FINAL REPORT

NATIONAL AIDS SPENDING ASSESSMENT 2011-2012

NASA

Submitted to UNAIDS, National AIDS Comission and Ministry of Health

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EXECUTIVE SUMMARY

HIV and AIDS are among health issues prioritized in the Millenium Development Goals (MDGs) and require considerable attention from various stakeholders. The Government of Indonesia, along with international partners has been working hard in suppressing the spread of AIDS in the country through various programs. However, more challenges remain, and despite considerable amount of money spent in resources to combat HIV and AIDS in Indonesia, the rate of new cases of HIV continue to persist.

that In 2009, data revealed the number of people with HIV and AIDS which was reported by 32 provinces and 300 districts/municipalities. The highest number was found among those in reproductive ages, ranging from 20 to 29 years old. The Ministry of Health released data revealing that between October to December 2009, additional 1,531 new cases were added to this figure. Data also revealed that Papua was no longer the province with the highest number of HIV and AIDS cases, although with regard to prevalence per population, it is still on top of the list. West Java was on top of the list with number of case reaching 3,598 cases. East Java was on the second spot with 3,227 cases, followed by DKI Jakarta with 2,628 cases and Papua with 2,808 cases. The spread of HIV and AIDS in all provinces and most districts/municipalities leads to considerable number of people with HIV-AIDS (PLHIV) requiring health care services. Health service provision for PLHIV requires much time and resources, thus needing more effective and more efficient program management.

To analyze spending for HIV and AIDS in Indonesia, data was collected from various sources: public, international partners, private. Data was collected from 17 ministries, 11 provinces, six external partners and private contributions through IBCA.

Key Findings

- Spending for HIV and AIDS program interventions from public and international partners in 2011 was USD 72,543,624, where 40.98% was contributed by the government. The total spending was increased to USD 87,002697 in 2012, of which 42.36% was contributed by the government. Out of external funding source, Global Fund is the main contributor covering 63.85% in 2011 and 49.53% in 2012, of the total Multilateral and Bilateral funds. Among the public sources, Ministry of Health is the main player, supporting most of the drug for HIV/AIDS in the country.
- In 2011, the highest proportion of HIV/AIDS spending was dedicated for prevention (28.05%) while in 2012 was for care and treatment (35.84%). NASA did not include spending for hospital treatment paid by Jamkesmas or Jamkesda program (subsidy for the poor) or Jamsostek (private company which provide benefit package for patient with HIV and AIDS). At the hospital, treatment for opportunistic infection is provided and covered under benefit package paid by the government (funding from the MOH).

- The main provider for HIV and AIDS programs in both 2011 and 2012 was public sector and benefiaries in 2011 with no targeted population and focusing on PLHIV in 2012.
- Increased figures on the total spending was partly due to additional data that was collected. However challenges remain, such as incomplete data from some provinces or difficulty in breaking down sectoral contribution to AIDS related activities at the district and municipaty level. In addition, the number of sectors (Local Government Agencies or SKPD) involved in the data collection varied. Some regions initially provided data only from provincial AIDS Commission; however, local Government contribution was from district government and sector contributions, particularly from SKPD of District Health Office and Local/Regional AIDS Commission.
- A more complete figure is obtained for the 2011 and 2012 NASA and disaggregate data was analyzed. However, challenges remain in particular because of lack of awareness on the importance of information on spending. Data from private institutions was not sufficient and showed lower response to sharing information on the spending in comparison to 2009-2010 NASA .

Recommendations

- NAC should enhance the role of local AIDS Comission to ensure sustained regular data collection from the local level. This would help to monitor government contributions to support HIV and AIDS intervention programs in the country.
- NAC and MOH need to enhance the role of private to participate HIV and AIDS programs and sharing information. Private contribution through CSR needs to be captured and used as the basis for planning to include private support for HIV and AIDS responses.
- NASA data can be used to provide a complete picture of funding for HIV and AIDS programs in Indonesia and is useful for better resource allocation plan, such as balancing roles between central and local government, sharing contribution between government and other sources, including external partners and social security schemes.
- NAC and MOH need to advocate the Government to secure funding for HIV and AIDS program and gradually decrease dependency on external funding.
- To improve data quality, sample selection from districts/cities should be considered from the beginning of the process so that result can be extrapolated based on the number of population, fiscal capacity, as the basis to obtain data for subnational level. Furthermore, aggregated data can be collected from all provinces but detailed data can serve as the basis for disaggregation which is collected from selected province and districts. This needs to be planned carefully in order to obtain comprehensive data.
- Local government should also play a role, as HIVAIDS is one of the MDGs target and need to be spelled out in the target of Minimum Service Standars or SPM as the performance indicator of the local government

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PART 1. INTRODUCTION

1.1 BACKGROUND

HIV and AIDS are among health issues being prioritized in the Millenium Development Goals (MDGs) and require considerable attention from various stakeholders. The Government of Indonesia, along with international partners has been working hard in suppressing the spread of AIDS in Indonesia through various programs. However, more challenges remain, and despite considerable amount of money spent in resources to combat HIV and AIDS in Indonesia, the rate of new cases of HIV continue to persist.

During the mid 1990s, a rapid increase in number of drug users was observed. Sharing needles among IDUs triggered a rapid increase of HIV cases in Indonesia. For example, if only one person was found HIVpositive in 1993, then in 2002 data showed that 116 people were already infected. In 2004, the number of people with HIV reached 2,682 cases and almost 70% of them were injecting drug users.

that In 2009, data revealed the number of people with HIV and AIDS which was reported by 32 provinces and 300 districts/municipalities. The highest number was found among those in reproductive ages, ranging from 20 to 29 years old. The Ministry of Health released data revealing that between October to December, 2009, additional 1,531 new cases were added to the figure. Data also revealed that Papua was no longer a province with the highest number of HIV and AIDS cases, although with regard to prevalence per population is still on the top of the list. West Java was on top of the list with number of case reaching 3,598 cases. East Java occupied the second spot with 3,227 cases, followed by DKI Jakarta with 2,628 cases and Papua with 2,808 cases.

The spread of HIV and AIDS in all provinces and most districts/municipalities leads to considerable number of people living with HIV-AIDS (PLHIV), requiring health care services. Thus health service provision for PLHIV requires much time and resources needing more effective efficient and program management.

The Indonesian response to HIV has been co-financed by the Government of Indonesia (GOI) and direct and indirect financial support by the international community. The recent GFATM Request for Renewal (i.e., Phase 2) indicates that GOI funding for HIV has risen substantially over the years (table 1). However, financial analysis undertaken in connection with the Review of the Health Sector Response HIV and AIDS in Indonesia in 2011 undertaken by the MOH and the WHO, suggest that rate of increase in GOI funding has not been sufficient, and may have actually declined between 2007 and 2010. The review also concludes that while budget increases at the MOH have been substantial, particularly in financing a larger share of ART costs, most other HIV budgets in the country have not increased substantially.

National AIDS Spending Assessment or NASA is a process of tracking expenditure on HIV and AIDS program that has been undertaken since 2005. A series of NASA data has been reported and used for relevant policy making.

Table 1. Trend of Expenditure on HIV AIDS, 2006-2010

Source of Fund	2006		2007		2008		2009		2010	
	Total (000 USD)	%	Total (000 USD)	%	Total (000 USD)	%	Total (000 USD)	%	Total (000 USD)	%
International	41,538	73.4	43,258	74.1	30,046	58.0	38,966	64.6	41,367	59.8
Government	15,038	26.6	15,162	26.0	21,514	42.0	21,318	35.4	27,779	40.2
TOTAL (Current Price- USD)	56,576	100	58,420	100	51,560	100	60,285	100	69,147	100
TOTAL (Constant Price/PPP)	65,846	100	56,550	100	38,670	100	41,803	100	36,245	100

Source: National AIDS Comission

For years 2011 and 2012, data on expenditure needed was tracked and reported by National AIDS Comission and by the Ministry of Health with external partners and other stakeholders.

1.2 OBJECTIVES

In general, NASA is aiming at obtaining the overall picture of the total spending on HIV and AIDS program interventions undertaken by public, international partners and private sources.

