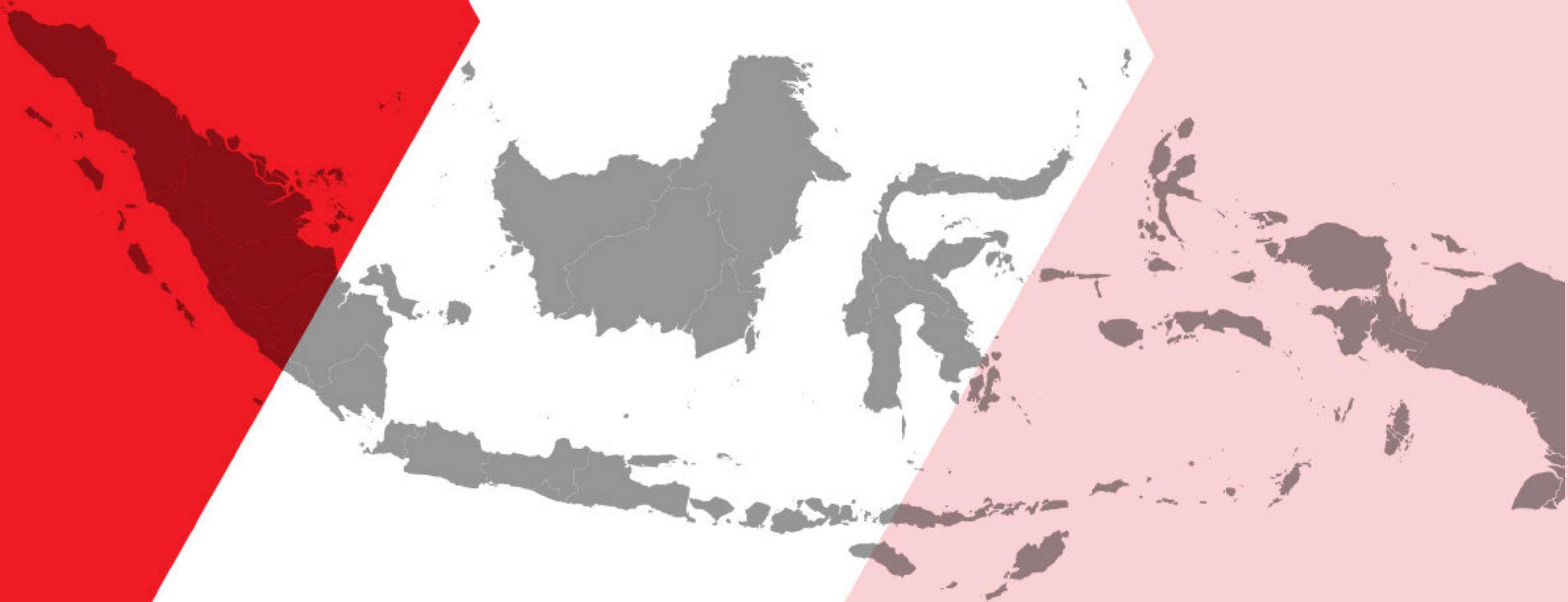
National Situational Assessment of HIV Financing in

INDONESIA



SHIFT
Sustainable HIV Financing in Transition

Executive Summary ❯

Sustainable HIV Financing in Transition (SHIFT) Programme is a two-year regional advocacy programme funded by the Global Fund. Beginning in January 2017 the goal is to empower civil society and communities, especially key population communities, to advocate for sustainable HIV financing in four Southeast Asian countries: Indonesia, Malaysia, the Philippines and Thailand.

To better understand the four countries' HIV financing a National Situational Assessment, which studied published data, was conducted in the middle of 2017. A total of 118 resources in English, Bahasa Indonesia and Bahasa Malaysia were reviewed, including National AIDS Spending Assessments (NASA) and Global AIDS Response Progress Report (GARPR). The availability and sufficiency of HIV financing resources, as well as how funding resources are allocated in Indonesia, Malaysia, Thailand and the Philippines was examined. The following findings provides an overview of the key themes across the four countries.

Key Findings

I. Increasing Domestic Financing of National HIV responses

The four SHIFT countries of Indonesia, Malaysia, the Philippines and Thailand are seeing a trend towards more domestic spending on HIV. Between 2010 and 2015, the Philippines' domestic spending rose 286%, the biggest funding increase of any SHIFT country, however, this increase came as new HIV infections doubled over the same period[1].

Malaysia funds the bulk of its HIV programmes, at 96% in 2015. This is followed by Thailand with 89% (2015), Philippines with 74% (2015) and Indonesia with 57% (2014)[2]. Indonesia in particular recorded a shift from mainly international funding to domestic financing beginning in 2013, with more than half of its HIV response funded domestically by 2015[3].

