This report is supported by:

GESTOS, LACCASO, The Ford Foundation, HIVOS.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>B</td>
<td>OBJECTIVES OF THE REPORT</td>
<td>3</td>
</tr>
<tr>
<td>C</td>
<td>METHODOLOGY</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>C.1. Assessment sites and data collectors</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>C.2. Informants and data collection</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>C.3. Data analysis</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>C.4. Ethical clearance</td>
<td>5</td>
</tr>
<tr>
<td>D</td>
<td>RESULTS</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>D.1. UNGASS INDICATORS 1 &amp; 2: GOVERNMENT LEADERSHIP – SPENDING AND HIV POLICIES</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>D.2. UNGASS INDICATOR 4: HIV TREATMENT (ANTIRETROVIRAL THERAPY)</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>D.3. UNGASS INDICATOR 5: PMTCT</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>D.4. UNGASS INDICATOR 7 &amp; 8: HIV TESTING (GENERAL AND MARP)</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>D.5. UNGASS INDICATOR 9: PREVENTION PROGRAM AMONG MARP</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>D.6. UNGASS INDICATOR 10: SUPPORT FOR CHILDREN AFFECTED BY HIV AND AIDS</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>D.7. UNGASS INDICATOR 11: LIFE-SKILLS BASED HIV EDUCATION IN SCHOOLS</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>D.8. UNGASS INDICATOR 12-21: KNOWLEDGE AND BEHAVIOR OF MARP</td>
<td>22</td>
</tr>
<tr>
<td>E</td>
<td>BIBLIOGRAPHY</td>
<td>24</td>
</tr>
<tr>
<td>F</td>
<td>ATTACHMENTS</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>ETHICAL CLEARANCE</td>
<td>26</td>
</tr>
</tbody>
</table>
FOREWORD AND ACKNOWLEDGEMENT

“For there to be any hope of success in the fight against HIV/AIDS, the world must join together in a great global alliance.

Kofi Annan, Foreword – Declaration of Commitment (June, 2001)

When we enter the 3rd decade of our fight against AIDS global epidemic, it is obvious - even though that technology has evolved and progressed; ARV drugs became available in countries we never imagined will be able to provide the drugs; and government & community groups succeeded in opening few doors that never been opened before – however, we know that we still have many work to do ahead of us. A work that can never be done alone.

We realized that more leaders are needed from both sides – government and community groups. Leaders who are not only know how to stand up & talk, but also to sit & listen. And most importantly, leaders who know how to work together with their constituents, and with other leaders. Through Indonesian UNGASS Forum, we are trying to pursue the idea of collaboration between national networks & organizations that are solely based on our willingness & commitment, to work together against one of the worst epidemic the world ever suffer from: AIDS. And if the world ever taught us anything on “ideas”, is that it will never be perfect when we bring it into the reality. However, the pursuit of that idea is what keeps the Indonesian UNGASS Forum running in its path.

Through Indonesian UNGASS Forum, we are fulfilling one of our basic roles as civil society-based movement: a watchdog. However, we realized that we’re not supposed to be only watching the progress of our government or other external parties, however we are also using the chance to reflect on our progress as civil society movement. Although we found many progresses that have been done by governments, bi-multilateral agencies and community groups, we also found many significant room-for-improvements that, again, can only be improved if we find a way to work in an alliance.

Indonesian UNGASS Forum would like to thank all parties that have been joining hands in raising the forum, including National AIDS Commission for their partnership and HIVOS for their support. However, Indonesian UNGASS Forum would like to express our deepest gratitude to GESTOS, LACCASO and Ford Foundation, in particular, for their endless support to the forum.

For a better world,

Indonesian UNGASS AIDS Forum

A. INTRODUCTION

Strengthening Civil Society Organization is a crucial task by the state and other stakeholders in strengthening national response to HIV/AIDS. One can not deny that CSO has been involved in the national response against HIV and AIDS since early on when the government was not even ready to deal with stigma and discrimination that goes along with the progression of the epidemic.

Since 2007 a coalition of civil society representative have been working very hard to capture possible elements in the national response to HIV and AIDS that may be missed in the national reporting mechanism to UNAIDS due to the way indicators are formulated. In 2008, they now called Indonesian UNGASS AIDS forum submitted its’ first independent report to UNAIDS.

In 2009, the forum continues the process with more members and hosted by JOTHI (Indonesia PLHIV Network). Currently Indonesian UNGASS Forum has 18 members CSO, which pervade five national networks of NGOs of HIV affected communities and 13 HIV Related NGOs. In the 2010 reporting period, it is committed again to contribute to the UNGASS 2010 reporting by composing a shadow report which highlights qualitative aspects of UNGASS indicators otherwise may not be included in the state report. To do that, the coalition did a field study in six cities, conducted in-depth interviews with important stakeholders and reviewing secondary data. Results are used in this report to highlights our analysis of related indicators. Since this report is based on our field study funded by GESTOS, LACASSO, Ford Foundation and HIVOS to assess the situation of gender and human rights monitoring related to violence against women, sexual and reproductive health issues, and HIV and AIDS – not all UNGASS indicators are relevant to this report.

B. OBJECTIVES OF THE REPORT

The objectives of the present assessment are the following:

1. To understand how are issues of human rights are addressed, implemented, and monitored in relation to HIV and AIDS prevention.
2. To highlight how issues related to children, youths, and women are addressed in the current response to HIV and AIDS.
3. To understand the qualitative nature of experiences in dealing with accessing or utilizing HIV and AIDS related services and prevention programs.
4. To understand issues of leaderships among government institutions, development partners, and civil society organization in the implementation of the National Strategy to deal with the HIV and AIDS epidemic.

C. METHODOLOGY

C.1. Assessment sites and data collectors

This assessment covered six cities: Aceh, Jakarta, Jogyakarta, Samarinda, Manado and Jayapura (see Figure 1). These locations were based on reported prevalence of HIV
Indonesian UNGASS - AIDS (Depkes RI – 2009). Data were collected from September – December 2009. Members of the UNGASS Forum and members of local NGOs were invited to participate in data collection. They were trained to use the assessment instruments and to collect secondary data from relevant institutions.

