection in AIDS cases as of 31 December 2000

- Heterosexual: 58.6%
- Blood transfusion: 0.7%
- IDU: 19.1%
- Hemophiliac: 0.2%
- Homo-bisexual: 19.9%
- Perinatal: 1.4%

as of 31 December 2000

Figure 10. Trend risk factor in AIDS cases 1987-2000

as of 31 December 2000
Figure 11. Cumulative AIDS cases in Indonesia by Age Group

Figure 12. Indonesia AIDS case rate by Province

as of 31 December 2000

as of 31 December 2000

AIDS rate per 100,000 people
National average

COUNTRY REPORT: HIV/AIDS IN INDONESIA
Figure 13. AIDS cases in Indonesia by Sex
1981-2000

as of 31 December 2000

COUNTRY REPORT: HIV/AIDS IN INDONESIA
<table>
<thead>
<tr>
<th>No</th>
<th>Issues</th>
<th>Current Situation/Problems</th>
<th>Solution</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>HIV/AIDS in Africa</td>
<td>It reveals obviously the deep and wide gap between the established rich countries and developing/underdeveloped poor countries especially countries in South Sahara Africa with respect to HIV/AIDS. In contrast to the established rich developed countries, developing poor countries can hardly provide adequate treatment for STIs and opportunistic infections and unable to provide HAART for PLWHAs</td>
<td>Limited number of qualified manpower has to be solved by providing both technical and financial assistance</td>
</tr>
<tr>
<td>2</td>
<td>International funding and cooperation</td>
<td>Still inadequate and inappropriate. Benefit for end beneficiaries is still very limited. International funding is usually marked with &quot;not for consumable items&quot; (including drugs).</td>
<td>Increase international funding to meet the needs of needed countries</td>
</tr>
<tr>
<td>3</td>
<td>Socio-economic impact of HIV/AIDS epidemic</td>
<td>The socio-economic impact depends on the stages of HIV/AIDS epidemic. Indonesia is still a low prevalence country with possibility of emerging concentrated epidemic in some high-risk subpopulation for examples: in a subpopulation of CSWs in Merauke in Irian Jaya province, in a subpopulation of transvestite in Batam in Riau province, and in subpopulation of transvestites and IDUs in Jakarta province. A research in Indonesia revealed that loss due to an HIV infected individual in</td>
<td>Anticipating bigger and more serious impact</td>
</tr>
<tr>
<td>No</td>
<td>Issues</td>
<td>Current Situation/Problems</td>
<td>Solution</td>
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<td></td>
<td></td>
<td>Indonesia was US$ 39,700. Therefore with the current estimated 52,000 HIV infected individuals in Indonesia the total loss is estimated to 52,000 x US$39,700= US$ 2,064,400,000</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Human Rights and HIV/AIDS</td>
<td>Indonesia has already made some progress in the country's effort to abolish discrimination, isolation, and stigmatization of PLWHAs based on the nine principles of the Indonesian National AIDS Strategy</td>
<td>Improve human right policies, laws, and regulations.</td>
</tr>
<tr>
<td>5.</td>
<td>Gender specific with focus on women and girls</td>
<td>Indonesia has already made some progress in the country's effort to empower women and girls and improving their status.</td>
<td>Increase women's negotiation skills and gender sensitivity</td>
</tr>
<tr>
<td>6.</td>
<td>HIV prevention</td>
<td>The country is not yet successful in preventing and controlling increasing incidence of HIV/AIDS and needed support to provide adequate treatment for STIs and opportunistic infections and HAART for PLWHAs</td>
<td>Establish the above mentioned bridge.</td>
</tr>
<tr>
<td>7.</td>
<td>Improving access to treatment and care</td>
<td>Inadequate treatment for STIs and opportunistic infections and HAART for PLWHAs is a matter of fact the main constraint to improve access to treatment and care</td>
<td>Establish the above mentioned bridge.</td>
</tr>
<tr>
<td>No</td>
<td>Issues</td>
<td>Current situation/problems</td>
<td>Solution</td>
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<td>8.</td>
<td>Protection and care of children especially orphans</td>
<td>The protection and care are not yet a significant problem because the limited total number of children infected by HIV, suffering from AIDS or because orphans after their parents were already dead due to AIDS.</td>
<td>Increase number of orphanages as necessary in the future. Implementing mother to child transmission prevention. Alternative traditional treatment and care inducing herb medicine will be further studied in the future.</td>
</tr>
<tr>
<td>9.</td>
<td>Research and development especially vaccine</td>
<td>NGOs carry out researches on HIV/AIDS. There is a wide spectrum of research carried out but none of them research on vaccine, because Indonesia is still a low HIV prevalence country. It is very difficult to have sufficient samples to carry out a vaccine. Indonesia has successfully established collaboration with civil society in preventing and controlling HIV/AIDS. Fund from international donor agencies is mainly provided for NGOs.</td>