While the trend is moving towards greater domestic government support, a significant amount of that expenditure goes towards provision of care and treatment, ranging from 33% in Indonesia for 2014 to 67% in Thailand for 2015[4]. Compared to investing in prevention, especially for key populations, healthcare provisions for HIV care and treatment remains the predominant expenditure categories. The obvious utility of treating diseases aside, healthcare provision fits well within the mandate of the government and state as providers of healthcare, without the political sensitivity of spending on stigmatised or criminalised populations. However, this overshadows the importance of the prevention approach needed to stall and reverse the epidemic, and especially the gains made possible when investing in the most affected populations.

1. UNAIDS (2017). Press Release: UNAIDS report indicates new HIV infections in the Philippines have doubled in the past 6 years, 1st August 2017.
2. UNAIDS DataHub (2017). Country Snapshots 2017.
3. NASA Indonesia (2015)
4. UNAIDS DataHub (2017). Country Snapshots 2017.

II. Allocative Efficiency and the Issue of Investing in Key Populations Prevention

Despite the growing epidemic and the financial burden of HIV, investment in prevention spending for key populations is low. Figure 3 illustrates prevention spending across the three key populations in the four SHIFT countries. Of note in advocating for efficient, targeted investment is the current MSM prevention spending. Although 50% to 80% of new infections affect MSM in the four SHIFT countries[5], only an average of 10% of domestic HIV prevention investment is spent on MSM.

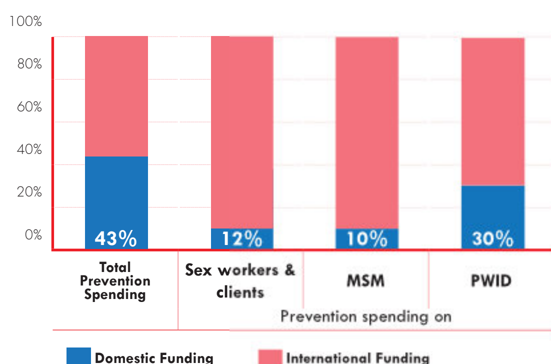


Figure 3: Distribution of prevention spending by financing source in 4 SHIFT countries, latest available year, 2014-2015 [6]

HIV prevention activity delivers the biggest impact and return on investment if it is targeted at the key populations of MSM, sex workers and PWID who are disproportionately affected by the epidemic. However, countries in the region fail to allocate appropriate resources for key populations, with an estimated 8% of overall HIV spending in Asia and the Pacific going towards prevention for key populations[7]. A case worth noting is the response in the Philippines to the rapidly growing epidemic. Four out of five new HIV infections are MSM, but despite the disproportionally high risk of infection, only 8% of HIV spending was allocated to MSM prevention programmes[8].

As seen in Figure 3 above, the bulk of prevention spending in key populations is supported by international donor funding. This raises the issue of sustainability and the potential impact on the epidemic once international donors exit and countries transition to domestic financing. This has been observed in Romania by the Eurasian Harm Reduction Network. A dramatic increase in HIV prevalence among PWID was recorded, with it rising from 1.1% in 2009 (prior to end of Global Fund support), to 6.9% in 2012 and spiking at 53% in 2013 in the years after Global Fund exit [9]. The risk of prevention for key populations to fall through the cracks in this transition stage warrants an urgent allocative efficiency analysis and evidence-based advocacy to ensure an effective response to HIV.

III. Accessibility of Domestic Financing Sources

In the SHIFT countries, with the exception of Malaysia, civil society access to domestic financing remains an ongoing challenge. Prohibitive conditions such as stringent registration criteria, CSO accreditation, absence of enabling laws and policies as well as government attitudes towards CSOs further complicates the issue.

Feedback from country partners noted key constraints between CSOs and governments. There is a lack of government trust in CSOs, largely due to concerns over financial management and issues of corruption. In the Philippines the pork barrel corruption scandal involving government officials establishing fake NGOs to channel funds illegally has resulted in a crackdown and tightening of NGO laws[10], resulting in more stringent rules and barriers to CSO registration[11]. CSO and country partner representatives distrust government agencies to make evidence-based decision in HIV financing, especially when it relates to financing key populations who are potentially criminalised or marginalised.