Specifically, this National AIDS Spending Assessment (NASA) aims to:

1. Determine the total expenditures on HIV and AIDS interventions in year 2011 and 2012 from different sources
    a. Government (national/ central and subnational)
    b. International partners (bilateral and multilateral)
    c. Private company
2. Determine the expenditures on HIV and AIDS intervention in 2011 and 2012 by spending category
3. Determine who are the providers and analyze spending by each provider in 2011 and 2012.
4. Determine who are the beneficiaries and analyze spending by each beneficiary in 2011 and 2012.

PART 2. METHODS

2.1. NATIONAL AIDS SPENDING ASSESSMENT (NASA) AND CLASSIFICATION

National AIDS Spending Assessment (NASA), hereinafter called NASA, was developed by UNAIDS in order to help countries conducting HIV and AIDS programmes in identifying source and amount of funds already spent or the expenditures (not allocated fund or budget) for conducting programmes related with HIV and AIDS. NASA's results between one country to another may be compared with the help of international standards in spending categories and code account classification by source of fund, funding agents, program activities, functions, cost components, as well as the beneficiaries.

The spending for HIV and AIDS is classified into eight main categories, each of which has sub categories reaching 80 sub categories in total.[i]

Eight (8) main categories for AIDS spending (AIDS Spending Categories) are:

1. Prevention
2. Case, Support and Treatment
3. Orphans and Vulnerable Children
4. Program Management and Administration
5. Incentives for Human Resources
6. Social Protection and Services, excluding Protection for Orphans and Vulnerable Group
7. Enabling environment
8. Researches excluding Operational Research

In this regard, our NASA 2011 and 2012 followed the guidelines and consistently used the same classification. However, we are only able to compile information from the Government and international partners, while information from private company/ corporation is limited with no information on out-of-pocket expenditure.

2.2. DATA COLLECTION AND ANALYSIS

A. Preparation

Planning for NASA study was made before data collection process by holding several coordinating meetings among National AIDS Commission representatives and the NASA consulting team. The team developed plan of activities for data collection, discussed administrative and logistic issues, and schedule for all activities. The consulting team had a series of meetings with various parties (relevant sectors as well as international partners) under the coordination of NAC to ensure data availability and agreement on the classification method. It was agreed that data collection for subnational level is conducted by themselves and NAC will coordinate and supervise them.

B. Data Collection and Process

Data collection began after NASA training for the National AIDS Commission partners was conducted in Bogor in April 2013. The training was held by the National AIDS Commission in collaboration with avteam from the University of Indonesia for five (5) days and aimed to share the concept on NASA in order to understand the concept, followed by a self-assessment/ data collection. Representatives from 12 provinces were invited. To overcome issues of different interpretation in inputting data into the NASA template, a crosscheck process was conducted repeatedly to ensure each institution's perception was similar, thus allowing for information closest to analysis requirement was obtained.

Data from different sources were gathered and managed under the coordination of NAC (for public funding and GF), UNAIDS (for international partners' fund) and MOH (MOH and GF funds). Buy-in process was undertaken couple of times at the NAC office and visits to ministries, including a discussion with IBCA (Indonesia Business Coalition on AIDS) and some of its members such Chevron, Univeler Indonesia, Freeport.

Data on HIV and AIDS expenditures in 2011 and 2012 for HIV and AIDS program in Indonesia was collected from various sources including:

a) Data on AIDS expenditures from the central government fund or APBN was obtained from:
   1. Ministry of Health (kemenkes)
   2. Coordinating Ministry of People's Welfare (Menkokesra)
   3. Ministry of Manpower and Transmigration (Kemenakertrans)
   4. Ministry of Woman Empowerment and Child Protection (Meneg PP)
   5. Indonesia Planned Parenthood Association (IPPA) or PKBI
   6. Military and Police (TNI and POLRI)
   7. Ministry and Defense and Security (kemenhan)
   8. Ministry of Social Affairs (Kemensos)
   9. Ministry of Internal Affair (Kemendagri)
   10. Ministry of Transportation (Kemenhub)
   11. Ministry of Religion (Kemenag)
   12. Ministry of Communication and Information (Kemenkominfo)
   13. Ministry of Law and Human Rights (Kemenkumham)
   14. Ministry of Tourism and Creative Economy (Kemenparekraf)
   15. Ministry of Youth and Sport (Kemenpora)
   16. Indonesian Agency for the Assessment and Application of Technology (BPPT)
   17. Indonesian Red Cross (PMI)

b) Data on AIDS expenditures from the local government funds or APBD (provincial and district/ munipality level) was obtained from:

1. Provincial AIDS Commission of DKI Jakarta
2. Provincial AIDS Commission of Bali
3. Provincial AIDS Commission of Papua
4. Provincial AIDS Commission of East Nusa Tenggara
5. Provincial AIDS Commission of DI Yogyakarta
6. Provincial AIDS Commission of Riau Islands
7. Provincial AIDS Commission of Riau
8. Provincial AIDS Commission of West Java
9. Provincial AIDS Commission of Central Java
10. Provincial AIDS Commission of East Java
11. Provincial AIDS Commission of South Sulawesi

The process was coordinated by the National AIDS Comission. We did not conduct the data collection, instead, the local AIDS Comission sent the data which was compiled using a standardized format.

In the terms of data source, data gathered was improved significantly in which subnational level collected data from all stakeholders dealing with HIV and AIDS-related program in their respective region. The subnational level counterparts were willing and motivated to collect data from all districts involving all sectors in their respective province. However, not all provinces succeeded in commpiling information representing whole province level data due to reasons such as geograhical constraint (covering islands, remote districts etc). In this regard, the result of this tracking expenditure might be an underestimate, and need to be interpreted carefully to represent national / overall country level.

c) Data on HIV and AIDS expeditures from international partners was obtained from:

1. Australia Agency for International Development (AusAID)

2. United States Agency for International Development (USAID)
3. The Global Fund for AIDS, TB and Malaria (GFATM)
4. The World Bank
5. United Nations Agencies (UNAIDS, UNESCO, UNFPA, UNICEF, UNODC, WHO, ILO)
6. HIVOS

C. Data analysis

To ensure the reliability and accuracy of the data, we worked closely with all sources of information. Data verification and cleaning process, were conducted repeatedly to make sure the data was accurate and no double counting existed when we tracked from different angles.

We used funding matrix as the basis to assess and analyze the data. NASA guideline explained in detail how to maintain credibility of the information gathered. We also did triangulation by asking or checking the data from different sources, review documents and published information.

NASA analyzed the overall picture of the total spending on HIV and AIDS interventions in the country, for what purpose those funds are spent, and who are the providers and how much was spent by each provider, as well as who are the beneficiary. Compare to the previous NASA result, this 2013 NASA not only succeeded in gathering information on how much the spending for HIV and AIDS related activitie, but also aimed to gather information on how much funds being spent by program implementers and received by the beneficiaries. Although the information was not provided in detail, we were able to disaggregate data using 2 x 2 tables according to source and spending category.

PART 3. NASA 2011-2012: FINDINGS AND DISCUSSION

3.1. STUDY LIMITATIONS

Some of the challenges found during the data collection and analysis process were:

1. Considerable variation between activity name and ASC groups, thus posing difficulties in the data collection process. Therefore, discussions for having a similar understanding between informants and enumerators were required.
2. As usual, we received a strong and consistent support from external partners to provide data and information. This NASA report covers international contribution to various agents, disggregated by function, provider and beneficiry. However, some information was clear, whether it is cover its indirect costs such as spending for office and management. .
3. Different subnational level informants involved in current study compared to previous years and some of themvdid not have adequate knowledge regarding HIV and AIDS programs being conducted by their department/institution.
4. Number of subnational samples varied, leading to analysis which required considering comparable results accurately and not only merely look at more increasing contribution with the increasing number of samples of provinces being involved in NASA 2011 and 2012. Out of targeted 12 provinces with high prevalence to share data on its spending for HIV and AIDS, we could only obtain data from 11 provinces.
5. Data from subnational level were not completely described in terms of who were the providers.
6. Limited time and resources along with the bureaucracy were among the challenges in working in an efficient manner, it was not easy to access scattered data in various units and directorates, this led to taking longer time for completing data collection and unable to get

processed in a short period of time. We did not collect data for the subnational level, and relied on the process coordinated by NAC; therefore, tracking is possible only to institutions currently willing to report their spending data to the National AIDS Commission.