<td>Partnership with business coalition will be strengthened and extended New government policies, regulations concerning decentralization have to be developed in the near future. Capacity building to be focused at district levels.</td>
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<td>10.</td>
<td>Improving partnership with civil society</td>
<td>Partnership with business coalition will be strengthened and extended New government policies, regulations concerning decentralization have to be developed in the near future. Capacity building to be focused at district levels.</td>
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<td>11.</td>
<td>Improving National Capacity</td>
<td>Recently, the leadership of the National HIV/AIDS programme is strengthened by appointing a new Coordinator, i.e., The Vice President of the Republic of Indonesia. It will improve national capacity to coordinate inter-sectors and inter-programmes activities.</td>
<td>New government policies, regulations concerning decentralization have to be developed in the near future. Capacity building to be focused at district levels.</td>
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<td>12.</td>
<td>The process of bridging the deep and wide gap between the established</td>
<td>Participating in the process according to the country’s limited ability and capacity</td>
<td>Bridging forward this issues in the special session.</td>
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<td>No</td>
<td>Issues</td>
<td>Current situation/problems</td>
<td>Solution</td>
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<td>rich countries and the developing/underdeveloped poor countries.</td>
<td>Donated blood is not yet 100% screened for HIV, because in some very remote areas of the country (5%) blood transfusion units still have to be established in the future. During the current multidimensional crisis, which is still not yet ended, the country with some external support has hardly managed the 95% coverage of HIV screening of donated blood.</td>
<td>Bringing the issue of high prices of HIV test kits in the special session</td>
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<td>12.1 Blood safety</td>
<td>Indonesia is not yet successful in changing risky behaviors of high-risk behavior groups of people in the country although knowledge on HIV/AIDS among members of these groups is already very high.</td>
<td>Innovative approaches have to be developed in behavior change communication</td>
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<td>12.2 Behavior change communication</td>
<td>Indonesia is not yet successful in establishing national network of HIV/STIs counseling due to financial constraints.</td>
<td>Providing fund, necessary training, laboratory equipment and material, will have to be made available</td>
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<td>12.3 Establishing network of counseling</td>
<td>Indonesia has implemented the second generation of HIV surveillance in sentinel sites of sentinel populations in 15 provinces. The coverage of the surveillance will be stepwise extended in the near future.</td>
<td>Providing fund, laboratory equipment and materials</td>
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<td>12.5</td>
<td>Implementing life skills training programme focusing in reproductive health and HIV/AIDS</td>
<td>The Ministry of National Education has already launched the training programme in 11 provinces in Indonesia with UNICEF's collaboration. The coverage of the training will be significantly extended in the near future.</td>
<td>To give the right and appropriate information on reproductive health and HIV/AIDS to 2 million new members of youth in the age group of 15-25 years old yearly by expanding coverage of the training.</td>
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<td>13.</td>
<td>The controversial needle exchange programme and methadone replacement therapy</td>
<td>The country cannot adopt needle exchange programme and methadone replacement therapy because Indonesians are doing their best to establish the supremacy of laws and the adoption on the contrary is severely violating the laws.</td>
<td>Needle exchange programmes and methadone replacement therapy has to be carried out in the corridor of national laws.</td>
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<td>14.</td>
<td>Condom promotion for preventing HIV/STIs</td>
<td>Although consistent and appropriate use of condom to prevent HIV/STIs is not yet practiced by the majority of people with high-risk behavior in Indonesia, the promotion is making a significant progress because it is no longer strongly condemned by the majority of Indonesians. Up until now condom use among clients of CSWs is still very low.</td>
<td>Creating innovative approaches for condom promotion.</td>
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