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HIV/AIDS in Indonesia: Building a Coordinated National Response

"Before 2006 international partners financed their own programs and it was impossible to show any collective progress on national HIV indicators. Now, we insist no one can do their own thing without acknowledging and working with the AIDS commissions at all levels."

--Dr. Nafsiah Mboi, Indonesia's National AIDS Commission Secretary

Surveying a map of her expansive island nation in late 2009, Nafsiah Mboi, Indonesia's National AIDS Commission (NAC) secretary, discussed the nation's progress toward meeting goals around expanding HIV prevention and treatment, improving program effectiveness, and reducing financial dependency on foreign donors. Since Mboi was appointed to direct the restructured NAC in 2006, the Commission had made significant progress toward coordinating domestic and international entities working on HIV/AIDS prevention and treatment. Key to this progress was the Indonesian Partnership Fund, a USD 47 million flexible financing mechanism provided by the British Government. The Partnership Fund supported the NAC's work to develop a system of AIDS commissions at the provincial and district levels. Mboi believed this nationwide system dedicated to coordinating HIV services was critical to responding effectively to the nation's heterogeneous HIV epidemic.

Significant work remained, however, and new challenges loomed on the horizon. Starting in 2010, the Global Fund to Fight AIDS, Tuberculosis and Malaria would be the NAC's primary funder. In contrast to the flexible Indonesian Partnership Fund, the Global Fund disbursements were contingent upon meeting specific annual targets. Managing this multinational donor investment was a complex undertaking, requiring close cooperation with two other fund recipients and the oversight of numerous subcontractors. While developing systems to manage and implement the six-year program supported by the Global Fund, Mboi would be challenged to continue institutionalizing a comprehensive response across sectors and government levels.

Sarah Arnquist and Rebecca Weintraub prepared this case for the purposes of classroom discussion rather than to illustrate either effective or ineffective health care delivery practice.

Overview of the Republic of Indonesia

Indonesia is an archipelago of 13,000 islands located in the Indian and Pacific Oceans in Southeastern Asia. The islands stretched nearly 5,000 kilometers along the equator, roughly the distance from London to Moscow (see **Exhibit 1** for map).[1]

History

Following 350 years of colonial rule, Indonesia declared its independence in 1945. The Dutch recognized it as an independent country in 1949. Led by President Sukarno, Indonesia's politics were volatile for the next two decades. In 1967 General Suharto became the acting president, and for the next 32 years he led a government with a highly centralized planning system, a prominent military, and doors open to foreign investment. Then, in 1997, a severe economic crisis struck Asia, devastating the Indonesian economy and precipitating Suharto's fall. In 1999 Indonesia held its first free and democratic parliamentary elections.[1] Starting in 2001, the new democracy initiated one of the world's largest efforts to decentralize government administration. The rapid devolution of power largely bypassed the provincial level and granted districts significant autonomy and power in budgeting and planning.[2] Separatist disputes in the provinces of Aceh and Papua and inter-ethnic and religious tensions complicated governance, which remained a challenge. A 2004 tsunami killed more than 100,000 Indonesians and nearly obliterated some islands. The natural disaster led to a significant increase in international attention and aid.[3] Major political issues in 2009 included alleviating poverty, improving education, preventing terrorism, and consolidating the new democracy.[1]

Basic Socioeconomic and Demographic Indicators[1]

INDICATOR		Year
UN Human Development Index ranking	111	2009
Population (million)	227	2008
Urban population (%)	51.6	2008
Drinking water coverage (%)	56	2005
Poverty rate (% living under USD 1.25 per day)	29.4	2007
Gini index	39.4	2007
GDP per capita in PPP (constant 2005 international dollars)	3,689	2008
GDP per capita (constant 2009 USD)	2,349	2009
Literacy (% adult, % youth)	92, 97	2006

Demographics

In 2009 Indonesia was divided into 33 provinces, 465 districts and municipalities, and more than 60,000 villages. Indonesia was the fourth most populous country in the world; the average district had 500,000 people, and a typical village had 3,000 residents. The vast majority of Indonesians lived on five major islands: Sumatera, Java, Kalimantan, Sulawesi, and the western half of New Guinea. About 60% of people lived in the densely packed cities of Java, including Jakarta, the capital city and home to 12 million people,

[1] This data was comprised from the following sources: United Nations (UN), United Nations Children's Fund (UNICEF), World Bank, United Nations Educational, Scientific, and Cultural Organization (UNESCO).

towering skyscrapers, and shopping malls selling international luxury goods. In contrast, Papua and West Papua, the easternmost provinces on the western side of the island of New Guinea, were sparsely populated and underdeveloped.[1]

Indonesia was home to the world's largest Muslim population. About 86% of people were Muslim, 9% Christian, and 4% Hindu or other. Multiple ethnic groups comprised Indonesia's population, with Javanese being the largest at 40%, followed by Sundanese at 15%. The official language was Bahasa Indonesian.[1] Monogamous marriage and close relations with extended family were typical. While no national laws outlawed prostitution, sex work was strongly disapproved of and restricted in some localities. Sex work was not criminalized except in relation to child prostitution and trafficking. Illicit drug use was highly criminalized, and drug traffickers could be subject to the death penalty.

Economy

Indonesia experienced strong economic growth throughout the 2000s and, by World Bank standards, reached lower-middle-income country status in 2006.[4] With its numerous international factories, ports, and tourist destinations, Indonesia was a major Asian commercial and transportation hub, especially the city of Jakarta. Still, 40% of people relied on agriculture as their primary income source.[1] During the 1997-1998 Asian financial crisis, an estimated 8 million Indonesians lost their jobs; wages declined for others; and inflation topped 50%, pushing food prices beyond reach for the poor.[5]

Health in Indonesia

Through poverty reduction and health service program expansions, Indonesia achieved a one-third decline in child mortality and a one-quarter decline in infant mortality in the second half of the twentieth century. Despite this progress, the nation was unlikely to meet several health-related Millennium Development Goals by 2015. Indonesia still had one of the highest maternal mortality rates in East Asia; child malnutrition rates remained around 25%, and female literacy and access to clean water and sanitation remained low among the poorest people.[6] Infectious diseases were major causes of morbidity and mortality in Indonesia (see **Exhibit 2** for top 10 causes of death). Indonesia had the third-highest tuberculosis (TB) burden in the world, with 250 people dying of TB daily. Malaria was common in many parts of the country, and large-scale outbreaks of dengue fever occurred annually. Throughout the 2000s the highly fatal Avian influenza was a major international public health and security concern.[7]

Health System

The expansive island geography and diversity of Indonesia's population posed enormous challenges to health surveillance and service delivery. During the 1970s and 1980s, Indonesia improved its health system through the expansion of a vast network of district primary health care centers. By the mid-1990s, the country had more than 7,000 of these district health centers and 20,000 sub-district health centers staffed by doctors, nurses, and midwives.[8]

Starting in 2001, the health system underwent rapid decentralization. Responsibility for financing and delivering health services shifted to district governments. This change led to dramatic reductions in public health spending and a near collapse of national disease surveillance systems. Although districts now had the authority to plan services, they lacked sufficient funding to deliver them. Poorly defined responsibilities between the districts, provinces, and central levels of the Ministry of Health (MOH) led to an accountability vacuum and poor performance for several years.[8] District heath departments had significant autonomy in

governing but struggled to absorb funding from the central government; in 2006, only 73% of the public health budget was spent. In 2007, public sector health spending surpassed 1% of GDP for the first time.[2]

While health care expenditures increased following decentralization, disparities in access to health services persisted. A majority of people relied on the private sector for care and paid for it out of pocket.[9,10] Many public health centers were poorly equipped and lacked basic infrastructure, such as clean water, sanitation, or regular access to electricity. Maintaining adequate stocks of basic medicines remained problematic. Remote areas had insufficient doctors, exacerbated by high levels of absenteeism, and nurses and midwives were often the only health workers available.[6] The government launched a community health insurance program in 2005 that aimed to provide a safety net for the poor.[6]

Health System and Epidemiologic Indicators[3]

INDICATOR		YEAR
Average life expectancy at birth (total, female, male)	67, 69, 66	2008
Maternal mortality ratio (per 100,000 live births)	240	2008
Under five mortality rate (per 1,000 live births)	41	2008
Infant mortality rate (per 1,000 live births)	31	2008
Vaccination rates (% of DTP3 coverage)	82	2008
Undernourished (%)	16	2006
Adult (15-49 years) HIV prevalence (%)	0.2	2007
HIV antiretroviral therapy coverage (%)	15	2007
Tuberculosis prevalence (per 100,000)	210	2007
DOTS coverage (%)	98	2005
Malaria cases (per 1,000)	16.45	2008
Government expenditure on health as a % of total government expenditure	5.7	2008
Government expenditure on health per capita (Int'l dollar, USD)	45, 25	2008
Total health expenditure per capita (Int'l dollar, USD)	82, 26	2008
Physician density (per 10,000)	1.3	2007
Nurse and midwife density (per 10,000)	8.2	2003
Number of hospital beds (per 10,000)	6	2003

HIV/AIDS in Indonesia

Indonesia tracked reported AIDS cases but, like many countries, lacked data on HIV incidence. Between 1987, when Indonesia reported its first AIDS case, and 2000, 1,000 AIDS cases were diagnosed and officially reported in 16 provinces. Suspecting the official case reports underestimated the actual prevalence, in 2002 the MOH, with assistance from international partners, developed a revised estimate of the national HIV prevalence. After developing statistical models to extrapolate surveillance data on the HIV prevalence of at-risk adults (ages 15-49) in each province, epidemiologists estimated that 190,000 people were infected with HIV nationally.[4,20] Official AIDS case reports remained much lower than the modeled prevalence

[2] In 2006 countries in the Southeast Asian World Health Organization (WHO) region devoted on average 3.4% of GDP to health care, of which 66% was funded privately and 34% by the government.

[3] This data was compiled from the following sources: WHO, UNICEF, UN.