7. NASA did not include spending for hospital treatment paid by Jamkesmas or Jamkesda program (subsidy for the poor) or Jamsostek (private company which provide benefit package for patient with HIV and AIDS). At the hospital, treatment for opportunistic infection is provided and covered under benefit package paid by the government (funding from the MOH). A special study or survey need to be undertaken to capture data on this spending component, as well as survey to capture data on out-of-pocket spending. At this time, it is not realistic to conduct such a study.
8. Data on private contribution was obtained only from IBCA's administrative office. In fact, spending made by those private companies for HIV and AIDS related activities as reported in the previous NASA was actually significant. Furthermore, contribution through CSR (Corporate Social Responsibility) was not captured in this NASA.

3.2. HIV AND AIDS EXPENDITURES in 2011-2012

There was a slight increase in the total expenditures for HIV and AIDS program in Indonesia in 2012 compared to previous year. AIDS expenditures from international partners source of fund was still larger compared to government source of fund. In 2011, there was 59,14% contributed by international partner, and the remaining 40,86% was from the government fund. In 2012, more proportion was shown from government source of fund and increased to 42,83% while international partners fund was 57,87%.

Table 2. HIV and AIDS Expenditure in 2011-2012 (in USD)

SOURCE	2011	%	2012	%
Public/ Government	29,727,979	40.98	36,851,918	42.36
International Partners	42,815,644	59.02	50,150,779	57.64
TOTAL	**72,543,623**	**100%**	**87,002,697**	**100%**

The total spending for HIV and AIDS interventions increased from USD 56,5 miilion in 2006 to USD 87 million in 2012. The government contribution has slightly increased in proportion to the total HIV and AIDS spending, as compared to previous years. In 2006, government contribution was 26.6%, increased to 40.2% in 2010, while in 2011 and 2012, it increased to 40.98% and 42.36% respectively. From this data it can be concluded that the government contribution was increased substantially particularly central government. However, international partners contribution was also increased and continue to play an important role in the program implementation, reaching to USD 43,8 million in 2011 and USD 50,150,779 in 2012.

If we consider including government contribution to pay officials (civil servants) who are working to provide HIV and AIDS program activities, the figures are slightly different. The salary of civil servants re USD 2,651,861 per year, it was estimated based on calculation indicated below:

- Salary of the government employees at the national level (ministries, NAC) and subnational level is USD 389,459 per year (estimated based on interviews with resource persons).

- Salary of the government employees who are working in hospitals and health centers per year would be USD 1,024,002 and USD 1,238,400 respectively. It was calculated based on the assumption that the basic salary for civil servant was USD 300 per month. The number of public hospital was 378 and health centers was 800, the number of staff in each hospital was seven and in health center was four, who dedicated 10-15% of their time to provide HIV and AIDS services.

Using above assumptions, the total government contribution including salary for civil servants in 2011 was USD 32,379,840 or equal to 43.06% of the total spending for HIV and AIDS program intervention. In 2012, the figure was USD 39,505,791 or 44.06% of the total spending.

3.3. HIV AND AIDS EXPENDITURES BY SOURCE

A. PUBLIC SOURCE OF FUND

1. CENTRAL GOVERNMENT/ MINISTRIES CONTRIBUTION

It was found that HIV and AIDS expenditures contributed by the central government through central budget (APBN) was USD 22,206,430 in 2011, and USD 28,199,758 in 2012.

The Ministry of Health was the main contributor. In 2011, the Ministry of Health spent USD 16,812,659 or 75.71% of all government funds for AIDS related program and was increasing around USD 23,300,197 (82,63%) in 2012. Most of MOH fund devoted for drugs procurement, reaching around 89%, more than 11% for OI drugs procurement, and the remaining 6% was spent for program management and prevention activities. Meanwhile, the fund from Coordinating Ministry of People's Welfare was entirely allocated for AIDS activities implemented by the National AIDS Commission with the largest distribution for program management and prevention program.

The Ministry of Social Affairs (MOSA) initiated a program for empowering PLHIV by supporting cash transfer amonted of Rp 7 million for each selected PLHIV. It is expected that they use the money to start doing something for the famiily. MOSA also provided support to the families with nutrition for the baby, Rp 3000 per person. MOSA also implemented social rehabilitation program for the transgenderd, particularly in East Java. Its spending in 2012 also included deconcentration fund to support rehabilitation centers such as *Panti Penyandang Kesejateraan Sosial* (PMKS). The Ministry of Law and Human Rights in 2011 did not allocate specific fund for HIV and AIDS program since funding from AusAID through HCPI was still available for program in prison including capacity building for staffs and other support for operational costs. We did not include spending for health maintenance of the prisoners with HIV/AIDS or routine budget.

Table 3. HIV and AIDS Expenditure from Government Fund in 2011 and 2012

No	CATEGORY	2011		2012	
		USD	%	USD	%

1	Ministry of Health	16,812,659	75.71%	23,300,197	82.63%
2	Coordinating Ministry of People's Welfare	2,366,021	10.65%	1,546,186	5.48%
3	Ministry of Manpower And Transmigration	281,597	1.27%	612,068	2.17%
4	Ministry of Women Empowerment & Child Protection	12,990	0.06%	41,040	0.15%
5	Ministry of Social Affairs	1,461,763	6.58%	1,294,363	4.59%
6	Ministry of Internal Affairs	494,380	2.23%	537,983	1.91%
7	Ministry of Law And Human Rights	1,682	0.01%	15,983	0.06%
8	Ministry of Defense	58,415	0.26%	91,945	0.33%
9	Ministry of Transportation	202,688	0.91%	183,043	0.65%
10	Ministry of Information	25,086	0.11%	62,327	0.22%
11	Ministry of Religion	82,379	0.37%	72,126	0.26%
12	Ministry of Tourism and Creative Economy	68,415	0.31%	47,198	0.17%
13	Ministry of Youth and Sports	-	-	31,962	0.11%
14	National Family Planning Coordination Body	275,608	1.24%	294,348	1.04%
15	Board for Assessment and Application of Technology (BPPT)	62,474	0.28%	1,598	0.01%
16	Indonesian National Police (POLRI)	274	0.00%	256	0.00%
17	Indonesia Red Cross (PMI)	-	-	67,135	0.24%
TOTAL		**22,206,430**	**100%**	**28,199,758**	**100%**

Indonesian Agency for the Assessment and Application of Technology (BPPT) is focusing its activities on research and development in technology, including for HIV and AIDS alternative medicine. In 2011, this institution successfully tried "appropriate technology using traditional medicine" from local plants namely "sambiloto" and "temulawak" to improve immune system against HIV/AIDS infection. Military and Police in 2011 and 2012 did not have any specific spending for HIV and AIDS. However, they still received certain amount of support from the Global Fund, including VCT program. Ministry of Youth and Sport (Kemenpora) reported that in 2012, a training of trainer was done to improve awareness among the youth on HIV prevention, and is expected to continue in the future.

2. SUBNATIONAL / LOCAL GOVERNMENT CONTRIBUTION

HIV and AIDS subnational expenditure data was collected from 11 selected provinces. The data obtained was a compilation from various sources including from the district/city AIDS Commission. Unfortunately, we could not obtain data from West Papua province.