C.2. Informants and Data collection

Our informants were voluntary recruited through local NGOs, except for those representing sectoral government institutions, National AIDS Commission, and Human Rights Bodies, and development partners in Jakarta. See Table 1 (attached) for description.

Figure 1: Map of research sites

In Focus Group Discussion, 165 informants participated representing key populations (39), female sex workers (39), female IDU sex partners (37), youths (43), HIV related NGOs (7). Our exit interviews were able to engaged 13 clients. In-depth interviews were conducted to 28 individuals working for various organizations related to HIV and AIFDS (see table 1)

Secondary data informations were obtained through NAC, The Women Rights Commission, Human Rights Commission, and The National Commission of Child Protection. We also obtained data from development partners, especially UNAIDS, FHI-ASA, and HCPI.
Table 1: Informants

<table>
<thead>
<tr>
<th>Informants</th>
<th>FGD</th>
<th>In-depth Interviews</th>
<th>Exit interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Key Population</td>
<td>- Key Population(^1)</td>
<td>Provincial/Cities:</td>
<td>Patients of HIV relevant services in Hospitals or Community Health centers</td>
</tr>
<tr>
<td>- Female Sex Workers</td>
<td>- Female Sex Workers</td>
<td>Office of MoH AIDS Commission</td>
<td></td>
</tr>
<tr>
<td>- Sexual Partners of IDUs</td>
<td>- Sexual Partners of IDUs</td>
<td>Senior High School principals (state)</td>
<td></td>
</tr>
<tr>
<td>- Youths</td>
<td>- Youths</td>
<td>National:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>NAC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>KPAI (Child protection)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Human Rights Commission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Women’s Rights Commission</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>HCPI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>FHI</td>
<td></td>
</tr>
</tbody>
</table>

| Number of informants                          | 6 – 8 informants per group | 1 informants                          | 1 – 3 informants |
| Sex                                            | Proportional               | -                                    | -                |

| AIDS related experiences                       | Have been accessing HIV/AIDS related services | Development Partners: at least 3 years managing HIV/AIDS programs | Exiting on going services |
| Age                                            | Youths 15 – 24 years old           | -                                    | -                |

C.5. Analysis of data

As indicate in the objectives of the study and methodology, most of the data and information that we collected are qualitative in nature. In the analysis we are interested to look at categories of common experiences and opinions with regards to the current HIV intervention and programming. This analysis will be linked to our analysis of available secondary data and information.

C. 4. Ethical Clearance

Ethical clearance was process and obtained through the Ethical Committee of Atma Jaya Catholic University (See letter no 827/LPPM-KE/12/2009 – attached). All informants from key populations, youths, female sex workers, and female partner of IDUs were asked to sign the informed consent after receiving information on this assessment. Confidentiality issues are treated seriously in this assessment.

---

\(^1\) Member of key populations: Gay, transvestite, lesbian, Drugs user, HIV positive people and Sex Worker.
D. RESULTS

The following descriptions of our results are categorized into UNGASS Core Indicators (Guideline of UNGASS on AIDS 2010 Reporting). Not all indicators were relevant for this report. Only those addressed in our assessment are included. As indicated earlier, we are more interested to look into the qualitative nature or the subjective experiences rather than in the quantitative aspects (scope, coverage, magnitude) of these indicators.

D.1. UNGASS INDICATORS 1 & 2: GOVERNMENT LEADERSHIP – SPENDING AND HIV POLICIES

D.1.a. Government Leadership

Since the implementation of the National Strategy 2007-2010, the new leadership in the NAC has been able to mobilize resources from local, national, and international stakeholders – including the Global Fund. We highly appreciate government commitment to support HIV and AIDS prevention, care, treatment. Funding for HIV and AIDS has been increasing significantly from 2006 to 2010. In fact, domestic funding already exceeded foreign funding in 2008/9. In his opening address, President Bambang Yudhoyono indicated that:

“The Indonesian Government has also significantly increased its domestic resource allocation for AIDS. Between 2006 to 2009, the budget allocated for AIDS rose 7 times, from US$ 11 million to US$ 73 million. The provincial and district budgets also increased around 350 %, from Rp 20 billion to Rp 74 billion.”

In addition to that, NAC has been able to provide real opportunities and space for representatives of HIV affected communities to participate in the formulation and decision making on AIDS related policies and programs. The president applauded such inclusive policy and indicated that he will sustain constructive leadership and continue to advocate for the following:

“... a comprehensive, compassionate and inclusive approach.”

This report also appreciates the concerted effort to synergize between the National Strategy 2010-2014 with the Medium-range National Development Plan (RPJMN 2010-2014. This means that the national strategy is adopted and committed by all sectoral ministries and will be implemented accordingly.

We also like to note that since 2005 the government has launched a subsidized state health insurance (JAMKESMAS) that may be accessed by PLWHIV. In fact, the newly enacted Law No. 36/ 2009 on Health contains a mandate to the central government to provide 5% of national budget and to provincial government to provide 10% of its budget to finance health services including the JAMKESMAS.

---


2 Ibid.
This report also likes to appreciate increasing transparency in government budgeting for HIV and AIDS. We acknowledge that it is relatively easy to find information on budgeting and program implementation issues within NAC.

It is acknowledged that the leadership at NAC has been able to pull important stakeholders together toward submitting successful proposal of Global Fund round 8 and 9. For the next five years Global Fund will play an important role in the national response to HIV and AIDS.

This report, however, takes the following notes:

1. It is difficult to obtain information on budgeting and program implementation in sectoral ministries (departments). While NAC, as the coordinator and a multi-sectoral agency, has committed its investment to low-cost, high-impacts programs which inevitably focused on most at risk population, other less at risk population should be addressed by sectoral programs. CSO has very little knowledge on what have been developed, implemented, and what are the impacts of sectoral HIV and AIDS related program. It seems that the coordinating mechanism at NAC has not been able to enforce transparency among sectoral agencies. One consequences of such loose coordination is the unchecked practices by migrant workers agencies that enforce mandatory testing as noted below.