[4] The WHO adopted Indonesia's estimation process as the gold standard for countries with concentrated epidemics.[20]

estimates, although reported cases started rising more sharply after 2004. By 2009 nearly 20,000 AIDS cases had been reported across all 33 provinces (see **Exhibit 3** for detailed HIV epidemiology). In 2009 Indonesia's estimated adult HIV prevalence had increased 0.2%, suggesting there were 333,200 infections.[11]

Like other Asian epidemics, HIV was concentrated in Indonesia's high-risk groups, including sex workers, men who have sex with men (MSM), injecting drug users (IDUs), and *waria*[5] (transgender people). HIV was primarily an urban problem, except in the eastern provinces of Papua and West Papua, which had a generalized epidemic with an adult prevalence of 2.4% in 2009. In 2009 about 25% of infections were among women, an increase from 21% in 2006[11]

In the 1990s a spike in HIV infections among IDUs followed a hidden epidemic of injecting drug use.[12] By 2001 IDUs comprised more than half of new infections, and in some areas half of IDUs tested were HIV-positive.[13] HIV prevalence in IDUs increased three-fold between 1999 and 2003, from 16% to 48%.[14] Parallel to the epidemic among IDUs, HIV infections increased rapidly in prisons due to overcrowding, ongoing injecting drug use, and sex between inmates. In 2008 the estimated distribution of HIV cases was: IDUs (46%), people living in Papua and West Papua (14%), clients of sex workers (15%), sexual partners of IDUs (7%), female sex workers (5%), MSM (5%), *waria* (2%), prisoners (3%), and other (3%). New infections resulted from transmission through sharing needles (59%) and heterosexual sex (41%; see **Exhibit 4** for description of high-risk groups).[15]

In 2009 epidemiologists believed incidence among IDUs was declining and that sexual transmission among sex workers and MSM would be the primary driver of future HIV infections. Models showed there would be 541,700 cases by 2014.[16]

HIV Surveillance

Tracking HIV hot spots across the 13,000 islands was challenging. The MOH set up regulations to oversee mandatory case reporting, blood screening, surveillance, and medical care in 1987. Systematic sentinel HIV surveillance started among sex workers in two provinces in 1998. Over time, the MOH expanded HIV surveillance to more sites and more at-risk populations. The Central Bureau of Statistics and MOH were responsible for surveillance, but most funding came from international donors. Behavioral surveillance among a range of high-risk populations began in 1996 in three cities and was expanded over time to more populations in more cities. In 2001 the government launched a second-generation surveillance system with updated case reporting and behavioral surveillance methods. Integrated biological and behavioral surveys were conducted in 2004 and 2007. There was not a national sexually transmitted infection (STI) reporting system.[17]

Early Response, 1987-2001

A National AIDS Committee formed in 1987. The four highest-prevalence provinces – Jakarta, Bali, Jogjakarta, and East Java – set up AIDS control plans with assistance from the WHO Global Program on AIDS.[18] In 1994 the Coordinating Minister for People's Welfare established a National AIDS Commission (NAC) that included 14 ministers outside the MOH to promote a multisectoral response. The NAC never actually met, but Indonesia adopted a national AIDS strategy that year. According to a World Bank report, the strategy "espoused broad principles rather than specific programs and did not include a focus on high-risk groups." National resources for strategy implementation were limited, particularly after the 1997 financial crisis. International partners supported the NAC and its activities financially and technically.[18]

[5] Transgender people in Indonesia prefer the word *waria*; it is a combination of the words *wanita* (woman) and *pria* (man).

Two pioneering AIDS activists, Drs. Zubairi Djoerban and Samsuridjal Djauzi, worked with the earliest HIV-positive patients and formed new non-governmental organizations (NGOs) to care for patients and fight for government attention. The NGOs were small and inexperienced, however, and struggled to attract policy leaders' attention to HIV/AIDS services amid the numerous other challenges Indonesia was facing, including high rates of malnutrition and TB and a poor education system.[2] Djoerban reflected, "At that time, the government was denying that there was AIDS. There was no support at all from the government, and that is why we established an NGO in 1989—because we thought that there might be an epidemic."

Indonesian society was not open to discussing transmission routes or the needs of marginalized populations. Stigma and discrimination against people living with HIV/AIDS, their friends and families, and at-risk groups were common and often fierce. "We took a lot of risks to bring HIV into the public," recalled Professor Irwanto, an activist and psychology professor. "I remember having to stand and physically block a crowd from stoning a group of female sex workers and seeing the mother of an HIV-positive son lose her food stall because it was burned."

Between 1993 and 1999, international donors provided USD 79 million for HIV/AIDS projects – almost all the HIV/AIDS funding for the country – primarily for building NGO capacity to deliver targeted prevention services and for technical assistance to the MOH.[19] The two largest donors were the United States Agency for International Development (USAID) and the Australian Agency for International Development (AusAID; see **Exhibits 5** and **6** for USAID and AusAID project descriptions). They supported the development of NGOs and local AIDS commissions. Other international partners included the World Bank, WHO, United Nations Development Program, and other UN programs. Technical assistance focused on the MOH's development of guidelines, the expansion of its laboratory capacity, and its ability to conduct surveillance and provide care for individuals with STIs. Antiretroviral therapy (ART) was not available. The government and NGOs lacked the capacity to absorb all available donor funding. For example, USAID gave USD 3 million to the MOH for HIV programs, but the MOH only disbursed USD 1 million by the end of the project.[18] There was little formal coordination or communication among NGOs or between the NGOs and government.

After 2000, following reports that HIV was spreading quickly among IDUs in the community and prisons, donors focused their efforts on expanding harm reduction services for these populations. The MOH worked with AusAID and USAID to help NGOs start community harm reduction programs. AusAID sponsored several government officials to visit and learn about world-class harm reduction programs in the Netherlands and Australia. USAID could not directly fund needle-exchange programs due to the US Congress' global prohibition of supporting the practice. Harm reduction services in Indonesia included needle exchange, methadone therapy, and addiction treatment. The National Narcotics Board, a regulatory and enforcement agency, considered such harm reduction activities illegal. Outreach workers exchanging clean and dirty needles worried about being arrested, but the donor programs pushed forward and began working with prison officials to develop an HIV prevention plan.[13]

Sexual education and condom promotion programs met steady resistance. Based on Thailand's success, the MOH recommended that local governments adopt regulations for 100% condom use in brothels. This gained little traction, and a mass media condom campaign sponsored by USAID and the MOH was cancelled after a few weeks when a radical Islamic group threatened to burn down TV stations.[17]

In 2001 Indonesia's Minister of Health, along with all UN member states, signed the UN General Assembly Special Session on HIV/AIDS's Declaration of Commitment. **T**he commitment established a framework to reverse the HIV/AIDS epidemic and meet and report on milestones for 2003, 2005, and 2010. It was also partly responsible for the development of the Global Fund, as it called for innovative financing to support program scale up.

Moving Toward a National Response

In 2002, with support from AusAID and the United Nations Development Program, Indonesia developed a National AIDS Strategy for 2003-2007. The strategy called for HIV/AIDS care and treatment, 100% condom use in brothel areas, and harm reduction for IDUs. Subsidized ART had not been available previously. No domestic funds accompanied the strategy, but the MOH was preparing to apply for financial support from the newly created Global Fund to Fight AIDS, Tuberculosis and Malaria. UNAIDS and the WHO provided technical support for Indonesia's Global Fund application.

In 2003 the WHO funded Indonesia's first methadone treatment sites at hospitals in Jakarta and Bali. That year the Narcotics Board officially declared needle exchange and methadone therapy illegal. In response, donor agencies supported the MOH's appeal for a compromise. A resulting agreement between the Narcotics Board and National AIDS Commission allowed harm reduction interventions at government health clinics; however, none were equipped to provide the service. NGOs remained the main providers of needle exchange services, and outreach workers continued to fear arrest.[13]

Global Fund Overview

The Global Fund was created in 2002 as a public-private partnership and international financing institution to attract and disburse additional resources to prevent and treat HIV and AIDS, TB, and malaria (see **Appendix A** for a detailed overview of the Global Fund). The partnership between governments, civil society, the private sector, and affected communities that the Global Fund supported was unique among global health funding mechanisms. The model was based on the concepts of country ownership and performance-based funding; stakeholders within a given country applied collectively and implemented their own programs based on their priorities; the Global Fund provided financing on the condition that verifiable results were achieved.

To facilitate this process, the Global Fund encouraged each country to develop a Country Coordinating Mechanism (CCM), an in-country, multi-stakeholder body (see **Exhibit 7** for Indonesia's CCM members). The CCM was responsible for coordinating proposal development, nominating the Principal Recipient for each grant, overseeing grant implementation, approving any adjustments to the grant, and ensuring effective linkages between the Global Fund-supported programs and broader national health programs.

The Principal Recipient(s) received funding from the Global Fund and used it to implement prevention, care, and treatment programs or passed it on to other organizations (Sub-Recipients) that provided those services. The Principal Recipient submitted progress updates to the Global Fund with each request for funding to cover the next period of implementation. In the first round of awards (Round 1), the Global Fund committed USD 1.67 billion to 36 countries.

Rolling Out Treatment

The Government of Indonesia was the Principal Recipient for Round 1 Global Fund grants, totaling USD 16 million for HIV, USD 50 million for TB, and USD 20 million for malaria. The MOH led the HIV project implementation from 2003 to 2007, focusing on expanding voluntary counseling and testing (VCT) and ART. Working toward the WHO's 3 x 5 Campaign to put 3 million people on treatment worldwide by 2005, the Indonesian MOH aimed to enroll 10,000 people on ART by 2005 at 25 designated AIDS referral hospitals. Starting in 2004, HIV patients would have access to publicly subsidized treatment for the first time. The MOH used Global Fund money to purchase antiretrovirals and distribute them for free to patients.

However, patients still had to pay for various administrative fees and for any CD4 and viral load tests performed (see **Exhibit 8** for timeline of HIV-related events in Indonesia).[2]

While the health system was undergoing a rapid and massive decentralization process, the MOH aimed to lead the Global Fund-financed project in a highly vertical and centralized manner.[21] Facing procurement and implementation problems, the MOH failed to spend the disbursed Global Fund money on schedule. After two years, the Global Fund cut USD 9.5 million from the original agreement and lowered the five-year targets, noting the MOH's rate of absorption would not allow it to reach the original goals. Despite these challenges, the Global Fund awarded the MOH USD 43 million in Round 4 to continue scaling up VCT and ART in 17 provinces between 2005 to 2010. The fourth round dedicated slightly more funding to prevention efforts with high-risk groups, but as one MOH official recalled, "Overall, we focused on treatment and forgot about prevention."