Table 4. HIV and AIDS Expenditures from Local Budget (APBD I and II) in 2011-2012

NO	PROVINCE	2011		2012	
		USD	%	USD	%
1	Riau	338,894	4.51%	422,508	4.88%
2	Riau Islands	323,724	4.30%	362,746	4.19%
3	DKI Jakarta	2,027,789	26.96%	1,527,629	17.66%
4	West Java	710,319	9.44%	742,060	8.58%
5	Central Java	455,719	6.06%	539,804	6.24%
6	DI Yogyakarta	161,245	2.14%	314,898	3.64%
7	East Java	376,064	5.00%	456,090	5.27%
8	Bali	175,515	2.33%	194,718	2.25%
9	East Nusa Tenggara	234,953	3.12%	225,421	2.61%
10	Papua Barat *)	-	-	-	-
11	Papua	2,276,247	30.26%	2,993,379	34.60%
12	South Sulawesi	441,079	5.86%	872,906	10.09%
TOTAL		**7,521,549**	**100%**	**8,652,159**	**100%**

***) Data was not available until this report is submitted to NAC and UNAIDS.**

In general, contribution made by the local/regional Governments from year to year was markedly increasing, yet not all provinces successfully recorded the data due to several reasons. First, for provinces where the geographic area is wide and population is considerable, it is difficult to collect data from all districts/cities in those provinces. The difficulty is even worse when those

districts/cities location is scattered that is geographically difficult to reach by land transportation. For example, Papua, East Nusa Tenggara, with more than 20 districts and air transportation is much required, a complete data is difficult to obtain from all areas. Some other provinces successfully obtained data from all districts, while other provinces only succeeded in collecting data from some of its districts. This will affect national aggregate data.

Provinces of DKI Jakarta, Riau Islands, Riau, Yogyakarta, Central Java, and South Sulawesi altogether are provinces with complete data on HIV and AIDS expenditures. Data from these provinces may be considered to calculate cost per capita or even a unit cost for certain programs. Analysis results will be more complete if we could get a representative data from all provinces and districts. NASA has some limitation and lack of samples which was only taken from 12 provinces. Provinces successfully collected all data from all districts reported decreased contribution of APBD to support programs. For example, DKI Jakarta reported a decrease in spending.

Table 5. Summary of Data Captured and Number of Sample District in Selected Provinces for NASA 2009-2012

No	Province	2009	2010	2011	2012
1	Riau	Source of data: Province Only	Source of data: Province Only	Source of data: All Districts/cities +Province	Source of data: All Districts/cities +Province
		USD 69,845	**USD 81,685**	**USD 338,894**	**USD 422,508**
2	Riau Islands	Source of data: Province Only	Source of data:Province Only	Source of data: All Districts/cities +Province	Source of data: All Districts/cities +Province
		USD. 33,420	**USD. 96,181**	**USD. 323,724**	**USD 362,746**
3	DKI Jakarta	Province of DKI Jakarta, North Jakarta, South Jakarta, East Jakarta, West Jakarta, Central Jakarta	Province of DKI Jakarta, North Jakarta, South Jakarta, East Jakarta, West Jakarta, Central Jakarta	Province of DKI Jakarta, North Jakarta, South Jakarta, East Jakarta, West Jakarta, Central Jakarta	Province of DKI Jakarta, North Jakarta, South Jakarta, East Jakarta, West Jakarta, Central Jakarta
		USD. 2,588,811	**USD. 2,451,532**	**USD. 2,027,789**	**USD. 1,527,629**
4	West Java	Unclear information, most likely only covered province level	Unclear information	- Province + districts	- Province + districts
		USD 789,505	USD 1,710,879	**USD. 710,319**	**USD. 742,060**

No	Province	2009	2010	2011	2012
5	Central Java	13 districts/cities + Province	13 districts/cities + Province	- Province + Districts	- Province + districts
		USD. 448,815	**USD. 400,417**	**USD. 455,719**	**USD. 539,804**
6	DI Yogyakarta	Province of DI Yogyakarta, City of Jogjakarta, District of Sleman, District of Bantul, District of KulonProgo, District of GunungKidul.	Province of DI Yogyakarta, City of Jogjakarta, District of Sleman, District of Bantul, District of KulonProgo, District of GunungKidul.	- Province + districts	- Province + districts
		USD. 203,666	**USD. 148,587**	**USD. 161,245**	**USD. 314,898**
7	East Java	19 districts/cities + province	19 districts/cities + province	- Province + districts	- Province + districts
		USD. 728,384	**USD. 1,792,946**	**USD. 376,064**	**USD. 456,090**
8	Bali	9 districts/cities + province)	9 districts/cities + province)	3 Districts +province,	3 Districts +province,
		USD. 341,534	**USD. 371,087**	**USD. 175,515**	**USD. 194,718**
9	East Nusa Tenggara	Source of data: Province	Source of data: Province	3 districts/cities + province	3 districts/cities + province
		USD. 12,489	**USD. 9,151**	**USD. 234,953**	**USD. 225,421**
10	West Papua	**No information**	**No Information**	**No information**	**No information**
		USD 235,008	**USD 263,989**	**N/A *)**	**N/A*)**
11	Papua	Source of data: Province (covers districts)	Source of data: Province (covers districts)	18 ditricts involving 5 relevant sectors, as well as Province level	19 districts involving 5 sectors, and province level data
		USD. 1,983,911	**USD 2,565,500**	**USD. 2,276,247**	**USD. 2,993,379**
12	South Sulawesi	No Data/ information	Province Only	- Province + districts	- Province + districts
		N/A	**USD 155,783**	**USD. 441,079**	**USD. 872,906**

*) No data until this this report is submitted to NAC and UNAIDS

Another issue observed was the difficulty in dividing sectoral contributions to AIDS related activities at the district level. The number of sectors (local/regional Government Agencies or SKPD) involved in the data collection varied. Some regions initially provided data only from the provincial AIDS Commission, when local/regional Government contribution was mainly from district/city government and sector contributions, particularly from SKPD of District Health Office and Local/Regional AIDS Commission. In order to better increase data quality in the future, early

sample selection from districts should be considered and extrapolated based on the number of population, fiscal capacity, etc. using relevant weighing factors.

B. INTERNATIONAL FUNDING SOURCE

As discussed earlier, in 2011 and 2012, HIV and AIDS program in Indonesia was mostly supported by the international source of funds. Table 6 depicts that the Global Fund is the largest funding source covering 64.06% in 2011 and 49,57% in 2012 out of the entire HIV-AIDS spending from international partners including multilateral and bilateral partners.

Table 6. HIV and AIDS Expenditures contributed by International Partners, 2011-2012

No	INTERNATIONAL SOURCE	TOTAL 2011		TOTAL 2012	
		USD	%	USD	%
A	**MULTILATERAL**	**30,239,464**		**27,734,502**	
	GLOBAL FUND	27,428,479	64.06%	24,858,113	49.57%
	UN AGENCIES	2,764,342	6.46%	2,821,289	5.63%
	WORLD BANK	46,643	0.11%	55,100	0.11%
B	**BILATERAL**	**12,576,180**		**22,416,277**	
	GOVERNMENT OF AUSTRALIA	8,788,691	20.53%	16,496,612	32.89%
	GOVERNMENT OF USA	3,736,517	8.73%	5,728,045	11.42%
	GOVERNMENT OF NETHERLAND	50,972	0.12%	191,620	0.38%
TOTAL		**42,815,644**	**100%**	**50,150,779**	**100%**

Global Fund transfered its funding to four (4) primary recepients (PR) : MOH, NAC, Nahdatul Ulama and PKBI. NAC received support from GF in 2011 and 2012, in the amount of USD 8.4 million and USD 7.2 million respectiveley. Nahdatul Ulama (NU) received USD 1.4 million and USD 1.6 million in 2011 and 2012 respectively, while PKBI received USD 1.8 million and USD 3.3 million respectively. The remaining and the highest amount was received by MOH. Each PR is responsible for activities at subnational level (141 districts/ municipalities and 33 provinces). The GF support

will be ended by the year 2015, while various program activities substantially depend on GF. Riau province reported that more than 80% of the program is supported by the GF.

The Government of Australia is the second largest fuding source and through AusAID, donating more than USD 8 million in 2011 and increased to more than USD 16 million in 2012. Fifty of the funds were disbursed through GRM/HCPI to support program activities in collaboration with national implementors. The remaining funds were donated through CHAI, NAC, UNDP and other implementors.

Meanwhile in 2011, the Government of USA through USAID supported USD 3.7 million and increased in 2012 to USD 5.7 million, mostly through Sum1 and Sum2 projects. Government of Netherland supported Unicef in 2011 and 2012 (table 6).