2. Based on NASA (National AIDS Spending Assessment 2008)\(^4\) total HIV and AIDS expenditure in 2008 was USD 50,831,105 of which 60.97% (USD 30,989,683) was financed by international sources and 39.03% (USD 19,841,422) by the domestic/public sector (central and local government). Almost half of the HIV and AIDS expenditures was committed for prevention (47.5%), while program management spending and human resources incentives reached 29.06% and care and treatment spending was 14.41% meanwhile for OVC and social protection still remain low. There was no adequate data to know the absorption of government. The Global Fund was the largest sources of funding from multilateral source in Indonesia during 2008 while no adequate data to shows role of national private sector.

3. Available report on budgeting by local government is not aggregated by province and amount of contribution. In addition to that, it is important to know how the local government budget is invested. There is an indication that HIV and AIDS strategic plan in sectoral ministries may not receive adequate commitment from provincial/municipal, or district authorities.\(^5\) According to the Law No. 32 year 2004 on regional autonomy, provincial and district authorities may have their own development priorities. Aggregated budgetary information is needed for community advocacy at provincial/municipal/district level.

---

\(^4\) NAC (2008), National AIDS Spending Assessment.

4. Administrative and technical issues in accessing JAMKESMAS often prevent PLHIV from utilizing this scheme. Our field study found the following example:

“...not worth it... I had to go to the hospital anyway... the Hospital said no room available. I had to pay too and had to sign this and that for transvestite like me who do not have ID.. it is difficult... I would have died if I should follow all the procedures.” (FGD – key population, Jakarta)

“.... Only in this Hospital I can use JAMKESMAS and JAMKESDA... This hospital can help us fill all administrative requirements for the insurance...” (Exit Interview – HIV client - Jogja)

“...If I used government insurance, more often the doctor will give us prescription of drugs which are not supported by JAMKESMAS because the supported drugs were not available.. so we have to pay anyway....” (FGD key-population, Jakarta)

5. With reference to the implementation of Global Fund round 8, our limited observation suggests that decision making in CCM is lacking of transparency, especially with regard to the selection of PRs and implementing agencies. Although CSO was represented in the 2007-2009 CCM, CSO constituents outside of CCM did not receive much information from and opportunities to provide feedbacks to CCM. In addition to that, all information related to CCM is available in the English language. Although CCM now has a secretariat, it has not been able to set up a mechanism that ensures transparency and accountability to the public.

D.1.b. The Role of Development Partners

The role of development partners is undeniably very important in shaping up our national response to HIV and AIDS. They have been instrumental in providing technical assistance for capacity building, program implementation, as well as in developing enabling policy environment for effective intervention. Currently we see more concerted efforts by development partners to synchronize their assistance with the national strategy. In fact, many HIV and AIDS programs are embedded within existing government health infrastructures. Since 2006, all development partners’ initiatives have been coordinated by NAC according to the Three-ones principles on framework, coordination, and M&E. At the initial stage of our national response to HIV and AIDS, the development partners was able to bring representatives of vulnerable and affected communities to have salient position in policy making and program development. Since Indonesia is now considered as a middle income country, the country will received less International and bilateral support for its national development programs.

6 CCM II Advocacy Project Report “Enggaging CS Representative in CCM Global Fund Indonesia”, (Irwanto et al., 2010).
This report, therefore, likes to take the following notes:

1. We observe lack of in-depth and serious negotiation on exit strategy between developing partners and the government of Indonesia to sustain community based responses to HIV and AIDS supported by developing partners. The phasing out of ASA-FHI, for example, has reduced the number of NGOs from 135 to only 25 NGOs as of March 2010 that are partially supported by ASA and other developing partners. The rest of them had to find their own resources to sustain their activities. Sustaining less than a quarter of years of capacity building and services to the community is unacceptable. We would expect that in such circumstances the local government (KPAD) and Global Fund would naturally take them over. But it did not happen. If many of them would eventually close their operation or services, this would be a great loss to the community and a waste of years of investment.

2. This outcome reflects unwillingness, non-readiness, or simply lack of appreciation of any initiatives outside of government infrastructures. People forget that before the government started to provide services to PLHIV and the community, those small NGOs have been there doing outreach, providing information, and making a difference. Many of them could not sustain their activities afterwards, because they were conditioned to be donor dependent.

D.1.c. The Role of CSO and CSO Leadership

The community is always the first element in our society to respond to challenges or problems affecting or compromising the well being of its members. Since the official acknowledgement that Indonesia had been affected by HIV, a number of individuals in Bali, Surabaya, and Jakarta took the initiative to mobilize resources to meet the challenge. A number of NGOs were established and when Indonesia accepts international assistance to deal with the problem, the number of NGOs grew significantly to capture the opportunities. As HIV and AIDS is an epidemic saturated with stigma and discrimination, the government infrastructures – including hospitals – was quite resistant to accept or initiate HIV related programs.

Therefore, it is natural that the civil society took the leadership to fight the epidemic along with its stigma and discrimination. It is also natural, therefore, that when developing partners are looking for partnership, they found mostly NGOs that see the opportunities. Only after political reforms and strong rights based movement in 1998 and afterwards, government infrastructures are more open for civil society participation. NAC was established in 1994 through a Presidential Decree No. 36 as a multisectoral body to coordinate national response to HIV and AIDS. This body remained a purely state institution until the second National Strategy 2003-2007 was launched when GIPA principles was adopted. More dynamic partnership between government institutions, developing partners, and the civil society occurred only recently when NAC received its renewed mandate in 2006.

7 Interview with FHI representative date: December 15, 2009.
Aside from older national NGOs such as PKBI, Spiritia and YPI, currently we have six (6) networks of HIV affected communities: Jangkar, IPPI, GWL-Ina, PKNI, JOTHI and OPSI. These network represent hundreds of community based activities across the nation. Although, we witness a lot of progress in the CSO movement, this report takes the following notes:

1. Most of these NGOs are donor or project dependent. They are lacking of government and community input. This situation put them in a vulnerable position, especially when their resources stop or pulled out.

2. Most of these NGOs are doing activities specifically related to HIV and AIDS. Only very few of them address broader issues such as gender, poverty, access to justice and human rights. As such, they are isolated from mainstream social, cultural, and political development movement.