Mobilizing Domestic Resources

In 2004 the USAID-funded Aksi Stop AIDS Project and the AusAID-funded Indonesian HIV/AIDS Prevention and Care Project were Indonesia's two largest HIV prevention programs. Combined, they worked with 170 community NGOs and reached thousands of people in 12 provinces. Additionally, USAID and AusAID were working to strengthen local AIDS commissions that brought government and civil society together. National government efforts focused on the public health sector and engaged minimally with NGOs. There was no coordination among the efforts to organize a comprehensive response. According to a World Bank report, public agencies were unwilling to relinquish fiduciary responsibilities to NGOs, which were generally new and often lacked the capacity to absorb and manage large amounts of funding. The reviewers noted that the model of relying on donor-funded "boutique" prevention models had not demonstrated sufficient coverage and saturation to impact the epidemic. They reported, "The assumption that NGOs are better placed to work with high-risk groups than is the government needs to be tested at the country level and may not be well founded in Indonesia."[17]

In January 2004, six national ministers and six governors of the most affected provinces signed the "Sentani Commitment," a formal commitment to enhance HIV/AIDS services. Dr. Nafsiah Mboi was appointed to coordinate the Sentani efforts. While a visiting scholar at Harvard University in the 1990s, Mboi was inspired by Jonathan Mann, the founding director of UNAIDS. Mboi recalled, "He said to me if you don't do anything about HIV in Asia, it will become a time bomb because of the size of the population. That was when HIV prevention became my main obsession" (see **Exhibit 9** for Mboi's biography). Mboi, the wife of a former governor, was a physician who had worked within the Indonesian MOH for over three decades and served one term in Parliament before directing the WHO's Department of Gender and Women's Health in Geneva.

With the Sentani Commitment, government leaders backed their promise with funding. Local government allocations for HIV programs reportedly quadrupled between 2004 and 2005, from USD 420,000 to USD 1.74 million.[22] Despite advancements, Mboi recalled identifying the need for a single national entity to coordinate efforts and provide technical support and persuasive advocacy. The country needed help breaking through the denial at the senior policy and leadership levels and getting leaders to see that HIV was a crisis. She believed the National AIDS Commission should be empowered to carry out the UN's "three-ones" principle: instituting one national coordinating body, one national strategy, and one national monitoring and evaluation system.

Building a Coordinated National Response

The Indonesian Partnership Fund

In 2004 the United Kingdom's Department for International Development (DFID) proposed creating a pooled financing mechanism to harmonize donor practices within Indonesia. Driven by the Paris Declaration[6] to harmonize donor practices and by a focus on helping Indonesia achieve the Millennium Development Goals, DFID aimed to build the Indonesian government's ability to direct the scale up of HIV services according to the country's priorities. DFID donated USD 47 million to establish the Indonesian Partnership Fund for HIV and AIDS (Partnership Fund). The Partnership Fund served as a means of providing flexible financing for HIV services through 2009. The NAC had overall responsibility for the Partnership Fund. This was the first time Indonesia and other international development partners in the country had seen this kind of financing. Setting up the Partnership Fund "required a year of delicate maneuvers and negotiations," said Jane Wilson, the UNAIDS country coordinator at the time. "It was extremely complex, and I have a lot of respect for the way DFID went about channeling money through existing large organizations and not reinventing the wheel."

At the time, the NAC was described as "understaffed, poorly resourced and indecisively managed."[23] DFID set aside 17% of the Partnership Fund for UN agencies to build the NAC's administrative and managerial capacity and act as an interim fund manager (see **Exhibit 10** for the Partnership Fund budget). A steering committee comprised of representatives from major international development partners, government departments, and civil society organizations guided how the Partnership Fund financing was used. The Partnership Fund architects wanted to scale programs rapidly and reach high-risk groups quickly. They recognized, however, that few Indonesian NGOs could absorb large sums of money, and the country lacked a strong network of decentralized government HIV/AIDS programs. Thus, the Partnership Fund steering committee chose to channel money to existing programs established by AusAID, USAID, and other UN programs, enabling them to provide direct services and technical assistance to develop provincial and district AIDS commissions.[22]

With money from the Partnership Fund, USAID and AusAID's implementing programs enhanced their efforts toward building harm reduction programs. The bilateral partners supported work with the national prison system that led to a harm reduction strategic plan launched in 2005. A year later the MOH endorsed national guidelines on harm reduction that included methadone therapy and needle-exchange programs (see **Exhibit 11** for the WHO guidelines).

Revitalizing the National AIDS Commission

In 2006 a presidential decree restructured the NAC to report directly to his cabinet and empowered it with a new Secretariat. This action also renewed its mandate to "promote more intensive, holistic, integrated and coordinated prevention and management of the response to AIDS." The NAC had 27 members, including the Coordinating Minister for People's Welfare who served as chairman, the Ministers of Health and Home Affairs who served as vice chairs. For the first time, representatives from civil society were invited to join the commission. As a whole, the NAC rarely met. A smaller executive board met quarterly,

[6] The Paris Declaration was created in March 2005 when more than 100 signatories from donor and developing-country governments, multilateral agencies, and development banks committed to help developing-country governments formulate and implement their own national development plans, according to their own national priorities, using, wherever possible, their own planning and implementation systems.

and technical working groups met more frequently to develop strategies and guidelines for research, monitoring, and evaluation.

Mboi was appointed the full-time secretary to be in charge of coordinating all the NAC's activities. Mboi reported directly to the Coordinating Minister who reported directly to the President of Indonesia. With her appointment as NAC secretary, Mboi became the national director of the Partnership Fund. She reported to the Partnership Fund's steering committee but could alter fund allocations within a certain percent at her discretion. Using money from the Partnership Fund, Mboi established a secretariat of professional technical staff to support the NAC and ensure completion of its responsibilities, including issuing policies, drafting strategic plans and guidelines, coordinating prevention activities, and disseminating information to the media (see **Exhibit 12** for the NAC's statutory responsibilities).

Mboi hired professionals through an open recruiting process to staff the secretariat. In contrast to civil servants, the secretariat's contracted staff earned substantially more, worked longer hours, and could be terminated for underperforming. Some people believed this arrangement was unsustainable and fuelled the a parallel system to the MOH that exacerbated fragmentation. "Sustainability requires putting money into something that will last, and that is the Ministry of Health," a WHO official said. A high-ranking MOH official commented, "Salaries of NAC employees can be 10 times higher than their counterparts in the Ministry of Health. This is not sustainable. The NAC can do it because it receives outside funding, but who in the government will fund the professionals like that because it's above the standard of even experts in high level positions within the bureaucracy?"

The NAC was resolute on the need for an effectively managed and comprehensive system dedicated to building and managing a multisectoral HIV response. Mboi said:

> HIV had never been and never would be a priority in the MOH. The MOH has to deal with hundreds of thousands of people dying of other diseases. For us, HIV is our priority because we know it will affect the development of the country and morbidity and mortality from other diseases. The advantage with having a multisectoral AIDS commission is that we can have everybody on board. This disease cannot be eliminated by one sector or institution.

Working toward building a multisectoral response, the NAC Secretariat harnessed support from ministers of other sectors, including transportation, tourism, defense, and justice. From her long political career, Mboi knew many ministers personally whom she could call on for support. A MOH official commented, "The NAC would not function as it does without the powerful secretary. The leadership and charisma of Ibu Nafsiah Mboi are very important."

2007-2010 National Strategy

The newly staffed NAC Secretariat led the development in 2006 of a National Strategy and Action Plan for 2007-2010. The strategy development process began with updating national HIV prevention estimates and mapping "hot spots" to identify priority areas. Next, numerous partners, including representatives from several ministries and civil society, worked with the NAC to set the national objectives. The overarching national objective was "to prevent and reduce transmission of HIV infection, raise the quality of life for people living with HIV, and reduce the negative social and economic impact" asssociated with the disease. The strategy outlined future activities by ministry and sector around five objectives:[12]

1. Developing and distributing information to create a conducive environment, emphasizing high-risk groups
2. Increasing the offering and quality of care, support, and treatment

3. Strengthening the role of adolescents, women, families, and general public in the HIV/AIDS response
4. Developing and strengthening partnerships among government, civil society organizations, the private sector, professional organizations, and international development partners at national and local levels
5. Increasing policy coordination at the national and local levels

The NAC Secretariat estimated that four years of work toward meeting all the objectives would cost USD 256.26 million. Accompanying the strategy was an action plan describing each sector's contribution. While the National HIV/AIDS Strategy was an official decree by the NAC chairman, it had no binding authority. Mboi and her team had to advocate for other departments to adopt and implement the action plans laid out in the strategy. The response was mixed; some sectors responded quickly and completely, while others did not.

Provincial and District AIDS Commissions

The NAC Secretariat worked to build the capacity of AIDS commissions at the provincial and district levels. Starting with 100 districts, this network of local AIDS commissions became the system by which the NAC intended to manage the response. Using the Partnership Fund money, the NAC paid the salaries of local commission staff and provided training on HIV, monitoring, planning, and program management. The district commissions reported to the provincial commissions, which reported to the NAC. The NAC asked local governments to match its financial support. Initially, some local support came through donated office space or vehicles (see **Appendix B** for a detailed description of local implementation). The goal was to use national funding to catalyze local funding. Mboi reflected:

> In a decentralized government system like Indonesia's, you have to have the local government on board, and that is not an easy task. They say, "Why bother with HIV? That's a disease of sinners. We have thousands of other issues to worry about." Putting it into the local systems contributes to sustainability because Indonesia is so huge and the epidemic is so different from area to area. Local decision making and planning is necessary. The program in Papua is not the same as in Java.