C. PRIVATE SECTOR CONTRIBUTION

We were able to obtain data from private company contribution coordinated by IBCA for in 2011 and 2012 which was USD 71,205 and USD 51,746 respectively. The private sector data was gathered from IBCA secretariat and considered as an underestimate and only spent at the secretariate . IBCA should have a systematic process to gather data on the spending from all IBCA members and use it to advocate for better resource mobilization and cost-effective use of funds to support HIV and AIDS programs in the country. Our report focuses more on public and international contributions, thus we do not explore more on the private expenditures. Nevertheless, the increased contribution of the private companies through its CSR (Corportae Social responsibility) has to be captured. In the future, this can play as one potential source to finance a more structured and innovative HIV and AIDS response.

3.4 HIV AND AIDS EXPENDITURES BY SPENDING CATEGORY

Overall, national HIV and AIDS expenditures based on AIDS spending category still focus on prevention and treatment activities. In 2011, the largest spending was for prevention activities, which covered 28% of the entire spending in the year. In 2012, treatment-related activities covered 27.59% of all expenditures. The Government has started focusing on ARV procurement and the last 5 years, the demand for ARV is significantly increasing. In addition, large expenditures were also devoted for monitoring and evaluation of program activities. Approaching the termination of Global Fund support for HIV and AIDS-related activities in Indonesia in 2015, current activities are focusing more on monitoring and evaluation of programs.

Table 7. HIV and AIDS Expenditures by Spending Category in 2011-2012

ASC	ASC CATEGORY	2011		2012	
		USD	%	USD	%
ASC 01	Prevention	20,386,874	28.05%	24,000,461	27.59%
ASC 02	Care, Support and Treatment	18,425,218	25.40%	31,181,538	35.84%
ASC 03	Orphans and Vulnerable	17,151	0.02%	27,249	0.03%
ASC 04	Program Management and Administration	19,370,348	26.76%	16,073,220	18.47%
ASC 05	Incentives for Human Resources	9,604,374	13.24%	10,644,870	12.24%
ASC 06	Social Protection and Services, excluding protection for orphans and vulnerable	1,181,223	1.63%	1,133,268	1.30%
ASC 07	Enabling environment	2,726,453	3.76%	2,601,913	2.99%
ASC 08	Researches (excluding Operational Research)	831,982	1.15%	1,340,176	1.54%
TOTAL		**72,543,623**	**100%**	87,002,697	**100%**

Detail information on the spending classified under ASC 07, including spending for human rights activities (can be considered as spending for "critical enabler") which is important for sharpening the planning and resource allocation to increase "value for money". Recently, UNAIDS released (will be published soon) a tool to determine cost for human rights program activities related to HIV and AIDS that conducted by any institution. If the data is available, spending related to this component is classified under ASC.07.02, human rights programmes**.** This spending category

cover all the activities and resources invested for the protection of human rights, legislative aspects of a broad number of areas of social life, such as employment and discrimination, education, liberty, association, movement, expression, privacy, legal counselling and services, efforts to overcome discrimination and improve accessibility to social and health services. The Human Resource Costing Tool (HRCT) has been test in several institutions in Indonesia such as NAC, MOH, NU, PKBI, Spritia, GWL Ina, etc and the result indicated that spending for human rights may be substantial. Unfortunately for NASA 2011 and 201,2 we were not able to obtain detail spending for human right activities. Dissemination of information on the use of HRCT is needed as this component and other detail on ASC is useful to improve planning and budgeting. The next NASA is expected to provide data with more detail classifications.

3.5 HIV AND AIDS EXPENDITURES BY SOURCE AND SPENDING CATEGORY

The NASA assessment revealed that prevention was mainly supported by international partners in 2011, reaching to 71%, while the Government was the main source for care and treatment, reaching to 89%. Similar figure was found for 2012. We discovered that international partners were the main contributors (71%) and Government was the main source for care and treatment (almost 75%). Government support for care and treatment was substantial and amounted to USD 23 million in 2012, mostly for ARV drugs. Australian government support through AIPH - Rapidly Expanding Access to Care for HIV (REACH) – CHAI a substantial funds for care and treatment program amounted to USD 3.6 million. Previously, GF was the main contributor. Drugs from Government support was distributed to providers such as health centers and hospitals. International partners spent substantial amount for management, for both 2011 and 2012.

Human resource incentives weremainly supported by donors, including salary for AIDS comission staffs at subnational levels. We did not include salary as civil servant if they are working as official

government staff. Another program that highly depends on donor fund was program for *enabling environment.* The World Bank and AusAID were two main contributors for research activities.

Table 8. HIV and AIDS Expenditures by Source and Spenging Category in 2011-2012

ASC	CATEGORY	2011 (USD)				2012 (USD)			
		FA.01 The Government	%	FA.03 International Partners	%	FA.01 The Government	%	FA.03 International Partners	%
ASC 01	Prevention	5.888.726	28.88	14.498.148	71.12	6,881,439	28.67	17.119.022	71.33
ASC 02	Care, Support and Treatment	16.470.533	89.39	1.954.684	10.61	23,268,992	74.62	7.912.546	25.38
ASC 03	Orphans and Vulnerable	17.151	100			19,791	72.63	7.458	27.37
ASC 04	Program Management and Administration	3.719.884	19.20	15,650,465	80.80	3,375,269	21	12.697.951	79
ASC 05	Incentives for Human Resources	1.545.311	16.09	8.059.063	83.91	1,252,748	11.77	9.392.122	88.23
ASC 06	Social Protection and Services, excluding protection for orphans and vulnerable	1.072.345	90.78	108,878	9.22	1,127,268	99.47	6.000	0.53
ASC 07	Enabling Environment	631.977	23.18	2.094.476	76.82	843,867	32.43	1.758.046	67.57
ASC 08	Researches excluding Operational Research	382.052	45.92	449.931	54.08	82,543	6.16	1.257.633	93.84
	TOTAL	29,727,979		42.815.645		36,851,918		50.150.779	

3.6 CENTRAL GOVERNMENT CONTRIBUTION BY SPENDING CATEGORY

Government funding spent for HIV and AIDS related activities in 2011 were mostly channeled through the Ministry of Health as the main implementing ministry managing national HIV and AIDS program. The Ministry of Health through its intensive advocacy has successfully made attempts of increasing spending of HIV care and treatment, leading to an increased spending proportion for all treatment expenses, with particular priority on drug procurement. This decision

is in line with the exit strategy plan to secure service provision, especially on ARV drugs when external funding is no longer in place.

Table 9. Central Government Contribution by Spending Category, 2011-2012

ASC	CATEGORY	2011		2012	
		(USD)	%	(USD)	%
ASC O1	Prevention	2,785,411	12.54	2,787,613	9.89
ASC 02	Care, Support and Treatment	15,616,728	70.33	22,392,634	79.41
ASC 03	Orphans and Vulnerable	-	-	-	-
ASC 04	Program Management and Administration	1,349,423	6.08	1,308,901	4.64
ASC 05	Incentives for Human Resources	770,678	3.47	367,147	1.30
ASC 06	Social Protection and Services, excluding protection for orphans and vulnerable	969,213	4.36	1,039,810	3.69
ASC 07	Enabling Environment	368,947	1.66	243,041	0.86
ASC 08	Researches (excluding Operational Research)	346,030	1.56	60,613	0,21
TOTAL		**22,206,430**	**100**	**28,199,758**	**100%**

NASA did not include spending for hospital treatment paid by Jamkesmas or Jamkesda program (subsidy for the poor) or Jamsostek (private company which provide benefit package for patient with HIV and AIDS). Special effort needs to be taken to analyze claim data on Jamkesmas related to HIV and AIDS, while Jamkesda data varies depending on the local context and is not possible to collect from 33 provinces unless we undertake a special study. As such, Government contribution to support Jamkesmas including for HIV and AIDS patients (partcularly for Opportunistic Infection treatment) was not captured and underestimates the overall Government spending. In the future, this information may be easier to capture since the treatment will be managed and reported by the appointed payer, Askes or BPJS.