3. Our field study also suggests that most of these NGOs report to their source of funding. They are lacking of transparency, and therefore, accountability, to their own community constituents.

4. This lack of transparency complicates any concerted efforts to align or synergize their activities for optimum impacts and reduce unnecessary overlaps or repetition.

RECOMMENDATIONS:

1. NAC as a multi-sectoral agency should strengthen its role to coordinate HIV related policies, programs and activities of sectoral ministries. At least data on sector activities and best practices are reported and made available at NAC.

2. Government stakeholders should provide example of transparency, accountability, and sustainability in national response to HIV and AIDS. They should be able to promote those principles of good governance not only for their own institutional policies and program but also to CCM as the Global Fund implementation mechanism.

3. NAC, other government institution (especially MoH), development partners, should be able to formulate a workable exit strategy that will ensure sustainability of CSO programs and activities. KPAP (Province AIDS Commission) and other resources should be mobilized to adopt those programs and activities once their primary donor stop providing resources.

4. CSO has to be more vigilant in anticipating the end of their funded projects. They should accustom themselves with developing partnerships with other stakeholders, especially with their own constituents, the private sector or with international coalition of CSOs. They should find and learn from best practices in older NGOs such as Spiritia, YPI, and PKBI.

5. Development partners should include in their technical assistance to NGOs management skills that will help them sustain their programs and activities.
D.2. UNGASS INDICATOR 4: HIV TREATMENT (ANTIRETROVIRAL THERAPY)

The provision of ARV has been one of the most crucial interventions in the national Strategy to prevent mortality and further HIV spread of the HIV infection. Available data suggest that currently (MoH, December 2009) there are 15,422 PLHIV receiving and taking ARV from among 50,510 clients with HIV currently undergoing treatment (See Table 4).

The data also suggests that Indonesia is getting better in carrying out this policy. Mortality due to opportunistic infection that was 46% in 2006, in 2008 it could be suppressed to only 17%. Mortality after taking ARV in 2008 was 11.2% and in 2009 it was 10.8%. Lost to follow-up was improving as well, from 5.6% in 2008 to 5% in 2009. Despite quantitative improvements, we need to note the following:

1. It is not clear from the available data how PLHIV in Papua where the epidemic is generalized are able to access continued supply of ARV. Barraclough, et al., 2008 estimated that there are approximately 2,600 PLHIV who are in need of ART in 2009-10 and currently only 400 to 500 (20%) receiving it. This low uptake suggests some problems within the health system providing ART.

2. We do not have any services to detect resistance to ARV. Some PLHIV have taken ARV for sometime and found that his viral load was not reduced and got ill.

3. Although it is acknowledged that the provision of ARV is improving, we still have problems of supply chain management, especially in satellite cities or smaller towns. This problem also causes some clients to access commercially sold ARV.

4. Unavailability of pediatric ARV, especially in the form of syrup in most services. Some children who require ARV were prescribed with uncertain dose of drugs calculated from adult dose. Since this is partly to be supported by the Global Fund, we should note that we currently do not have access to any reports of the implementation of Global Fund related to this specific issue.

5. UIC-ARC study (2010) suggests that many IDU accessing ARV are experiencing a lot of mental health issues, including burnout, that affects their adherence and may result in resistance.

Our field study found the following:

“...we did experience when the ARV supply cut-off for two weeks – in such a case we borrow from friends...” (FGD-key population, Jogja)

“...I live in Klaten, I have to access services in RS Sardjito in Jogja..” (Exit interview, Jogja)

“...I have experienced when my ARV supply was not available for two weeks. The doctor gave me a prescription which he said to buy ARV substitute in the pharmacy.. I do not know what drug it was...” (FGD – key population, Manado)
“...my child is 5 years old and he needs ARV. The doctor gave him Neviral & Duviral because Zidofudin was out of stock...” (DKT Perempuan, Jakarta)

Table 4: The Situation of ARV treatment in Indonesia (2008 and 2009)

<table>
<thead>
<tr>
<th>Date</th>
<th>November 2009</th>
<th>December 2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total patient</td>
<td>%</td>
</tr>
<tr>
<td>Followed in HIV care</td>
<td>50510</td>
<td>36628</td>
</tr>
<tr>
<td>Not eligible</td>
<td>17335</td>
<td>34.3</td>
</tr>
<tr>
<td>Eligible</td>
<td>33175</td>
<td>65.7</td>
</tr>
<tr>
<td>Never on ART</td>
<td>7791</td>
<td>23.5</td>
</tr>
<tr>
<td>Ever on ART</td>
<td>25384</td>
<td>76.5</td>
</tr>
<tr>
<td>Died</td>
<td>2729</td>
<td>10.8</td>
</tr>
<tr>
<td>Lost to follow up</td>
<td>1272</td>
<td>5</td>
</tr>
<tr>
<td>Transfer out</td>
<td>932</td>
<td>3.7</td>
</tr>
<tr>
<td>Stop</td>
<td>15442</td>
<td>60.8</td>
</tr>
<tr>
<td>Still on ART</td>
<td>5009</td>
<td>19.7</td>
</tr>
<tr>
<td>Original 1st line</td>
<td>12358</td>
<td>246.7</td>
</tr>
<tr>
<td>Substitution 1st line</td>
<td>2734</td>
<td>54.6</td>
</tr>
<tr>
<td>Switch to 2nd line</td>
<td>30</td>
<td>0.6</td>
</tr>
<tr>
<td>Number of hospitals</td>
<td>163</td>
<td>150</td>
</tr>
</tbody>
</table>

IV Quarter report MoH, Dec 2009.

RECOMMENDATIONS

1. We need more information on the situation of Papua. Geographical distance, cultural and political factors have contributed to the vulnerability of Tanah Papua for neglect by the central government. It is important that all national report should explicitly include the situation in this region.

2. We would support government’s concerted effort to minimize incidents of stock-out of ART, especially in smaller cities and district. A report mechanism may be established which enable ARV clients from the district may report their complaints.