Monitoring and Evaluation

The NAC Secretariat led the development of a national monitoring and evaluation (M&E) system, which included guidelines, training, and a verification system. The M&E guidelines described key indicators and data flow from the districts to the national level. The guidelines were piloted for programs receiving Partnership Fund money in 100 districts. Health facilities reported data on STI services, testing and counseling, prevention of mother-to-child transmission (PMTCT), and ART directly to the district and provincial AIDS commissions, which reported them to the NAC Secretariat. The NAC's M&E system worked in parallel with the three existing data collection systems – the MOH's system, a joint donor database, and the Global Fund monitoring system. A WHO review noted that district health officials felt overwhelmed by the four M&E systems and found evidence of "limited compilation, validation, analysis, report generation, and utilization of available data reported by health facilities and NGOs at all government levels."[24]

In response, the NAC Secretariat worked with development partners to create a national M&E framework to guide all programs, regardless of the funding source. All donors were required to adopt the framework and coordinate their projects through the NAC. Mboi said, "We insisted no one can do their own thing without acknowledging and working with the AIDS commissions at all levels. It didn't happen

overnight. The NGOs first said, 'Why should we report to the AIDS commissions when we get our funding from AusAID or USAID?'" The NAC Secretariat also provided M&E training to the provincial and district AIDS commissions and gave them computers.

The MOH maintained its original data collection system and reporting to the Global Fund. The MOH offices were not always involved in the NAC data reporting process and would not always share data with the NAC. This led to tension between the MOH and NAC Secretariat.

Strengthening Civil Society

As the NAC Secretariat worked to build a national response, it supported the strengthening of civil society. It provided skill training and encouraged civil society to participate in policy making, program evaluation, and other activities. The Secretariat used Partnership Fund money to support national advocacy networks that represented key groups, such as IDUs, sex workers, and MSM, at national meetings. The national groups were also supposed to create networks of local civil society advocacy groups. The NAC gave the networks office space in its building, a USD 15,000 operating budget, and a dedicated a Secretariat staff member for support. One network leader commented that while the networks were still working through governance challenges, civil society's ability to voice its concerns and be heard had greatly improved. This included gaining seats on the Global Fund CCM and the NAC. Some remaining challenges, he pointed out, were insufficient unrestricted funding to support program implementation and difficulty in retaining qualified staff. "The international programs pay better salaries and hire all the good, qualified people away," he said.

Scaling up Services

Care, Support, and Treatment

The MOH was scaling up HIV/AIDS care, support, and treatment programs under the Global Fund Rounds 1 and 4 grants. It encountered several management problems, and in 2007 the Global Fund severely restricted payments to Indonesia for six months after finding evidence of misappropriated funding, primarily in the TB program. Partnership Fund money was used once to purchase emergency antiretroviral drugs during a supply shortfall in this period. In the wake of the scandal, the CCM restructured itself, and a new ethics and oversight committee formed.[25]

Harm Reduction Services

In 2007 the NAC chairman publicly reinforced the need for harm reduction. This formal declaration of support reassured the growing number of outreach workers that they could safely exchange needles without arrest. With Partnership Fund money, harm reduction services for the nation's estimated 219,000 IDUs had increased. The number of needle-exchange programs increased from 17 in 2005 to 147 at the end of 2007. Methadone programs increased from 3 in 2005 to 24 in 2007.[16]

Despite this progress, in 2007 AusAID officials noted that the harm reduction programs' overall epidemiological impact was low, with programs reaching less than 10% of IDUs. In order to mitigate the epidemic, coverage rates had to be at least five times higher. "That was when we started looking at alternatives to NGOs and started to explore working more with the public health system, prisons, and primary health centers," said the AusAID HIV program manager. After coordinating with the NAC, AusAID launched a new USD 38.3 million program in 2008 to strengthen the public health system's ability to deliver harm reduction services. Brazil's experience scaling up methadone therapy and needle-exchange

programs via public health clinics was an inspiration to those leading Indonesia's response. AusAID funded harm reduction programs in prisons and provincial health departments, topping off civil servant salaries to conduct outreach, distribute materials, and collect data. AusAID implemented this new approach in the seven highest-prevalence provinces and stopped working in two other provinces with a lower burden of disease.

The NAC supported this shift to deliver services via the public health system. The Secretariat believed that building on existing infrastructure and topping off civil servant salaries was less expensive than funding stand-alone NGOs and, therefore, a more scalable and sustainable model. There was opposition to this approach, however. Some NGO leaders believed that drug users would be reluctant to use government services, citing high levels of stigma and discrimination among public health care providers. They said NGOs staffed by impassioned former drug users would be more effective than trying to motivate and train overworked and underpaid civil servants who shifted jobs frequently.

Sexual Transmission Prevention

The NAC and development partners supported targeted condom promotion programs and provision of STI treatment services aimed to prevent sexual transmission of HIV. While focused on expanding treatment, the MOH moved away from condom promotion. Progress varied widely by province and district, various obstacles slowed effective condom promotion.[16] One international consultant reflected:

> Most top leaders understand the need for condom use and will allow it. But on the ground, some people who are supposed to promote condoms – even within harm reduction programs – cite their religion and don't. If you visit some NGOs or public health centers with a lot of drug users, they are very kind and promote methadone with no problem, but when it comes to condoms, they are hesitant. It's very easy to understand why partners of IDUs are getting infected.

Epidemiological evidence suggested the primary driver of HIV infections would be risky sex. The NAC Secretariat was working to increase "structural intervention" efforts in areas with concentrated high-risk sex, such as brothel complexes. This included securing buy-in from crucial stakeholders such as police, community leaders, and brothel owners; better management of condom supply and distribution; free STI management at public primary care clinics; and peer education and behavior change programs conducted by NGOs. In contrast to free-standing "AIDS projects," Mboi said, all these services needed to be integrated and coordinated through existing systems and structures. She said, "This approach has proved successful for reducing and managing HIV infections among IDUs both in the community and prison system. Now, we need to expand it to prevent sexual transmission."

The Global Fund Round 8

DFID's front-loaded contribution to the Partnership Fund was set to expire in 2009. Starting in 2008, AusAID committed USD 850,000 annually for the next seven years to the Partnership Fund. At the time, no other donors had committed to pooling financing in the Partnership Fund. To continue scaling up a comprehensive response, the NAC had to mobilize additional resources (see **Exhibits 13-15** for finance tables).

In August 2008 Indonesia submitted a Round 8 funding application to the Global Fund. The MOH, NAC Secretariat, and international partners developed the application based on the National HIV/AIDS Strategy and Action Plan. The application took into consideration reasons the previous round was rejected: the MOH had been listed as the only Principal Recipient, and it lacked prioritization of high-risk populations and civil society participation. The Round 8 proposal had three Principal Recipients. At the

Minister of Health's insistence, the MOH would be in charge of all care and treatment activities; the NAC would be in charge of most prevention activities; and the Indonesian Planned Parenthood Association, an affiliate of the international organization, would be responsible for outreach, peer education, and civil society-strengthening activities. Planned Parenthood was Indonesia's first civil society group to be a Principal Recipient for HIV funding.

The proposal emphasized prevention services for the highest-risk populations in the 72 districts within the 12 provinces where 70% of the target populations lived. The Global Fund awarded Indonesia USD 125 million for the proposal from July 2009 to June 2014 (see **Exhibit 16** for overview of Global Fund rounds). "The Global Fund is like a tank. It better be pointed in the right direction because that much money creates a lot of momentum. If things are not done according to their deadlines and policies, the funding will stop," one CCM member said.

Coordinating Activities

The three principal recipients had to coordinate their activities. Prevention among IDUs, for example, required Planned Parenthood's Sub-Recipient NGOs to refer clients to public health clinics for methadone therapy and needle-exchange programs. The MOH was responsible for training staff and distributing methadone to the clinics and prisons. The NAC was responsible for purchasing and distributing needles and condoms. Each Principal Recipient had to monitor and report its work. Daniel Marguari, CCM member and director of Spiritia, Indonesia's largest AIDS NGO, reflected, "If one Principal Recipient doesn't openly work with the others, it creates a challenge for all. Internally, each Principal Recipient has to understand, 'this is not my proposal, this is our proposal' because they depend on each other to meet their targets."

Ministry of Health

The MOH received 66% of the Round 8 funding to expand STI diagnosis and treatment; HIV testing and counseling; treatment of opportunistic infections; ART; TB/HIV collaborative activities; methadone maintenance therapy; and strengthening the national supply chain, procurement, and laboratory systems. By Round 8, the MOH provided free ART to about 10,000 patients. The MOH was now paying for first-line drugs and using Global Fund money to purchase all second-line therapies. Poor patient adherence worsened by frequent drug stock-outs was a problem, however. Under Round 8, the MOH would expand testing and counseling centers in prisons, and to address the generalized epidemic in Papua, the MOH aimed to provide testing and counseling to all pregnant women and newly diagnosed TB patients there.

National AIDS Commission

The NAC received 21% of the Round 8 funding to manage needle-exchange programs, condom promotion, community mobilization, and strengthening information systems. For the strategic information system, the Secretariat was responsible for training and mentoring staff at provincial and district AIDS commissions in addition to creating a data management system. The Secretariat had to distribute 35 million condoms via 20,000 condom outlets identified by the local AIDS commissions and thousands of clean needles and syringes to primary health clinics.

Indonesian Planned Parenthood Association

Planned Parenthood had been working on reproductive health issues in Indonesia since 1957. Its 2008 budget was USD 4 million. As a Principal Recipient, Planned Parenthood received 13% of the Round 8 funding and contracted 35 Sub-Recipient NGOs to provide outreach, peer education, and referrals. The

Global Fund management requirements overwhelmed the organization. Planned Parenthood Executive Director Inne Silviane recalled:

> The process of arranging contracts and disbursing money with Sub-Recipients and sub-Sub-Recipients takes a lot of time. We have to coordinate with the CCM, the MOH, the NAC, and the local fund agent. The watchdog is everywhere making sure we are accountable and transparent in everything we do. That is good, but for us, we are learning by doing, and it is a challenge. There's a lot of hope being put into us and a lot of burden on our shoulders.

Early on, Planned Parenthood leaders worried that the current funding levels would not allow them to roll out an ideal peer outreach and behavior change program. Their previous experience showed prevention required multiple and frequent contacts with people vulnerable to infection. The Global Fund objectives emphasized expanding coverage and continuously reaching new clients. It did not budget for ongoing contact with existing clients, nor was there money to pay for client transportation to the government health clinics.