3.7 LOCAL GOVERNMENT CONTRIBUTION BY SPENDING CATEGORY

Local government fund to support HIV and AIDS program has varied on its utilization according to the AIDS Spending Category. Contribution made by provincial government fund illustrated an increase in 2012 compared to previous years. Several provinces reported an increased in the number of spending such as South Sulawesi, dedicated for enabling environment programs for PLHIV. Other province such as Papua also spent substantial amount to support campaigns.

Table 10. Local Government Contribution by Spending Category, 2011-2012

ASC	CATEGORY	2011		2012	
		USD	%	USD	%
ASC O1	Prevention	3,103,315	41.26	4,093,826	47.32
ASC 02	Care, Support and Treatment	853,805	11.35	876,359	10.13
ASC 03	Orphans and Vulnerable	17,151	0.23	19,791	0.23
ASC 04	Program Management and Administration	2,370,461	31.52	2,066,368	23.88
ASC 05	Incentives for Human Resources	774,633	10.30	885,601	10.24
ASC 06	Social Protection and Services, excluding protection for orphans and vulnerable	103,132	1.37	87,458	1.01
ASC 07	Enabling Environment	263,030	3.50	600,826	6.94
ASC 08	Researches (excluding Operational Research)	36,022	0.48	21,930	0.25
TOTAL		**7,521,549**	**100%**	**8,652,159**	**100%**

Local government contribution was used mainly to support prevention and program management, while care and treatment is highly depending on the central level support. Other categories were financed by international partners, only limited amount shared by subnational level.

3.8 INTERNATIONAL PARTNER CONTRIBUTION BY SPENDING CATEGORY

Multilateral international partners provided around USD 30 million in 2011, and USD 28 million in 2012. Global Fund is the primary donor to AIDS-related activities outreaching district/city-level programs. The contribution also supported health system strengthening of HIV and AIDS prevention programs. Interestingly, unlike It was then followed by expenditures for prevention program and reagent procurement and other treatment activities. UNICEF has spent substantial amount of funding to support prevention programs in schools. Distribution of expenditures can be seen in the table below:

Table 11. International Partner (Multilateral) Contribution by Spending Category 2011-2012

CODE ASC	CATEGORY	2011		2012	
		USD	%	USD	%
ASC O1	Prevention	10,064,418	33.28	6,593,225	23.77
ASC 02	Care, Support and Treatment	1,015,357	3.36	4,261,140	15.36
ASC 03	Orphans and Vulnerable	-		7,458	0.03
ASC 04	Program Management and Administration	11,627,645	38.45	7,501,569	27.05
ASC 05	Incentives for Human Resources	6,288,346	20.80	7,405,065	26.70
ASC 06	Social Protection and Services (excluding protection for orphans and vulnerable)	108,878	0.36	6,000	0.02
ASC 07	Enabling environment	868,297	2.87	1,728,510	6.23
ASC 08	Researches (excluding Operational Research)	266,523	0.88	231,535	0.83
	TOTAL	**30,239,464**	**100%**	**27,734,502**	**100%**

HIV and AIDS expenditures from bilateral partner source of funding provides a similar distribution to multilateral partners in which priority is given to prevention activities and reached 47% of all expenditures in 2012. Program management spent around USD 4 million or 32% in 2011, and increased to 5 million or 23% of the entire bilateral funding support in 2012.

Table 12. International Partners (Bilateral) Contribution by Spending Category, 2011 and 2012

CODE	CATEGORY	2011		2012	
		USD	%	USD	%
ASC O1	Prevention	4,433,729	35.25	10,525,796	46.96
ASC 02	Care, Support and Treatment	939,328	7.47	3,651,406	16.29
ASC 03	Orphans and Vulnerable	-		-	
ASC 04	Program Management and Administration	4,022,819	31.99	5,196,382	23.18
ASC 05	Incentives for Human Resources	1,770,717	14.08	1,987,058	8.86
ASC 06	Social Protection and Services, excluding protection for orphans and vulnerable	-		-	
ASC 07	Enabling Environment	1,226,179	9.75	29,536	0.13
ASC 08	Researches (excluding Operational Research)	183,408	1.46	1,026,098	4.58
	TOTAL	**12,576,180**	**100**	**22,416,276**	**100**

3.9 SPENDING BY PROVIDER

The following tables depict spending by provider. Both in 2011 and 2012, NAC and ministries were the main providers of programs. Public sector is the main provider, at both national and subnational levels. At national level, ministries used the funds to implement their programs. MOH and NAC were also managing some program interventions, but their implementing agencies were at the subnational level. Since no detail data was available to disaggregate the use of the funds down to the provider such as health centers, and disaggregation on the use of funds for central vs

local level was not captured, we classified MOH and NAC contributions as part of PS 1.1.99. This means that the contribution was used at the national and subnational level (no specific classification in the NASA guideline for local AIDS Comission).

Private providers were non-profit faith-based organizations and non-profit non faith-based organizations. Donors supported and distributed funds mostly to the private providers such as NGOs (non faith based organization) and NU (faith based organization). NU is one of Global Fund's PRs and implement its programs through its network down to the subnational level.

Table 13. HIV and AIDS Spending by Provider, 2011

Code	PROVIDER	2011 (USD)	
PS 1	**PUBLIC SECTOR PROVIDERS**		**59,753,073**
PS.1.1.14.4	Departments inside the Ministry of Social Affair	1,736,627	
PS.1.1.14.5	Departments inside the Ministry of Defense	58,415	
PS.1.1.14.7	Departments inside the Ministry of Labour	22,936	
PS.1.1.14.8	Departments inside the Ministry of Justice	74,081	
PS.1.1.01	Hospitals (Public and Para-statal)	15,687,318	
PS.1.1.99	Government organization n.e.c	42,173,696	
PS 2	**PRIVATE SECTOR PROVIDERS**		**12,790,550**
PS. 2. 1.1	Non profit Non faith Based Organisation	11,371,590	
PS. 2.1.2	Non profit faith Based Organisation	1,414,126	
PS 3.2	Multilateral agency-incountry	4,834	
	TOTAL		**72,543,623**

Similar picture is found for year 2012, where most of the funds were disbursed to public providers. Private providers were non profit faith-based and non faith-based organizations. NU is a non profit faith-based organization and as one of the PRs of the Global Fund, one of its program is to advocate the community leaders on the needs to reduce stigma. NGOs working on harm reduction, reduce stigma, and other activities related to the MARP such as Spiritia, GWL Ina, Kharisma also received substantial amount of the funds from donors and the Global Fund.

Included in table under PS 1.1.99 was spending by NAC and MOH to support programs at both national and subnational levels.

Table 134. HIV AIDS Spending by Providers, 2012

Code	PROVIDER	2012 (USD)	
PS 1	**PUBLIC SECTOR PROVIDERS**		**61,416,667**
PS.1.1.14.4	Departments inside the Ministry of Social Affair	1. 534.687	
PS.1.1.14.5	Departments inside the Ministry of Defense	91.945	
PS.1.1.14.7	Departments inside the Ministry of Labour	69.364	
PS.1.1.14.8	Departments inside the Ministry of Justice	57.350	
PS.1.1.01	Hospitals (Public and Para-statal)	22.485.502	
PS.1.1.99	Government organization n.e.c	37,171,512	
PS 2	**PRIVATE SECTOR PROVIDERS**		**25,586,031**
PS. 2. 1.1	Non profit Non faith Based Organisation	23,956,703	
PS. 2.1.2	Non profit faith Based Organisation	1,629,328	
	TOTAL		**87,002,697**

3.10 HIV AND AIDS SPENDING BY BENEFICIARY

The identification of the beneficiary population (BP) is aimed at quantifying the resources specifically allocated to a population as part of service delivery process of a programmatic intervention.The BP will be selected according to the intention or target of the expenditure in programmatic intervention. This represents an outcome linked to the resources spent, regardless of its effectiveness or effective coverage.

We were able to obtain data on spending by beneficiary:

BP 01 People Living with HIV (ODHA)

BP 02 Most At Risk Population (Kelompok Berisiko Tinggi)

BP 03 Other Key Population (Populasi Kunci Lainnya)

BP 04 Specific “accessible” Population (Populasi Spesifik Terjangkau)

BP 05 General Population

BP 06 Non Targeted Intervention (Intervensi pada Kelompok Non Target)

BP 07 Specific targeted population not elsewhere clasified

BP.01 PEOPLE LIVING WITH HIV (regardless of having a medical/clinical diagnosis of AIDS). This BP should be cross-classified with ASC, which are conducted because the beneficiary of this activity is living with HIV; e.g. *ASC.02 Care and Treatment and ASC.01.07 Prevention of HIV transmission aimed at people living with HIV*.