3. We urge the government to treat the availability of pediatric ARC as a matter of urgency.

4. ART services should be linked to other mental health services to deal with emotional complications, including burnout, and ensure adherence.
D.3. UNGASS INDICATOR 5: PMTCT

Indonesia is beginning to see the inevitable impacts of HIV to children and young population. According to MoH annual report (2009), for the past five years we have been witnessing the rapidly increasing number of children and young people infected with HIV (see Figure 2). Despite low coverage of PMTCT in Indonesia in 2008 (less than 10%) we like to note the following:

1. Most of PMTCT services in antenatal clinics in major cities in Java have been provided by NGOs (Gustav, 2008). We need more investment in government health structures in the provinces, especially in Papua and other regions with high prevalence of HIV among women. Considering that only 31% of population in Tanah Papua, for example, know the availability of any test sites and only 20% of PLHIV requiring ART received such service, providing PMTCT services in those regions seem remain a huge challenge.

2. Our field assessment also suggests that information which link VCT, PMTCT, and HIV/AIDS prevention is often not very clear.

3. Most PMTCT services are available in big cities and in Java. Scaling up of services in smaller cities and other region is seriously needed.

4. Violence against women, including issues of (domestic) sexual violence, trafficking, and all kinds of sexual exploitation of women and children are all closely linked to vulnerability of women and children to be infected with HIV. These issues should be integrated in the national AIDS strategy (see also Indonesia Country Progress Report on Sex Trafficking of Children and Young Person, 2009).

5. According to UNAIDS report on HIV transmission in intimate partner relationship (2009) it is important to include and integrate services on male sexuality in all services on sexual and reproductive health usually dedicated for women. In that matter, we do see the need for and the lack of such provision and integration.

6. Fear of stigma and discrimination towards PLHIV, which may be found in treatment and care institutions, remains an important barrier to utilization of PMTCT services by mothers or pregnant women (see UNAIDS Intimate Partner Report, 2009).

Our field assessment found the following:

“... not all PLHIV understand about PMTCT. I have an HIV positive friend who was so shocked and sad when she found out that she was pregnant. She did not want to get pregnant. When she was told that there was a PMTCT service in a local hospital that may help reduce the chances of her baby infected with HIV, she was relieved....”

(FGD – key population, Jogja)

“...here (in Manado) information about PMTCT is not adequate. What it is about. I don’t know...”

(FGD – women, Manado)
“Here the doctors always advise PLHIV clients not to get pregnant.. so PMTCT services is not commonly available…” (FGD - women, Manado)

“many pregnant positive women were concerned that they may not get quality and safe services due to stigma to her status as PLHIV.. therefore, many of them were not open about their serostatus... because when the health workers found out that their client is HIV positive, many of them freaked out....” (FGD - women, Manado)

Figure 2: Cumulative HIV&AIDS Cases among 0-19 year old (1995-2009)

Source: MOH, 2009 (reported through June and Updated August 7, 2009)

RECOMMENDATIONS

1. More information that link VCT, PMTCT, and ARV should be provided in HIV related services.

2. Service providers should work very hard to ensure that their services are free from stigma and discrimination. In addition, those services established in high-risk area should be able to outreach clients than just waiting the clients to come for services. More importantly, male sexuality and reproductive health should also be part of the existing services to help the male client to attend to his risks and protect his partner/spouse.

3. Mental health services, especially individual and family counseling should be available in all PMTCT services.

4. It is urgent to include issues of Violence against women and related issues to be included in the National Strategy Plan.
D.4. UNGASS INDICATOR 7 & 8: HIV TESTING (GENERAL AND MARP)

It is acknowledged that VCT key to early intervention and treatment. We also appreciate concerted effort to scale up availability of VCT through NGOs, Clinics, and Community Health Centers. This report likes to note the following:

1. There have been no review or evaluation on the standard quality of VCT services. Since there have been a lot of training and hundreds of VCT services established, quality of care should be ensured. Our field study and report by Solidaritas Perempuan indicate that there are inappropriate practices of VCT.

2. There are a lot of unrecorded incidents of non-voluntary testing. Solidaritas Perempuan reported that most migrant workers were tested without counseling prior to their departure as part of the mandatory medical check-up. During medical check-up they are not informed what kind of medical check-up they going to undergo. Informed consent was not secured. When the test was found reactive, the migrant worker was informed that s/he is unfit and therefore could not go. For further explanation they are referred to NGOs or Hospitals providing HIV related services (Solidaritas Perempuan, 2009).

3. Many clients who went for VCT did not get the result back. There may be a number of reasons for this. First, clients are so afraid of the result and are not convinced of the benefits. Second, clients feel that they may not be able to cope with the results (reactive) and, therefore, choose not to know. Many VCT clients may have witnessed their peers who were depressed after receiving positive results. Interviews with IDUs who received the bad news after VCT suggests that many of them were emotionally and mentally down, could not think straight, and some were suicidal (ARC-UIC, 2010). This suggests that scaling up VCT services without providing follow up mental health support may produce undesirable consequences. Third, many people may have heard stories of discrimination against PLHIV. Stories like that make them believe that there is no benefits whatsoever when one is diagnosed with HIV.

Our field study revealed the following:

1. Difficulties or problems accessing VCT services

   “...for HIV related services, they should be provided in places where it is easy to access. So, when we need to access the service we do not have to go to a hospital.. because there it is difficult ...” (FGD – key population, Manado)

   “...yes, without saying a word he took my blood.. when I asked.. he replied “You know what for...” (FGD - women, Papua)

   “...we are often asked why we like to go outside at nights.. we were asked to change our habit.. we do that because that is what we do to earn a living.. after that we prefer to go to a mobile VCT provided by an NGO...” (FGD – key population, Jogja)

2. HIV and AIDS services provide bad examples and help promote negative stigma and discrimination to PLHIV.
“...I was pregnant at that time but I was not infected with HIV. My husband was the one infected with HIV. When the doctor examined me.. all of a sudden he put on his mask, put on his gloves, something he did not do when my pregnancy was in the first trimester. He concluded that I could not deliver my baby in that hospital due to incomplete instruments. I said many times that I have been tested three times and I am and the baby are OK. But he insisted that I could not have my baby there....” (FGD - women, Jakarta)