Progress

Comprehensive surveillance data needed to gauge program effectiveness was two years old by 2009. The 2007 survey data showed continued high-risk sex and low levels of condom use among high-risk groups (see **Exhibit 18** for estimated program coverage rates based on surveillance data). Data suggested risky behavior among IDU had decreased. Between 2004 and 2007, IDUs reported increased usage of sterile injecting equipment and decreased sharing of contaminated needles. HIV mortality decreased from 46% in 2006 to 17% in 2008.[16]

The Government of Indonesia financed 39% of HIV services in 2008. Provincial budget allocations for HIV activities increased. In 2004 about half of the provinces allocated funding for HIV services totaling USD 1 million, and by 2009 all 33 provinces had allocated money for HIV services, totaling USD 3.5 million. District budget allocations for HIV activities increased from a total of USD 360,000 among 43 districts in 2005, to USD 3.8 million among 172 districts in 2009. (Some people questioned those numbers, citing the gap between budget allocations and disbursed funds.) All 33 provinces and 172 districts had active AIDS commissions supported by the Partnership Fund and NAC (see **Exhibit 17** for charts of prevention scale up).[23]

The NAC's monitoring system showed that HIV prevention activities in 2008 reached 30% to 50% of sex workers, 15% to 21% of IDUs, and 4% to 15% of MSM. Coverage was higher in priority districts but remained below the 80% target. In Papua, mass HIV prevention campaigns involving churches, community organizations, and schools reached about one-third of the population.[23]

By the end of 2009, there were 722 VCT centers across Indonesia. VCT utilization increased for all key risk groups but remained below the 80% target. The MOH supported 154 referral hospitals that provided ART to 12,500 people (45% of those in need).[16]There were 281 needle-exchange programs at the end of 2009. About 49,000 of the estimated 230,000 IDUs accessed needle-exchange services. Forty-six methadone therapy programs (27 in primary health centers, 15 in hospitals, and 4 in prisons) served 2,700 people. As of July 2009, 15 prisons offered some form of harm reduction services, including testing 4,285 prisoners, providing methadone therapy to 80 prisoners, and offering education and behavior change communications to about one-third of the nation's 100,000 prisoners.[16] There were 245 STI service sites nationwide and 15,000 condom outlets through which 20 million condoms had been distributed.[16]

Ongoing lobbying from community advocates, international donors, and the NAC improved the political environment for harm reduction, especially in certain provinces and districts. The official position

of the National Narcotics Board, however, was that needle and syringe exchange was only legal for prescribed drugs at public health centers. A Board spokeswoman said, "The law is validated when it's socially accepted. Socially, needle exchange is not accepted, and so it's violating the law. … Millions of Indonesians are poor and have no money for clothes and basic health care, and the NAC wants to give all this money to people who brought the disease onto themselves. The people will say that's not fair."

Because it was not institutionalized within any ministerial bureaucracy, the NAC depended on current political priorities and leadership. Many people worried that if Mboi (who was almost 70) retired, the NAC would be less effective given her strong connections and advocacy. A MOH AIDS program leader said, "Since the leadership of Ibu Naf (Mboi), there has been a lot of progress made, but I'm personally afraid that if she retires and there is no strong leadership to replace her, the success is very vulnerable."

Looking Forward

Starting in July 2009, the 12 priority provinces and 72 districts received Global Fund Round 8 money to further scale up the comprehensive HIV response. Now that the NAC Secretariat was also a Principal Recipient implementing with Global Fund money, some stakeholders expressed concern that it was overstepping the scope of its mandate. Jane Wilson of UNAIDS commented, "It's a classic dilemma. It's a fine line between coordinating, facilitating, and implementing programs. When you have a Secretariat that's staffed by qualified public health professionals, it must be tempting to take on more when you want the best results possible and have limited time before the money will run out."

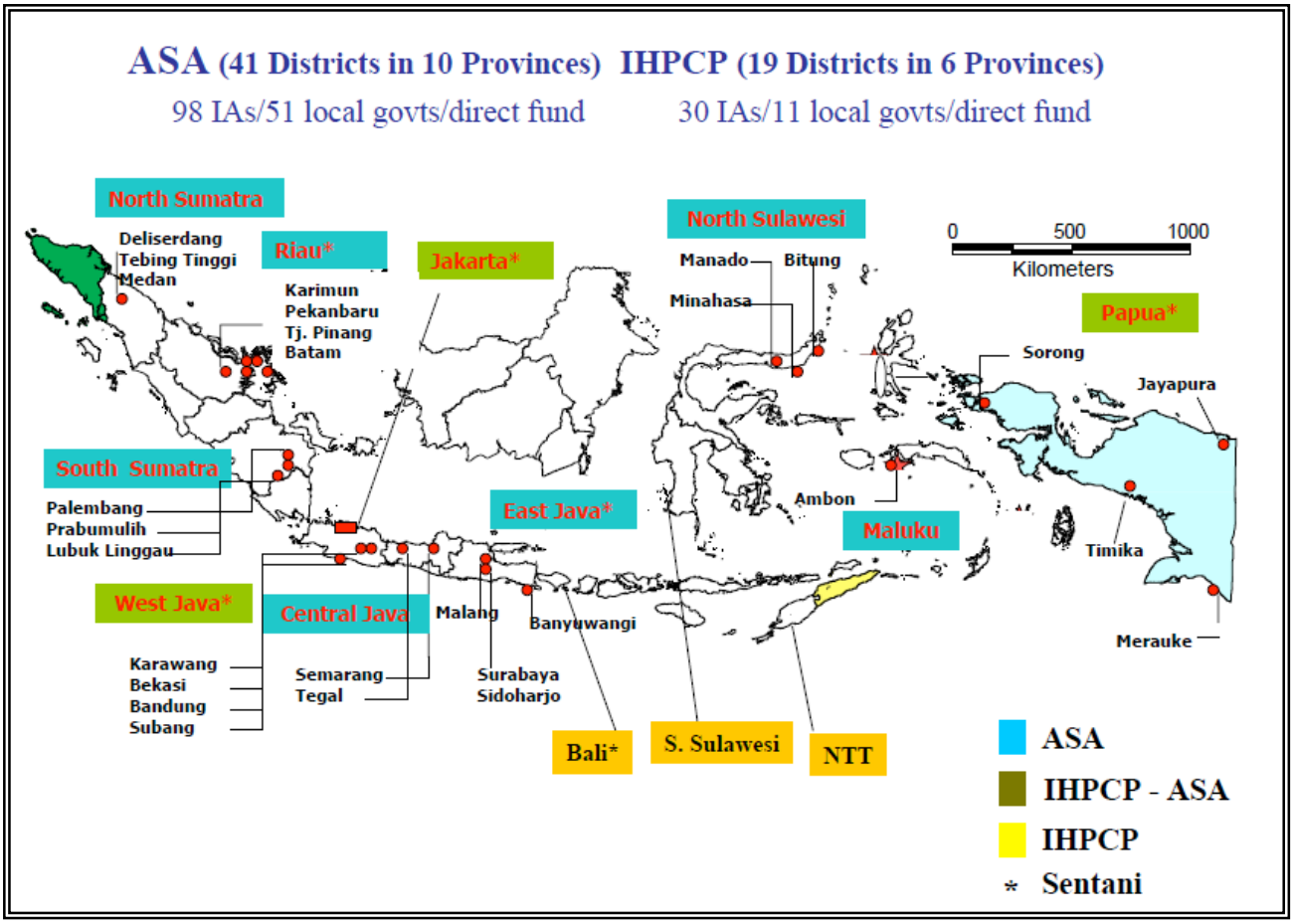
National HIV/AIDS leaders hoped to secure another USD 80 million from the Global Fund Round 9 in 2010 to augment the Round 8 projects. Planned Parenthood leaders chose not to reapply as a Principal Recipient for Round 9, expressing concerns that the project consumed too much managerial time. Few other Indonesian civil society organizations had the national reach and management ability to absorb a Global Fund grant. To replace Planned Parenthood's role in expanded districts, the CCM selected Nahdlatul Ulama, Indonesia's largest Muslim organization that operated 600 community health centers and had experience working with international partners on family planning programs.

Fearing Indonesia may not attain Global Fund awards beyond Round 9, Mboi suggested Round 9 should expand services to all 33 provinces, targeting 137 of the 450 districts. One CCM member disagreed with this approach, noting that controlling the epidemic among high-risk groups in the major hot spots, especially Papua, was most important. Preventing new infections, he said, required higher coverage levels of intense programs. One CCM member commented that spreading the money to all 33 provinces would result in coverage "a mile wide and an inch deep." Citing statistics that young people were increasingly mobile, however, Mboi said this was an opportunity to catalyze a truly national response.

Mboi and other national HIV program leaders had to decide how to best support civil society going forward. USAID, the main financer of NGOs delivering direct services, planned to shift its funding strategy in 2010 to provide more technical assistance to the government and less direct support to NGOs.

While the Secretariat increased its capacity to manage the programs funded by the Global Fund, Mboi and her staff could not afford to stop lobbying other Indonesian ministers to support HIV/AIDS programs. Mboi hoped the National Planning Board would include HIV as a priority issue in the nation's development plan for 2010 to 2014, which greatly influenced budget allocations. Mboi believed such collective, multisectoral efforts and financial commitments were necessary to meet the 2015 national goals of: 1) reaching 80% service coverage to most at-risk populations; 2) establishing highly effective programs that led to 60% reductions in high-risk behaviors; and 3) increasing domestic resources for HIV from 30% to 70%.

Exhibit 1 *Map of Indonesia Showing HIV Program Implementers, 2005*



Source: Indonesia National AIDS Commission.

Exhibit 2 *Top 10 Causes of Death in Indonesia*

	Portion of Deaths
1. Ischemic heart disease	14%
2. Tuberculosis	8%
3. Cerebrovascular disease	8%
4. Respiratory infections	7%
5. Perinatal conditions	5%
6. Chronic obstructive pulmonary disease	5%
7. Road traffic accidents	3%
8. Diabetes	3%
9. Hypertensive heart disease	2%
10. Diarrheal disease	2%

Source: WHO Death and DALY Estimates by Cause, 2002.