BP.02 MOST-AT-RISK POPULATION can be grouped based on the behaviour they engage in, that puts them at greater risk of exposure to HIV. This in turn, identifies those populations that should be a priority for monitoring and evaluation efforts for the national and subnational programmes. These groupings of most-at-risk population include the following: sex workers (SW), their clients, injecting drug users (IDUs), and men who have sex with men (MSM). These populations are more likely to have high rates of sexual partner exchange, practice unprotected sex with multiple partners, or use non-sterile drug injecting equipment, all activities which put them at risk of exposure to HIV. Each MARP has a specific ASC.

BP.03 OTHER KEY POPULATIONS includes population such as orphans and vulnerable children, children born or about to be born to HIV-positive mothers, refugees, internally displaced people and migrants, considered as “key population” both in terms of the epidemic’s dynamics and the response. In this group include orphans and vulnerable children (OVC), children born or to be born of women living with HIV, prisoners and other institutionalized persons, truck drivers/transport workers and commercial drivers, Partners of persons living with HIV.

BP.04 SPECIFIC “ACCESSIBLE” POPULATIONS include children in school, women attending reproductive health clinics, military personnel, and factory employees.

BP.05 GENERAL POPULATION comprises interventions targeting the general population as a whole and not any particular key population. For example, a TV or radio campaign of communication for social and behaviour change. The resource tracking team must use two-digit

or three-digit level categories to track the specific segment of the general population, for which the intervention was intended and is available. If there is no information available about age or gender, the interventions targeting the general population should be accounted for as BP.05.98. General population is not broken down by age or gender.

BP.06 NON-TARGETED INTERVENTIONS: expenditures not belonging to explicitly selected or targeted populations. Interventions not targeted to a specific population, or interventions benefiting a population in an indirect way, such as interventions coded under ASC.04. Programme management and administration, ASC.05 Human resources and ASC.08 HIV-related research. When there was no explicit intention of directing the benefits to a specific population, the expenditures need to be labelled BP.06, non-targeted interventions. When the target population is unknown, it needs to be recorded as BP.06, non-targeted interventions, since the objective is to identify the intended beneficiaries. Individuals may belong to more than one category; however, what needs to be classified is the expenditure according to the primary objective of the programme depending on the implementation of such programmes, e.g. point of the service delivery, type of service provider or specific outreach strategy.

BP.99 SPECIFIC TARGETED POPULATIONS not elsewhere classified (n.e.c.): targeted populations not included in above classes.

Table 15 below illustrates PLHIV and MARP as two main beneficiaries for HIV and AIDS program funds in 2011 and 2012 (mostly to support programs for IDUs, MSM and CSW). In 2011 and 2012, spending to support PLHIV was USD 18,8 million and USD 29,4 million respectively. It accounted to 26% to 34% of the overall HIV/AIDS spending in 2011 and 2012. Support for MARPs was also substantial in 2011 and 2012 and funds were used to support programs related to MARP USD 17.4 million and 23.7 million respectively (to support IDU, MSM, FSW programs). Spending for non-targeted interventions includes funding used for indirect activities such as management. It also includes support for supervision, capacity building for personnels, and human resources.

Table 145. HIV and AIDS Spending by Beneficiaries in 2011-2012

Beneficiary	2011		2012	
	USD	%	USD	%
PLHIV	18,811,838	25.93	29,470,740	33.87
MARP	17,379,143	23.96	23,692,860	27.23
Other key population	2,744,656	3.78	1,626,325	1.87
Soecific "accessible" population	5.857.475	8.07	8,639,351	9.93
General Population	2.366.704	3,26	1,854768,	2.13
Non-targeted intervention	24,020,626	33.11	20,661,336	23.75
Specific targeted population n.e.c	1.363.514	1,87	1,057,316	1.22
TOTAL	72,543,623	100	87,002,697	100

3.11 THE WAY FORWARD: THE USE OF NASA

Some points of discussion can be highlighted in regard to NASA for policy making, how to optimize NASA results that can be integrated to the National health Account (NHA) information. Before any plan is proposed, data accuracy and credibility of the data collection process needs to be improved. The proposed approch includes conducting workshop(s) at sampled/ selected provinces and invite selected districts and local authorities representing different units and SKPD (relevant sectors). Consultant(s)/ researcher(s) to be involved closely with data collection at the subnational level and not only at the central level. There is a possibility to obtain overall picture of the local Government's contribution accross the country by sending a simple format asking the aggregate data on spending. This will allow local AIDS Comission and PHO and DHO to submit their data (macro data only). NAC and MOH are expected to lead this activity. This action can be followed by collecting a detailed data as the basis for disaggregation in some selected provinces and districts coordinated by NAC.

NASA pictures have been published on a regular basis by the National AIDS Comission in collaboration with the Ministry of Health, UNAIDS, and other bodies. It has been used for several

purpose on policy development such as Resource Needs Model and identifing the weaknesses, advocacy to convince the needs to develop a systematic plan when Global Fund support comes to an end, develop a model for Investment Case Analysis Framework, develop a model on Cost-Effectiveness Analysis and as the basis for information needed to assess the inclusion of HIV and AIDS intervention under Social Security. ILO and UNICEF have extensively worked on the assesment and advocacy and NASA may help by adding information needed related to the resources available, how it has been spent and improve program achievement. NAC and MOH need to continuously initiate process to make use of the NASA results effectively. One example of the importance on the NASA information submitted is the trend of Global Fund vs Government contribution. This information would be useful to give a brief, but pertinet information on the declining share of GF and develop an exit strategy.

Table. 16. Global Fund vs Government contribution, 2009-2011

Source	SPENDING IN YEAR (USD)			
	2009	**2010**	**2011**	**2012**
GF contribution	19.208.072	23.588.860	27,428,479	24,858,113
Government contribution*				
• Central government	13.883.445	17.731.539	22.206.430	28.199.758
• Subnational	7.435.388	10.047.741	7.521.549	8.652.159

*excluding salary of government's employee

Another important point is the proposal to integrate NASA data and result as the sub-account of the National Health Account or NHA. The NHA has been produced routinely for many years and the approach used is also follows the international standard of SHA (System Health Account). NASA guideline also provides information on the possibility to recode NASA data to NHA classification code. However, this plan needs to be discussed further with the NHA team and coordinated under the Center for Health Financing (P2JK) MOH.

PART 4. CONCLUSION AND RECOMMENDATIONS

4.1 CONCLUSION

NASA 2011 and 2012 revealed that

- Spending for HIV and AIDS program interventions from public and international partners was USD 72,543,624 in 2011, where 40.98% was contributed by the government. Total spending was increased to USD 87,002,697 in 2012, of which 42.36% was contributed by the Government. NASA did not include spending for hospital treatment paid by Jamkesmas or Jamkesda program (subsidy for the poor) or Jamsostek (private company which provide benefit package for patient with HIV and AIDS). At the hospital, treatment for opportunistic infection is provided and covered under benefit package paid by government (funding from the MOH). No information was available on spending for OI in hospital or health centers.
- From external funding sources, Global Fund is the main contributor covering 64.06% in 2011, and 49.57% in 2012 of the total multilateral and bilateral funds.
- Among the public sources, Ministry of Health is the main player, supporting most of the drug for HIV/AIDS in the country.
- In 2011, the highest proportion of the HIV and AIDS spending was dedicated for prevention (28.05%), while in 2012 was for care and treatment (35.84%).
- The main provider for HIV and AIDS programs in both 2011 and 2012 was from the public sector.
- Benefiaries in 2011 was non-targeted intervention, and in 2012 was PLHIV.
- Increased figures on the total spending due to better data collected; however, challenges also remain, such as incomplete data from some provinces or difficulty in dividing sectoral contribution to AIDS related activities at the district level. Number of sectors (Local Government Agencies or SKPD) involved in the data collection varied. Some regions initially provided data only from provincial AIDS Commission, when local Government contribution was much from the district government and sector contributions, particularly from SKPD of DHO and Local AIDS Commission.