“...they knew that I am HIV positive so that they keep me waiting from morning until noon (in the doctor waiting room). When I asked why .. the nurse said “you are HIV positive” I am ashamed in front of other patients” (FGD - women, Jakarta)

“..when I went to a dentist in the Community Health Center, I was asked to wait until the last patient.. the nurse explained to me that it is because I am HIV positive. She also said that she has been kind by asking me to wait rather than reject me..” (FGD - women, Jakarta)

“..in the middle of a job interview, the management stop the interview when they know that I am an ex-drug user...” (FGD – key population, Samarinda)

“... My boyfriend was unconscious when he was brought to a hospital. His blood was tested positive. I went unconscious. My neighbors were informed about that. We were evicted at 1 o’clock in the morning. They said we carried a terrible disease and could infect others in the community..” (FGD - women Samarinda)

RECOMMENDATIONS

1. More information on the benefits of VCT to people engaged or associated with people engaged in risky behavior should be made available in all HIV related programs and activities.

2. VCT should be linked directly with other services, especially with, couple counseling, trauma or addiction counseling, basic medical care, STI, NSP, and substitution therapy services. Whenever possible, it is recommended that those services are available in integrated manner.

D.5. UNGASS INDICATOR 9: PREVENTION PROGRAM AMONG MARP

Community groups included in the Most at Risk Population:

a. IBBS-MARP 2007/2008 (MOH, 2008): Sex Workers (SW-Male and Female. Direct and indirect), Injecting Drug Users (IDU), Gay, Transvestite, MSM, Customers of SW, Men engaging in risky occupations (Sea-farers, Truck and Ojek drivers), and adolescents.

b. The 2010-2014 National Strategy: Sex Workers (M/F), Customers of SW, Sex-partners of Customers of SW, MSM, and IDU.

---

c. Estimation team 2009: all of the above (b), Prisoners

Under the above inclusion, we may note that Migrant Workers, IDU sexual Partners, military recruits and personnel, and probably other community groups who may be at risk due to their occupation, sexual orientation, or contact/relationships with highly at risks individuals were not included in any assessment and prevention strategies/interventions.

A number of challenges with the current intervention:

1. Data: According to the estimation team 2009 (KPA, 2010) not all community groups can be estimated based on available data, both nationally or at provincial/municipal/district level. In fact, many of these community groups (Indirect SWs, MSM, costumers of SW, Men engaged in risky occupations) have very little data.

2. Investment: Due to limited resources and prioritization - not all community groups listed in IBBS-MARPS receive equal investment for prevention. SWs, IDUs, and MSM have been treated as primary target groups for prevention. Prisoners are beginning to get some attention. Costumers of SWs and their sexual partners, and all other community groups listed above (including adolescents) are currently not being considered as priority target groups.

3. Secondary and tertiary target groups: The current prevention strategy seriously needs to define and identify secondary and tertiary target groups for prevention. Customers of SWs and IDU sex partners should be seriously considered as important secondary and sexual partners of SWs costumers as tertiary target groups for IEC and other prevention programs.

4. Go beyond MARP: Although it is understood and important to define MARP in the National Strategy, it is also immediately obvious that this strategy may be harmful to our overall strategy to prevent HIV if we neglect other less at risk but closely associated population. It is acknowledged that most members of the key population are also engaged in sexual relationship with female steady partners who are at risk of unknowingly infected with HIV (UNAIDS, 2009; FHI-ARC, 2010). On the other hands, other groups currently not considered as highly at risk population are actually very much at risk, especially young people out of school, those working in highly at risk settings, etc. Therefore, it is important to combine risk specific and sectoral specific population approaches. KPAN (NAC) should stay with the current MARP population but delegate responsibilities to sectoral institutions and assist in strengthening their responses. We believe that such mechanism exists in NAC.

For example:


b. MoNE: School students and their families.

c. MoSA: direct and indirect SWs, costumers of SWs, street based MSM,

out of school adolescent.
e. MoL&T: Workplace, migrant workers and their families.

As indicated earlier, although the mechanism is there, NAC should enforce reporting and sharing so that the public may be informed of their achievements and challenges.

5. **GIPA principles**: Since adopted by the Paris AIDS Summit in 1994, we have been struggling to implement the principles. Technical, cultural, and legal barriers have slowed down significant participation of HIV-affected population in planning and decision making at local and national level. NAC has been working very hard to develop an inclusive working environment that should be appreciated and maintained.

The achievement of receiving Global Fund round 8 and 9 is a testimony of NAC hard work to involve important stakeholders in the process of proposal writing. We need to note, however, that our current observations on the implementation of Global Fund programs is lacking of transparent and constructive collaboration and participation of affected community organizations.

This report is seriously concerned that even among CSOs representing affected communities in the CCM, there is not enough reaching out beyond specific group boundaries. In other words, elected members representing positive people or other specific network or organization, for example, will assume responsibilities only to their direct constituents while many people affected with HIV may not belong to their networks. In a situation where resource for prevention is very limited, especially government and foreign funding, we should be able to empower communities to assume responsibilities to help themselves using their own available resources.

6. There are significant barriers to implementing GIPA principles in Indonesia as long as there are legislations which discriminate against members of MARP.

Our interview with members of the National Commission on Women (KOMNAS Perempuan) suggests that there are 19 Provincial, 134 Municipal, and 1 District Regulations and policies contain provisions which criminalize or discriminate against certain groups of people based on occupations and sexual orientation (*KOMNAS Perempuan, 2010*). NAC as a multi-sectoral state institution should state its inclusive policy to the Ministry of Law and Human Rights and to the Ministry of Domestic Affairs.

Our field assessment revealed the following:

1. There are many IEC materials distributed in the community. They vary in formats and contents. Most of these materials are distributed to very limited audience/target groups, especially those considered as beneficiaries of certain programs by certain service institutions or NGOs.
2. In Papua, most IEC materials are not considered as effective instrument to inform the public about HIV and AIDS and how to prevent the infection. A lot of IEC materials are designed to reach sub-population who can read, while a lot of HIV affected population have very low or no education at all.