Exhibit 3 *HIV Epidemiology in Indonesia*

	1995	2002	2009
Estimated adult (15-49) prevalence	<1%	<1%	0.16%
Estimated number of people living with HIV	52,000	190,000	333,200
Cumulative reported AIDS cases	112	1,171	19,973
Percent of people needing ART receiving it	N/A	N/A	12,000/50,000
Direct female sex workers prevalence[26]	~1%[27]	4.9%	9.4% (N=95,000-107,000)
Indirect sex worker prevalence[26]	N/A	N/A	4.6% ***(N= 85,000-107,000)***
IDU prevalence[28,29]	16%	48%	***43%-56%*** ***(N=219,000)***
Prevalence in *waria* (transgender people)[30]	7.9% (Jakarta)	22% (Jakarta)	***24.4%*** ***(N=28,210)***
Prevalence in MSM	N/A	N/A	***5.2%*** ***(N=385,000-1,150,000)***
Prevalence in populations of Papua and West Papua provinces	N/A	N/A	***2.4%*** ***(N=2.5 million)***

Source: Data compiled by case writers using multiple sources.

Exhibit 4 *Detailed Descriptions of Most At-risk Populations*

Injection Drug Users (IDUs) *Transmission through the sharing of contaminated needles was the primary mode of HIV transmission in Indonesia. The five provinces most affected were the Jakarta metropolitan area, East Java, West Java, North Sumatra, and South Sulawesi. The MOH estimated there were 219,200 IDU in 2006. Hepatitis C prevalence was estimated to be 80% among IDUs. Most IDUs injected heroin, and 90% were men. Half of the IDU population was between ages 15 and 24. Half lived in the four provinces on the central island of Java.*[29,28]

Direct and Indirect Sex Workers Officially, prostitution is illegal in Indonesia, although it was tolerated in many cities. In 2006 it was estimated that Indonesia had between 95,000 and 157,000 direct female sex workers (FSWs) and 85,000 to 107,000 indirect FSWs. Direct FSWs worked in brothels while indirect FSWworked in Karaoke bars and massage parlors. High mobility of the population presented significant challenges for providing prevention services. Reported consistent condom use in 2007 was about 33% among direct brothel-based FSWs and 22% among indirect street-based FSWs. About 25% had been tested for HIV in the previous year.[26] Overall, both indirect and direct FSWs entered commercial sex work reluctantly as a way to earn money for their families, or they were sold or traded into sex work by parents or boyfriends.

Waria *(transgender people)* *There were an estimated 21,000 male-to-female transgender people in Indonesia called* waria *in 2007.* Waria *commonly experienced discrimination, making it harder for them to finish school, find a job, housing, and access to public health services and increasing the necessity for transactional sex. Reported consistent condom use among* waria *in 2007 was 36%.*[31]

Men Who Have Sex with Men (MSM) *Estimates of the number of MSM in Indonesia ranged from 385,000 to 1.1 million. About 5% of MSM surveyed in 2007 were HIV positive. Stigma and discrimination were high and common, forcing the MSM community to hide, although being openly gay in major cities, such as Jakarta, was becoming more common. Reported consistent condom use was 35% with male partners and 20% with female partners.*[32]

Clients of Sex Workers *There were an estimated 3.16 million men who frequented sex workers including truck drivers, sailors, fishermen, dock workers, and taxi drivers. They were identified as a bridge population between the high-risk groups and general population. Generally they did not use condoms consistently and had little knowledge about HIV transmission and effectiveness of condoms for prevention.*[15]

Prisoners *An estimated 120,000 prisoners (96% male) were crowded into spaces meant for half as many prisoners. One-third of detainees were incarcerated for drug-related offences, and about half of those were IDUs. An estimated 20% to 30% of IDUs continued injecting in prison, and at least half reported sexual activity while incarcerated.*[33]

Papua and West Papua *Covered in tropical rain forests and rich with natural resources, these provinces were less developed than other regions of Indonesia. The two provinces were home to 2.4 million people, of which 42% lived on less than USD 1 per day in 2004. The reported AIDS case rate per 100,000 people was 15 times higher in these provinces than the rest of the country (133 versus 8.6). Because the islands were sparsely populated, however, the total number of AIDS cases reported was still low in comparison to densely populated urban areas. Condoms were difficult to obtain in Papua and West Papua. Pharmacies and clinics were the main condom sources, but many people lived far from them.*[11]

Source: Data compiled by case writers using multiple sources.

Exhibit 5 *Descriptions of USAID-funded Programs*

	Year	Budget	Project Implementer(s)	Activities
HIV/AIDS Prevention Program (HAPP)	1995-2000	USD 26 million	Family Health International (FHI)	Established demonstration projects with most-at-risk populations (MARP) in four provinces, focused on strengthening STI/HIV service delivery and education/ behavior change communication, including condom use promotion
Aksi Stop AIDS (ASA) Program: Phase One	2000-2004	USD 35.5 million	FHI	Focused on containing the STI/HIV epidemic in 8 provinces through (1) reduced incidence of STI/HIV in MARP; (2) reduced incidence of STI/HIV/AIDS within the general population of Papua; and (3) supported integrated biological and behavioral surveillance, strengthened capacity for delivery of local governments and NGOs
ASA Program: Phase Two	2005-2009	TOTAL: USD 53.3m USAID: USD 32.2m Partnership Fund: USD 18.6m Global Fund: USD 2.6m	FHI	Same as above, with additional focus on donor harmonization and collaboration – established framework of the Indonesian National Response to HIV/AIDS and utilized combined resources from USAID, the Indonesia Partnership Fund and the Global Fund
Scaling Up for Most-At-Risk Populations (SUM I-II)	2010-2014	USD 35 million	FHI and Research Triangle Institute (RTI) International	Shifted focus on providing technical assistance to national and local government and civil society capacity in technical capacities and organizational performance to increase HIV program effectiveness

Source: Exhibit compiled by case writers from multiple publicly available data sources.

Exhibit 6 *Descriptions of AusAID-funded Projects*

	Year	Budget	Activities
Indonesia HIV/AIDS Prevention and Care Project: Phase One	1995-2001	USD 13.38 million (ER 1995-2001: 0.7AUD = 1USD)	Worked at the national level and in three provinces, focusing on increasing services for high-risk groups
Indonesia HIV/AIDS Prevention and Care Project: Phase Two	2002-2008	USD 30.22 million (ER 2002-2008: 0.7AUD = 1USD)	Expanded to work at national level and six provinces, focusing primarily on increasing services for IDUs
HIV Cooperation Program for Indonesia	2008-2015	USD 40.7 million (ER 2008-2011: 0.9AUD = 1USD)	Refocused on IDUs and prisoners, Papua, West Papua, and Bali and continued to include a major component on leadership at the national and sub-national levels

Source: Exhibit compiled by case writers from multiple publicly available data sources.

Exhibit 7 *Global Fund Country Coordinating Mechanism Members*

2002 CCM Members		**2009 CCM Members**	
Total Members	21	Total Members	26
Private	11 (2 civil society)	Private	10 (4 civil society)
Government of Indonesia	9	Government of Indonesia	10
International Partner	1	International Partners	6

Source: The Global Fund to Fight AIDS, Tuberculosis and Malaria.

Exhibit 8 *Timeline of HIV Events in Indonesia*

Date	Event	Cumulative AIDS cases
1987	First AIDS case identified in Bali tourist.	5
1988	MOH requires HIV case reporting.	7
1992	MOH passes a decree requiring mandatory HIV, syphilis, and Hepatitis B and C testing of all blood donations.	45
1993	USAID launches an HIV prevention program.	69
1994	Presidential decree establishes the National AIDS Commission; several branches were developed in provinces thereafter.	89
1994	First National HIV/AIDS Response Strategy is adopted, establishing guidance for a multisectoral response.	
1995	AusAID launches its HIV prevention program.	112
2002	AusAID launches second phase of IHPCP focused more on harm reduction with IDUs.	1171
2003	Launch of second five-year National HIV/AIDS Response Strategy; Department of Education begins Life Skills HIV prevention in schools; MOH develops national guidelines for HIV care, support, and treatment services; memorandum of understanding (MOU) on harm reduction between NAC and National Narcotics Board.	1,371
2004	"Sentani Commitment" signed by several ministers and governors from the six provinces most seriously affected by HIV, marking a renewed pledge to fight HIV/AIDS; East Java province adopts a local regulation calling for universal precautions for HIV/AIDS prevention; Global Fund Round 1 funding begins; MOH designates 25 hospitals as ART sites and publishes National Guidelines for ART; Department of Manpower and Transmigration launches workplace HIV program.	2,682
2005	Global Fund Round 4 begins; treatment set to expand to 17 provinces, and HIV response in jails and prisons starts; Indonesian Partnership Fund launches with DFID funding.	5321
2006	Presidential decree restructures the National AIDS Commission to expand to include participation from all government sectors; Dr. Mboi becomes the NAC Secretary; National Guidelines for PMTCT are finalized and published; Minister of Health issues a ministerial decree endorsing national guidelines on harm reduction.	6,871
2008	Indonesia receives USD 125 million through Global Fund Round 8.	
2009	AIDS Commissions in 33 provinces and 172 districts and cities, an increase from 100 in 2007.	19,973

Source: Exhibit compiled by case writers from multiple publicly available data sources.

Exhibit 9 *Biography of Dr. Nafsiah Mboi*

NATIONAL AIDS COMMISSION

Nafsiah Mboi, MD, SpA, MPH
Secretary, National AIDS Commission
Republic of Indonesia

Dr Nafsiah Mboi, a Pediatrician and Master of Public Health by training, has studied in Indonesia, Europe and the United States of America. She has been active in the field of HIV and AIDS since its first appearance in Indonesia. She presently serves as Secretary of the National AIDS Commission, a position to which she was appointed by the President of Indonesia in 2006.

Dr Nafsiah has had a lengthy career of public service. For 35 years she was a civil servant with the Ministry of Health. Thereafter she served one term in the Indonesian Parliament. She later joined the World Health Organization as Director of the Department of Gender and Women's Health.

In addition to her professional career, Dr Nafsiah has been active through the years on a voluntary basis having founded and led a succession of community organizations in a range of fields including, family planning, social welfare, women's economic advancement, and rural family welfare. Nationally, she was founding Secretary General of the National Commission on Child Protection; she served as a member of the National Commission on Human Rights; and as Vice Chair of the National Commission on Violence Against Women. Internationally, she has served as chair of the UN Commission on the Rights of the Child and Vice Chair of the Global Commission on Women's Health prior to that. She has been honored for her work both at home and abroad, notably receiving the Roman Magsaysay Award for Government Service in 1986.