- A more complete figure obtained for NASA 2011 and 2012 and disaggregate data can be analyzed. However, challenges remain in particular because lack of awareness on the importance of information on the spending. Data from private institutions was not sufficien which showed lower responses to share information on the spending as compared to NASA 2009-2010. No available data on out of pocket expenditures on HIV and AIDS was incorporated in the NASA.

4.2 RECOMMENDATIONS

- NAC should enhance local AIDS comission's role to ensure sustained NASA data collection. This would help policy makers to monitor Government contribution to support interventions.
- NAC and MOH need to enhance role of private to participate in HIV and AIDS programs and sharing of information. Private contribution through CSR needs to be captured and used as the basis for planning to include private support for HIV and AIDS responses.
- NASA data can be used to provide a better picture of funding for HIV and AIDS programs in Indonesia and can be used for better resource allocation plan, such as for balancing role between central and local Government, sharing contribution between Government and other sources including external partners and social security schemes.
- NAC and MOH need to advocate the Government to secure funding for HIV and AIDS programs and gradually decrease dependency on external funding.
- To improve data quality in the future, sample selection from districts/cities should be considered from the beginning of the process and so that the results can be extrapolated based on number of population, fiscal capacity in order to obtain data for subnational level. Aggregate data can be collected from all provinces but detailed data should be used as the basis for disaggregation collected from selected province and districts only. This need to be planned carefully to obtain comprehensive data.
- Local government should also play a role, as HIVAIDS is one of the MDGs target and need to be spelled out in the target of Minimum Service Standars or SPM as the performance indicator of the local government

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ANNEXES

ANNEX 1. Questionnaire of NASA 2013 (2011-2012)

2013 National AIDS Spending Assessment Survey

Name of Organisation	
Acronym of Organisation	
Address of Organisation:	

Status of Organisation

Crosscheck the appropriate cell

Organisation	Public	NGO	Bilateral	Multilateral
National				
Provincial				
International				

Contact person in the organization

Full name:	
Position:	
Telephone (Office/ Mobile):	
Email:	
Address:	

The reported information is used in an aggregate manner only. The use of the reported information is strictly confidential and the ethic and administrative responsibility is ensured by the NASA Taskforce

Year of report:	2013
Funds Spent by your organisation	
Funds Transferred to other organisations	
TOTAL	-
Currency reported:	

DETAILED EXPENDITURES BY PROJECT / ACTIVITY

AIDS Spending Categories		Project/Activity 1		
	Name of Project/Activity :			
	Name of Donor:			
	Name of Financial Intemediary:			
	Name of Project Implementer:			
Total spent in 2011:		Activity (short decritpion)	Expenditure	Beneficiary
TOTAL			0	
1. Prevention (sub-total)			0	
1.01 Communication for social and behavioural change				
1.02 Community mobilization				
1.03 Voluntary counselling and testing (VCT)				
1.04 Risk-reduction for vulnerable and accessible populations				
1.05. Prevention - Youth in school				
1.06 Prevention - Youth out-of-school				
1.07 Prevention of HIV transmission aimed at people living with HIV				
1.08 Prevention programmes for sex workers and their clients				
1.09 Programmes for men who have sex with men				
1.10 Harm-reduction programmes for injecting drug users				
1.11 Prevention programmes in the workplace				
1.12 Condom social marketing				
1.13 Public and commercial sector male condom provision				
1.14 Public and commercial sector female condom provision				
1.15 Microbicides				
1.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)				
1.17 Prevention of mother-to-child transmission				
1.18 Male Circumsicion				
1.19 Blood safety				
1.20 Safe medical injections				
1.21 Universal precautions				
1.22 Post-exposure prophylaxis				
1.98 Prevention activities not disaggregated by intervention				
1.99 Prevention activities not elsewhere classified				

AIDS Spending Categories		Project/Activity 1		
	Name of Project/Activity :			
	Name of Donor:			
	Name of Financial Intemediary:			
	Name of Project Implementer:			
		Activity (short decritpion)	Expenditure	Beneficiary
2. Care and Treatment (sub-total)			0	
2.01 Outpatient care			0	
2.01.01 Provider- initiated testing and counselling				
2.01.02 Opportunistic infection (OI) outpatient prophylaxis and treatment				
2.01.03 Antiretroviral therapy				
2.01.04 Nutritional support associated to ARV therapy				
2.01.05 Specific HIV-related laboratory monitoring				
2.01.06 Dental programmes for PLHIV				
2.01.07 Psychological treatment and support services				
2.01.08 Outpatient palliative care				
2.01.09 Home-based care				
2.01.10 Traditional medicine and informal care and treatment services				
2.01.98 Outpatient care services not disaggregated by intervention				
2.01.99 Outpatient Care services not elsew here classified				
2.02 In-patient care			0	
2.02.01 Inpatient treatment of opportunistic infections (OI)				
2.02.02 Inpatient palliative care				
2.02.98 Inpatient care services not disaggregated by intervention				
2.02.99 In-patient services not elsew here classified				
2.03 Patient transport and emergency rescue				
2.98 Care and treatment services not disaggregated by intervention				
2.99 Care and treatment services not-elsewhere classified				
3. Orphans and Vulnerable Children (sub-total)			0	
3.01 OVC Education				
3.02 OVC Basic health care				
3.03 OVC Family/home support				
3.04 OVC Community support				
3.05 OVC Social services and Administrative costs				
3.06 OVC Institutional Care				
3.98 OVC services not disaggregated by intervention				
3.99 OVC services not-elsew here classified				

AIDS Spending Categories		Project/Activity 1		
	Name of Project/Activity :			
	Name of Donor:			
	Name of Financial Intemediary:			
	Name of Project Implementer:			
		Activity (short decritpion)	Expenditure	Beneficiary
4. Program Management and Administration Strengthening (sub-total)			0	
4.01 Planning, coordination and programme management				
4.02 Administration and transaction costs associated with managing and disbursing funds				
4.03 Monitoring and evaluation				
4.04 Operations research				
4.05 Serological-surveillance (Serosurveillance)				
4.06 HIV drug-resistance surveillance				
4.07 Drug supply systems				
4.08 Information technology				
4.09 Patient tracking				
4.10 Upgrading and construction of infrastructure				
4.11 Mandatory HIV testing (not VCT)				
4.98 Program Management and Administration Strengthening not disaggregated by type				
4.99 Program Management and Administration Strengthening not-elsewhere classified				
5. Human resources (sub-total)			0	
5.01 Monetary incentives for human resources				
5.02 Formative education to build-up an HIV workforce				
5.03 Training				
5.98 Incentives for Human Resources not specified by kind				
5.99 Incentives for Human Resources not elsewhere classified				
6. Social Protection and Social Services excluding Orphans and Vulnerable			0	
6.01 Social protection through monetary benefits				
6.02 Social protection through in-kind benefits				
6.03 Social protection through provision of social services				
6.04 HIV-specific income generation projects				
6.98 Social protection services and social services not disaggregated by type				
6.99 Social protection services and social services not elsewhere classified				

AIDS Spending Categories		Project/Activity 1		
	Name of Project/Activity :			
	Name of Donor:			
	Name of Financial Intemediary:			
	Name of Project Implementer:			
		Activity (short decritpion)	Expenditure	Beneficiary
7. Enabling Environment (sub-total)			0	
7.01 Advocacy				
7.02 Human rights programmes				
7.03 AIDS-specific institutional development				
7.04 AIDS-specific programmes focused on w omen				
7.05 Programmes to reduce Gender Based Violence				
7.98 Enabling Environment and Community Development not disaggregated by type				
7.99 Enabling Environment and Community Development not elsew here classified				
8. Research (sub-total)			0	
8.01 Biomedical research				
8.02 Clinical research				
8.03 Epidemiological research				
8.04 Social science research				
8.05 Vaccine-related research				
8.98 Research not disaggregated by type				
8.99 Research not elsew here classified				