“...there are a lot of brochures about HIV and AIDS but they are distributed by NGOs to specific people, the general population is not informed." (FGD - women, Jayapura)

“...most adults and old people in Papua never attend school – they do not know how to read those brochures..” (FGD - women, Jayapura)

3. Target audience also long for active participation so that they help make IEC materials appropriate for specific communities and dealing with specific problems of that communities.

“Why not make IEC materials according to stages – from basic to advance information? In that case we the common people will be able to understand...” (FGD, CSW, Jakarta)

“...it would a good idea to involve a sex worker in Kelurahan so that member of PKK will understand the risks and our position as sex workers ..” (FGD CSW, Jakarta)

4. Information on HIV and AIDS and on sexual and reproductive health for adolescents and young people should be written and imparted through young people friendly media, such as youth magazines, radio, and TV. A lot of money have been spent to develop ineffective media.

“...for radio .. information on HIV and AIDS should be composed in simple and easy to understand messages..” (FGD key-population, Jakarta)

“...there is a lot of money spent to print leaflets – why not invest them all to a production house – let them handle the information professionally to fit the target audience so that the information is interesting. ... I also notice the lack of participation of members of affected community..” (FGD – key population, Jakarta).

RECOMMENDATIONS

1. Although concentrated effort to curb the epidemic within MARP is very important, but there is always a possibility of the infection spilling over to the general population. More attention to adolescents, people engaged in occupation which may lead to risky behavior, partners of IDU and partners of customers of SW, and prison inmates should be supported and should have their own specific strategies. NAC, sectoral ministries, and CSO should discuss the strategies as soon as possible.

2. PLHIV from the key population should be actively engaged to protect their sexual partners, especially their wives/spouses.
3. NAC should be assertive on its inclusive policy Vis a Vis relevant sectoral minister. This has been supported by the president himself during ICAAP IX in Bali.

4. IEC materials to secondary and tertiary target groups should be customized according to the characteristics of the target audience.

D.6. UNGASS INDICATOR 10: SUPPORT FOR CHILDREN AFFECTED BY HIV AND AIDS

According to the latest reported data of MoH (December 2009), there are 1280 children 0-18 who have been living with AIDS. Considering the estimated number of PLWH (296,000), there may be more than 500,000 affected with HIV and AIDS. It is obvious, therefore, that we may be dealing with the tip of the iceberg phenomena.

Attention to children affected by HIV and AIDS in Indonesia is just started. Ministry of Social Affairs provide packaged assistance for children with HIV to help them able to access health services, paying school related costs, and to provide small income generating capital for the family. The program runs on 4 provinces. A number of NGOs in Jakarta and a few cities in Java and Bali have been taking care of children with HIV and those affected (orphaned) by the epidemic. They often find that children born from HIV infected parents are abandoned by their extended families. They still find support to access HIV testing, ARV, treatment for opportunistic infection very difficult. Many children are not diagnosed or tested until they have been very ill and their CD4 count very low. When their sero-status is revealed, they have to compete for free public care and treatment services with other children who are ill. Those children who are on ARV and able to attend school are at risk of stigmatization and discrimination. Parents are usually reluctant to reveal the situation and condition of their children for lacking of trust to the system\textsuperscript{10}. Many times it is too late.

RECOMMENDATIONS:

1. Data on children affected and infected with HIV and AIDS should be improved and made available to the public.

2. Children may suffer the negative impacts of HIV due to persisting stigma and discrimination to PLHIV. Parents with HIV could not find decent livelihood since the community are not well-informed about the disease. The government has a lot of homework to do to inform the public and to lift social and economic barriers to PLHIV.

3. There should be a very clear policy with regards to children with HIV/AIDS accessing hospitals and other treatment services to justify appropriate and prompt response and not to create conflict of interest with other children who are ill.

\textsuperscript{10} Interviews with 30 parents of children infected with HIV by Lentera Anak Pelangi, Atma Jaya University, January 2010.
4. The Ministry of National Education should compose a policy to protect children infected and affected with HIV and AIDS in the education/school system. This is a state obligation to protect children rights for education and their rights to health. The ministry of NAC cannot leave this serious matter to the policy of provincial/municipal/district government. It is in accordance with Law No. 32 year 2004 that Human Rights and Law is the authority of the central government.

5. Children who are orphaned and often abandoned by their extended families need special assistance and services. NGOs should be able to access the government package dedicated to these children.

6. Intervention to these children should include Psychosocial and mental health services.

D.7. UNGASS INDICATOR 11: LIFE-SKILLS BASED HIV EDUCATION IN SCHOOLS

We like to note that the education sector in Indonesia, although remains a conservative sector, has made a lot of progressive breakthrough in response to HIV and AIDS epidemic. Teachers' manuals for life-skills education related to health and further developed (renewed) to include sexual and reproductive health and drug abuse have been available since 2000. The issues have been included in the Minimum Standard of Competencies according to level of education (KTSP) 2006.

A Ministry of Education Decree No. 39 year 2008 on Guidance and Supervision of Student Activities (Pembinaan Kesiswaan) was issued in which HIV and AIDS and Drug Abuse prevention are mandatory activities. In fact, the sector has its own “HIV Prevention Strategy through Education” which was formulated in 2004 and since 2007 has been available as printed booklets.

In Papua, HIV and AIDS has been mainstreamed into education sector. In fact, a lot of schools have been able to provide in-service training for their teachers on HIV and AIDS in collaboration with national and international NGOs (UNESCO, 2010).

The following challenges, however, remain to be seriously addressed:

1. The distribution of the book “HIV Prevention Strategy through Education” did not reach schools in the provinces or is not used as a main reference.

2. Although the topic of HIV and AIDS and Drug abuse have been integrated in the Standard Minimum for Competencies in Junior and Senior Secondary school 2006, it is difficult for the education sector to respond to HIV and AIDS effectively due to:
   a. Not all schools have the appropriate materials to deal with HIV and AIDS issues. There are quality materials on HIV information and related life-skills, but distribution of the materials is limited by available resources.
   b. Most teachers have never been trained in HIV and AIDS and do not
feel capable to teach students on these topics.
c. Existing cultural and religious barrier prevent teachers to impart information on sex, sexuality, and sexual and reproductive health.
d. Teachers’ priority is to teach core competencies for final national exam, which may not substantially related to HI and AIDS.