Concerns for gender issues and promotion of government-community partnership have been abiding interests throughout her career.

Dr Nafsiah is married. She and her husband have 3 children and 5 grand children.

Source: Indonesian National AIDS Commission.

Exhibit 10 *Indonesian Partnership Fund Distribution, 2005-2008*

Funding Recipient	Total Amount (USD)	Portion
AIDS Commissions	7,907,060	17%
FHI (USAID)	19,448,977	41%
Indonesia HIV/AIDS Prevention and Care Project (AusAID)	8,079,690	17%
UN agencies	7,811,770	17%
DKT Condoms	999,900	2%
Administrative overhead	2,833,582	6%
Total	47,080,979	100%

Source: Indonesian National AIDS Commission.

Exhibit 11 *WHO Components for Comprehensive Harm Reduction Programs*

1. Outreach
2. Information, education, and communication
3. Risk reduction counseling
4. HIV testing and counseling
5. Disinfection programs
6. Needle and syringe programs
7. Disposing of used injecting equipment
8. Availability of drug treatment services
9. Drug substitution treatment
10. HIV/AIDS treatment and care
11. Primary health care
12. Peer education

Source: WHO Policy and Programming Guide for HIV/AIDS Prevention and Care among Injecting Drug Users, 2005.

Exhibit 12 *The NAC's Statutory Responsibilities*

1. To issue national policies, strategic plans, and guidelines for the prevention and combating of AIDS.
2. To determine the strategic measures that need to be taken as part of the HIV and AIDS prevention effort.
3. To coordinate the implementation of AIDS outreach, prevention, service, monitoring, and control activities.
4. To disseminate information on AIDS to the media for the purpose of encouraging the dissemination of accurate information to the public and the avoiding of sensationalism that could give rise to public unease.
5. To engage in regional and international cooperation in the context of the AIDS prevention effort.
6. To coordinate data and information management in connection with AIDS.
7. To control, monitor, and evaluate the implementation of the AIDS prevention and control effort.
8. To provide directions and guidelines to the AIDS Commission at the provincial and regency/municipal levels as part of the AIDS prevention and control effort.

Source: Indonesian National AIDS Commission.

Exhibit 13 *HIV/AIDS Spending by Category and International Donors, 2006-2008*

	2006		2007		2008	
	Total (USD)	Percent from donors	Total (USD)	Percent from donors	Total (USD)	Percent from donors
Prevention	23,179,628	78%	24,303,368	88%	24,703,080	61%
Care and Treatment	14,073,522	99%	9,242,355	92%	7,324,721	23%
Orphans and Vulnerable Children	45,849	100%	-	-	31,574	59%
Program Mgmt. and Admin. Strengthening	12,161,368	26%	20,094,700	47%	10,306,896	70%
Incentives for Human Resources	4,562,592	93%	1,867,288	72%	4,461,580	95%
Social Services	27,173	0%	202,065	84%	18,300	1%
Creating Enabling Environments	2,413,420	79%	2,336,534	84%	2,360,528	49%
Research (not for operations)	113,031	65%	374,023	98%	356,604	93%
Total	56,576,583	73%	58,420,333	77%	49,563,283	60%

Source: Compiled from 2010 UN General Assembly Special Session on HIV/AIDS Report and National AIDS Spending Assessment 2006-2007.

Exhibit 14 *HIV/AIDS Spending by National Ministry, 2003-2008*

	2001*	2003	2004	2006	2007	2008
Health/ Red Cross	96.0%	82.7%	86.3%	95.17%	75.8%	64.0%
National Family Planning Board	0.5%	0.8%	0.5%	0.14%	15.5%	21.87%
Coordinating Ministry for People's Welfare	-	0.1%	0.9%	-	2.45%	9.04%
Education	0.7%	13.0%	9.2%	0.88%	0.9%	3.26%
Social Welfare	-	0.8%	0.8%	1.43%	1.5%	1.65%
Transportation		0.1%	0.1%	0.20%	0.15%	1.11%
Internal Affairs	0.2%	0.3%	0.2%	0.2%	0.78%	0.46%
Defense/Armed Forces	0.2%	1.2%	0.4%	1.23%	2.2%	0.28%
Labor	-	-	-	0.1%	0.1%	0.07%
Women's Empowerment	0.2%	0.1%	0.2%	0.15%	0.4%	0.01%
Religious Affairs	0.4%	1.7%	1.1%	-	-	-
Law & Human Rights	-	-	-	0.07%	0.31%	-
Total (USD in millions, % of total HIV Spending)	**2.7** 29%	**4.7** 20%	**9.6** 27%	**13.2** 26%	**13.3** 26%	**17.0** 32%

Source: Compiled from UN General Assembly Special Session on HIV/AIDS reports, 2004-2010.

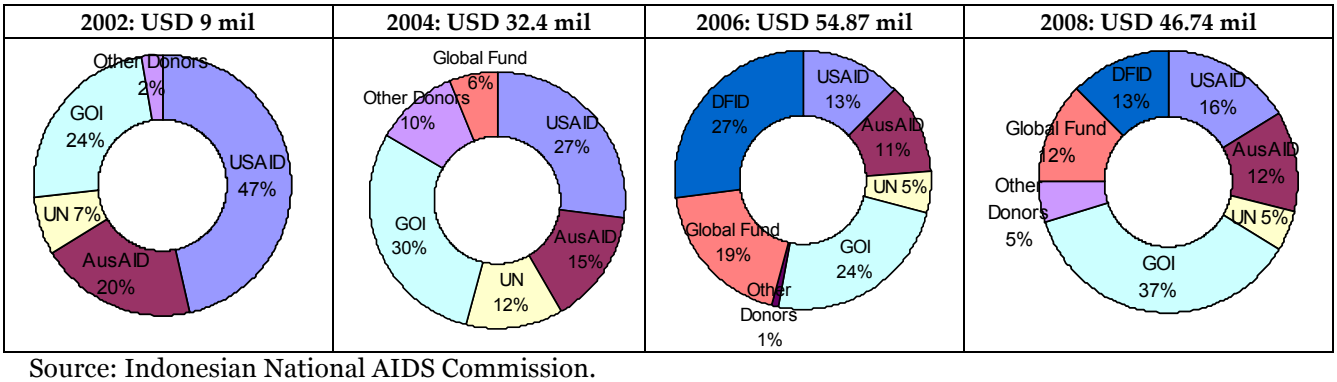
*Percents may not total 100% due to rounding.

Exhibit 15a *International Funding for HIV/AIDS in Indonesia, 2001-2008*

	2001	2002	2003	2004	2005	2006	2007	2008	Total
USAID	2,462,343	6,340,441	8,300,000	8,800,000	9,000,000	7,084,881	9,234,395	7,710,100	60,232,160
AusAID	2,700,000	2,700,000	4,.800,000	4,760,000	4,760,000	6,013,785	9,639,336	5,706,267	41,039,388
Germany (KFW)	440,138	330,159	3,000,000	3,000,000	3,500,000	167,499	65,514	295,290	8,798,600
U.K. (DFID)	-	-	-	-	8,603,670	14,859,921	14,542,239	5,880,900	43,886,730
Other Bilaterals	-	-	-	391,657	260,000	199,472	92906	560,739	1,779,606
UN Agencies	500,000	1,000,000	1,500,000	3,915,675	-	2,897,137	5,400,313	2,241,962	17,896,160
Global Fund	-	-	2,500,000	2,000,000	12,000,000	10,464,951	3,656,642	5,818,972	36,040,565
Other Multilaterals	-	-	-	-	-	-	623,128	1,503,787	2,126,915
International Subtotal	6,102,481 (67%)	10,370,600 (75%)	16,959,024 (75%)	22,867,332 (73%)	38,123,670 (77%)	41,687,646 (74%)	43,254,473 (74%)	29,718,017 (68%)	209,083,243 (73%)
Government SubTotal	2,953,127	3,244,970	5,678,899	9,600,000	11,500,000	13,179,462	13,292,688	17,025,871	76,475,735
Total	9,056,326	13,615,570	22,637,923	32,467,332	49,623,670	54,867,108	56,547,161	46,743,888	285,558,978

Source: Indonesian National AIDS Commission.

Exhibit 15b *International Funding for HIV/AIDS in Indonesia, 2001-2008*



Source: Indonesian National AIDS Commission.

Exhibit 16 *Summary of Indonesia's Global Fund Proposals for Rounds 1, 4, and 8*

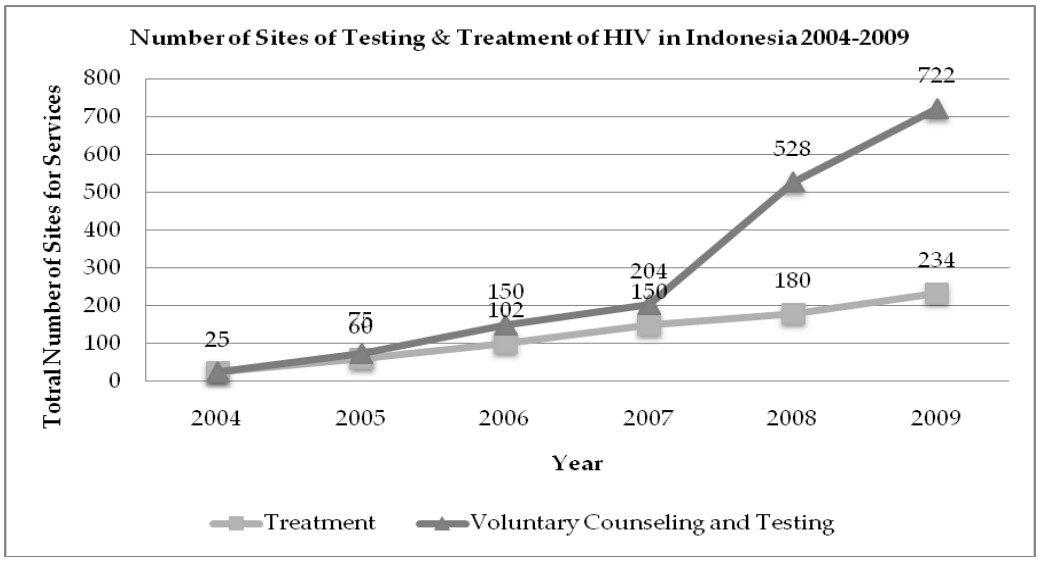
Round	Principal Recipient	Budget (USD)	Dates	Location	Summary of Activities
1	MOH	15.96 million (allocated) 5.5 million (disbursed)	July 2003-June 2007	4 provinces	♦ Improve care, support, and treatment for people living with HIV ♦ Improve program capacity at national and local levels ♦ Improve surveillance and M&E systems ♦ Develop information, education, and communication materials for high-risk groups, including youth, sex workers and their clients, and IDUs
4	MOH	43.45 million (allocated)	April 2005-March 2010	17 provinces	♦ Expand care, support, and treatment for people living with HIV ♦ Prevent HIV transmission in high risk groups, including sex workers, IDUs, and *waria* ♦ Prevent HIV infection among vulnerable men through workplace education programs in targeted industries
8	1. MOH 2. NAC 3. Planned Parenthood	125 million (allocated)	July 2009-June 2014	72 districts in 12 provinces	♦ MOH responsible for treatment-related activities, including ART, VCT, and methadone ♦ The NAC responsible for distribution of condoms, needles, and strategic information ♦ Planned Parenthood responsible for outreach and behavior change communication to groups most at risk

Source: Compiled from Global Fund documents available at http://www.theglobalfund.org/.