3. We also acknowledged that the World Population Fund and BKKBN have been providing cyber-based information on sexual and reproductive health such as DAKU (Dunia Remajaku Seru) and CERIA. These programs are accessed by school and out of school children to learn about sexuality and reproductive health.

Our field assessment suggests that students do need objective and frank information on issues related to HIV epidemic and they often look for such information in the popular media and cyber world.

Concerted efforts are needed to find and use opportunities in the education sector to inform and educate students on HIV prevention. Extra-curricular activities, school health programs, pre-and in-service teacher training are among a few opportunities that have been utilized to bring HIV and AIDS issues into the system. There are may be more opportunities outside the classroom and school textbooks that can be explored.

RECOMMENDATIONS:

1. More concerted efforts should be invested to inform children in and out of the school. Development partners and NAC and other sectoral ministries should work together to capitalize on what have been developed and tested in the education sector, NFPB, and MoSA to reach widest possible audience. More serious challenges are in Tanah Papua where culture, language, level of education, and geographic areas may present barriers to effective prevention activities. Special effort is needed in this region.

2. There are a lot of NGOs or CSOs (including faith-based organizations) capable of providing effective information and training. NAC (also Provincial/Municipal/District AIDS Commission) should seek partnership with them. This especially important as most newly established Provincial/Municipal/District AIDS Commission are not ready to work by itself to deliver effective programs.

D.8. UNGASS INDICATOR 12-21: KNOWLEDGE AND BEHAVIOR OF MARP

IBBS-MARP 2007/8 clearly revealed that knowledge on HIV prevention among MARP community members has been improving. Over 69 to 89% knew that condom use and faithful relationship can prevent HIV infection. However, 24 to 75% of the respondents also revealed false understanding about how HIV is transmitted. On the behavioral aspects, the surveillance also suggests that needle sharing among IDU and engaging in unsafe commercial sex are still common among MARP members. This
report likes to note the following:

1. Behavioral change intervention that includes the provision of relevant information and skills is very useful and has been helpful to help MARP member to change their risky behavior.

2. The problem, however, is to sustained or maintained behavioral change. The following are causes of failure to maintain constructive behavior change:
   a. Human rights violations related to handling people who are addicted to drugs and “forced” to do risky livelihood activities, such as sex workers. A rapid assessment of female IDU and Harm Reduction program revealed incidents of human rights violation during arrest and detention by police officers (Stigma Foundation, 2010).
   b. Criminalization of members of the key population, especially to members of sexual minorities, sex workers, IDUs, and prisoners – as indicated earlier.
   c. Interventions that promote punishment and social exclusion to members of MARPs.
   d. False believe and practices often supported by community leaders on condom use.
   e. In Harm Reduction services, leadership in the government, especially in MoH, NAC and NNB, have failed to reach consensus on the provision of clean/sterile needle. This one HR program is still controversial and creates confusion among outreach workers, HR staff at Community Health Centers, and prospective clients.
   f. The law on regional autonomy was often misinterpreted by district legislative and executive authorities that they may have their own legal instruments that deviate from the national law. Some District Regulations that criminalize sexual minorities, for example, are not supported by existing national laws.

RECOMMENDATIONS:

1. Sustained effort to develop inclusive policies by eliminating or reducing legal/policy, socio-cultural, and religious barriers is seriously needed. Stop criminalizing key population based on their risky livelihood, drug use, or sexual minority status. NAC and its CSO partners should provide more information to the public to eliminate bias and prejudices against members of its partners.

2. Meaningful and significant participation of MARP members in program planning, design, and implementation should be facilitated. Coordination and collaboration among and within these diverse groups should be improved.

3. Psycho-social intervention and mental health services should be added to the current intervention to deal with traumatic experiences related to addiction and long-term discrimination, revelation of serostatus, relational affairs with significant others and resolving false believe about themselves and their situation.
BIBLIOGRAPHY


Irwanoto et al., 2010. CCM II Advocacy Project Report “Engaging CS Representative in CCM Global Fund Indonesia”.


### Table 03: Number of participants

<table>
<thead>
<tr>
<th>Cities</th>
<th>FOCUS GROUP DISCUSSIONS</th>
<th>Exit Interviews</th>
<th>In-depth Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>KEY POPULATION</td>
<td>FEMALE SEX WORKERS</td>
<td>IDU SEX PARTNERS (FEMALES)</td>
</tr>
<tr>
<td>Aceh</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Jakarta</td>
<td>6</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Jogjakarta</td>
<td>9</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Samarinda</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Manado</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Jayapura</td>
<td>5</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Institusi Nasional</td>
<td>9 (KPAN, KPAI, Komnas HAM, Komnas Perempuan, FHI, HCPI)</td>
<td></td>
<td>9 (KPAN, KPAI, Komnas HAM, Komnas Perempuan, FHI, HCPI)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>39</td>
<td>39</td>
<td>37</td>
</tr>
</tbody>
</table>
4 Desember 2009

No. : 827/LPPM-KE/12/2009
Hal : Ethical Clearance

Yang terhormat,
Koordinator Forum UNGASS AIDS Indonesia
Jalan Matraman Dalam 2 No. 4 Rt 016 Rw 08
Jakarta Timur

Dengan hormat,
Komisi Etika Penelitian Unika Atma Jaya, setelah melakukan peer review terhadap berkas asemen cepat desain penelitian kualitatif UNGASS untuk pelaporan UNGASS ke PBB, yang diajukan oleh Forum UNGASS AIDS Indonesia, menyatakan bahwa desain penelitian tersebut dapat dilaksanakan.

Diharapkan setelah pelaksanaan, ada uraian pelaporan pelaksanaan penjaman aspek etika penelitian tersebut.

Komisi Etika Penelitian Unika Atma Jaya

Dr. phil. Michaelius Prua  
Ketua

Dr. ydr. pol. A. Y. Agung Nugroho  
Sekretaris