Exhibit 17a *Harm Reduction Services Scale Up*

Source: Indonesian National AIDS Commission.

Exhibit 17b *Scale up of VCT and ART Services*



Source: Indonesian National AIDS Commission.

Exhibit 18 *Estimated Program Coverage Rates in 2009*

	2004	2007
Direct Sex Workers (N = 95,000 - 157,000)		
% tested for HIV	15	33
% reached by prevention programs	18	68
% reporting condom use at last sex	55	66
Injecting Drug Users (N = 219,000)		
% receiving clean needles and syringes in the last week	-	33 - 98
% tested for HIV	18.1	30
% reached by prevention programs	5.6	36
% reporting condom use at last sex	18.5	34
Men Who Have Sex with Men (N = 384,320 - 1,150,000)		
% tested for HIV	15.4	23 - 57
% reached by prevention programs	1.9	58
% reporting condom use at last sex	56.5	39
***Waria* (transgender)** (N = 21,000 – 35,300)		
% tested for HIV	-	17
% reached by prevention programs	20	50 - 89
% reporting condom use at last sex	47.5	79

Source: Data compiled from the Country Report on the Follow-up to the Declaration of Commitment on HIV/AIDS (UN General Assembly Special Session on HIV/AIDS) (2004-2005) and Republic of Indonesia Country Report on the Follow-up to the Declaration of Commitment on HIV/AIDS (UN General Assembly Special Session on HIV/AIDS) Reporting Period 2008 – 2009.

Appendix A *Useful Abbreviations*

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
AusAID	Australian Agency for International Development
CCM	Country Coordinating Mechanism
DFID	United Kingdom's Department for International Development)
DOTS	directly observed treatment short course
DTP3	third dose of diphtheria toxoid, tetanus toxoid, and pertussis vaccine
GDP	gross domestic product
HIV	human immunodeficiency virus
IDU	**injecting drug users**
M&E	**monitoring and evaluation**
MOH	**Ministry of Health**
MSM	men who have sex with men
NAC	National AIDS Commission
NGO	non-governmental organization
PMTCT	prevention of mother-to-child HIV transmission
PPP	purchasing power parity
STI	sexually transmitted infection
TB	tuberculosis
UN	United Nations
US	United States
USAID	United States Agency for International Development
USD	United States' dollars
VCT	voluntary counseling and testing
WHO	World Health Organization

Appendix B *Overview of The Global Fund to Fight AIDS, Tuberculosis and Malaria*

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a public-private partnership and international financing institution that attracts and disburses funding to prevent and treat HIV/AIDS, TB, and malaria. The Global Fund Board and its specialized committees govern the organization; the Board includes members from donor and recipient country governments, non-governmental organizations, the private sector, and people affected by HIV, TB, and malaria. Donations from the Group of Eight (G8) countries finance the Global Fund, with the United States being the largest donor. The Geneva-based Secretariat manages daily Global Fund operations such as fundraising, grant management, and administrative support. Regionally-focused Fund Portfolio Managers based in Geneva liaise with various stakeholders in the recipient countries, including the Country Coordinating Mechanism (CCM), Principal Recipient(s) and Sub-Recipients, and a Local Fund Agent.

The Global Fund's model is based on the concepts of country ownership and performance-based funding. People in countries implement their own programs based on their priorities, and the Global Fund provides financing on the condition that verifiable results or targets agreed upon when a grant agreement is signed are achieved. The performance-based financing system holds recipient countries to high standards of accountability. Global Fund grants typically last five years and are disbursed in two phases: Phase 1 and Phase 2. Phase 1 is a two-year period, and Phase 2 typically lasts three years. The initiation of Phase 2 funding is contingent upon the country's demonstrated ability to manage its Phase 1 funding and achieve its proposal objectives. Over the course of each phase, funds usually are disbursed every three to six months.

Country Coordinating Mechanism

The Global Fund encourages countries to establish a multisectoral Country Coordinating Mechanism to prepare and submit funding proposals, identify grant recipients, and oversee the implementation of grant-financed programs. CCMs are independent entities, but they must meet a number of Global Fund requirements before submitting applications. The CCM is intended to encourage collaboration between the government, the private sector, multilateral and bilateral agencies, academic institutions, civil society, and people living with HIV/AIDS, TB, and malaria while ensuring local ownership and participatory decision making. The CCM meets regularly to vote on key decisions. The CCM's primary responsibilities include coordinating proposal development, nominating the Principal Recipient for each grant, overseeing grant implementation, approving any adjustments to the grant, and ensuring effective linkages between the Global Fund-supported programs and broader national health programs.

Principal Recipient and Sub-Recipient(s)

The CCM nominates one or multiple Principal Recipients to receive Global Fund funding directly and manage the implementation of Global Fund grants. The Principal Recipients then uses the funding to implement prevention, care, and treatment programs or passes it on to other organizations (Sub-Recipients) who provide those services. Principal Recipients and Sub-Recipients can be government departments and civil society organizations. Depending on the country, the CCM and/or the Principal Recipient select the Sub-Recipients. The Principal Recipient creates a work plan and budget based on the grant proposal and signs the final legal contract (Grant Agreement) with the Global Fund. The Grant Agreement includes the program description, budget summary, and a list of performance indicators and targets. These indicators and targets allow the Global Fund to assess performance for multiple reporting periods throughout the grant's lifetime. The Principal Recipient oversees the sub-recipients' activities and submits program updates and disbursement requests to the Local Fund Agent every three to six months.

Local Fund Agent

The Global Fund's performance-based funding system requires close monitoring of grant performance. Because the Global Fund does not have in-country offices, it hires Local Fund Agents to be in-country monitors that assess the Principal Recipient's capacity to implement grants, track and verify recipients' performance reports, and communicate regularly with the Global Fund Portfolio Manager in Geneva. The Local Fund Agent, however, cannot act as an agent of the Global Fund and is therefore not permitted to represent the Global Fund's views or make decisions concerning grants.

Appendix C *Building an HIV Response in Malang, East Java: local implementation of the national response*

Starting in 2002, the USAID-funded organization Family Health International (FHI) began organizing local AIDS commissions in priority provinces. In the Malang district of East Java, FHI paid the salary of health department worker Adi Purwanto to coordinate local efforts around HIV. In 2002 the groups most at risk for HIV – sex workers, MSM, and IDU – were largely invisible. Most local politicians refused to acknowledge them. FHI provided the local AIDS Commission financial and technical support to plan and execute a five-year strategic plan. Over time, departments outside of health became involved. The social welfare office developed a job creation program for people living with HIV, and the labor department created an HIV education program for factory workers. In 2007, with funding from the NAC, Purwanto moved the Malang District AIDS Commission out of the local health department and hired a small staff. The mayor chaired the AIDS commission and visited a brothel complex to meet with the HIV prevention working group. "The mindset of the local leaders has changed," Purwanto said.

FHI also provided critical financial and technical support to several nascent NGOs in Malang, such as Paramitra, which supported and empowered female sex workers. In six brothel complexes, Paramitra started HIV prevention working groups that included prostitutes, pimps, madams, and police. Paramitra's outreach workers also gave the sex workers condoms and transported them to health services. Paramitra's target groups worked together to form a larger advocacy network, and Paramitra trained them to talk to local politicians about their needs. They succeeded in suppressing a movement to shut down the brothels by convincing lawmakers that sex workers, most of whom were mothers, had no other income source and would continue selling sex on the streets, where it was more difficult to provide HIV prevention services. A year later, the Malang Parliament adopted a regulation in 2008 requiring 100% condom use. This helped sex workers enforce condom use without worrying about losing business to competition. With Paramitra's help, the sex workers negotiated a 50% discount from the condom maker, Sutra, and sold the condoms at full price to clients in the brothel parking lot. The profits funded the sex workers' quarterly advocacy planning meetings.

Enabling sex workers to continue their advocacy efforts and keep the advocacy network active independently of the organization was part of Paramitra's exit strategy. Paramitra had to stop working with the network in 2009 because USAID was scaling back its NGO funding. Paramitra would become a Global Fund Sub-Recipient responsible for local outreach and behavior change programs. Paramitra's annual budget would double to USD 160,000, but its geographic and population responsibilities would quadruple. To meet the Global Fund target of 12,000 annual encounters with high-risk people, Paramitra staff had to stop providing intensive capacity building services and instead reach 30 new high-risk people per month without repeated visits. NGO staff worried that program quality and results would suffer.

By 2009 the Malang District AIDS Commission was receiving visits from members of AIDS commissions from across the country interested in learning how to replicate its progress. Representatives from the IDU, sex worker, and MSM communities were included in the AIDS Commission and met regularly with district leaders to plan and deliver HIV services. Starting in 2010, the local government would fund the AIDS Commission's entire budget, doubling it in the process. Paramitra's executive director explained the local success, "The government and NGOs have established good relationships here. And the NGOs work together to give the right information at the right time, so we have a uniform message. We aren't competitive, and that is the difference between us and the big cities where NGOs fight for money."

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