5. UNAIDS DataHub (2017). Men Who Have Sex Men 2017 Slides.
6. UNAIDS DataHub (2017)
7. WHO (2016). HIV financing status in selected countries of the Western Pacific Region (2009-2015).
8. UNAIDS DataHub (2017). Philippines Country Snapshot 2016.
9. Eurasian Harm Reduction Network (2016). The Impact of Transition from Global Fund Support to Governmental Funding On The Sustainability of Harm Reduction programmes.
10. Francisco, K & Geronimo, J (2013). Why fake NGOs got away. https://www.rappler.com/newsbreak/41913-why-fake-ngos-got-away
11. Philippines country partner ACHIVE noted that organisational registration can take up to 2 years.

Furthermore, understanding budget processes and meaningful engagement in budget advocacy has been limited. This is reflected in the complex structures and power brokers of the budgetary process that CSOs have traditionally been excluded from. However, in Indonesia and the Philippines budget advocacy and accountability NGOs, such a Seknas Fitra and Social Watch Philippines, have led community level engagement to 'democratise' the budget process. This has made complex information more widely accessible allowing CSOs to undertake and engage in budget advocacy.

An exception to the rule of domestic financing channels is the case in Malaysia, where a government-operated NGO - the Malaysian AIDS Council (MAC) was set up to allocate funds to CSOs[12]. However, even as MAC supports CSOs and actively includes key population representatives in its decision-making structures, many CSOs who are recipients question MAC's ability and willingness to advocate on complex issues and to represent civil society in its engagement with the government. As noted by other SHIFT country partners, a principle function of CSOs rests in its ability to advocate on behalf of the communities it represents, as well as serving as a watchdog to hold governments to account on delivering meaningful CSO engagement on national HIV responses.

Government funding may create a conflict of interest and put the CSO's independence at risk and make it a toothless watchdog. As one community respondent put it: "you don't bite the hand that feeds you"[13].

IV. Socio-Cultural and Political Contexts

In Asia, and especially in the SHIFT countries, illiberal governments and populist policies impact the ability of CSOs to advocate for their needs. Elements of military and religious governance operate in the SHIFT countries, hampering the ease of advocacy especially for key populations who are criminalised or discriminated against.

Criminalisation further marginalises key populations. It prevents organisations representing them to fully engage, both on the legislative front, where they are unable to legally participate as political citizens, as well as on the socio-political front, where perceptions and conservative ideologies dominate the decision-making and resource-allocation table.

This is especially observable in the Philippines with the "War on Drugs" – a populist policy criminalising drug use - effectively rules out any investment and advocacy for PWID and their programmes[14]. In Indonesia and Malaysia, gay people and LGBT issues are routinely targeted under conservative Islamic justifications, in addition to being used as political instruments to demonise and advance dominant political influence during election periods[15,16]. This situation presents a major challenge for CSOs to advocate for investment in key populations, especially MSM and transgender people. It makes these communities, and their need for greater domestic HIV financing, invisible.

A further socio-cultural challenge is governments viewing CSOs with suspicion. CSO are often perceived, as antagonistic towards governments, given that successes generated by CSOs imply a certain loss of face for the government and implies the government failed to meet the needs of their citizens[17]. This demonstrates the need for an advocacy strategy that shifts the relationship from adversarial to a mutually beneficial one, focused on the bottom line of controlling the country's HIV epidemic.

In particular, the economic argument for investment in key populations, the return on investment and the potential to mitigate the epidemic escalating are advocacy in-roads that warrant further exploration. The SHIFT programme will explore these ideas by analysing the cost of criminalisation and country case studies, in order to inform advocacy initiatives in the SHIFT countries and will share findings across the region with key partners and stakeholders.

12. Ministry of Health Malaysia (2016). The Global AIDS Response Progress Report 2016.
13. Pers. Comms. (2017). Regional Forum on CSO Financing Mechanisms and Progress Review, 4 – 6 September 2017.
14. Human Rights Watch (2017). "License To Kill". https://www.hrw.org/report/2017/03/02/license-kill/philippine-police-killings-duter-tes-war-drugs
15. Azlee, A. (2016). Anthropologist: Solidarity the only way to stop victimi-sation of LGBT. The Malay Mail Online. http://www.themalaymailonline.com/print/malaysia/anthropologist-solidarity-the-only-way-to-stop-victimi-sation-of-lgbt
16. Hutton, J (2017). Indonesia's Crackdown on Gay Men Moves From Bars Into the Home. The New York Times. https://www.nytimes.com/2017/12/20/world/asia/indonesia-gay-raids.html
17. Kingston, J. (2017). Civil society across Asia if flowering but fragile. The Japan Times. https://www.japantimes.co.jp/opinion/2017/04/29/commentary/civil-society-across-asia-flowering-fragile/#.WiDvyBOCzOQ

Indonesia

INDONESIA

I. Background Trends

Health expenditure per capita (current USD)	2015	99.41
Share of public health expenditure in **government expenditure**	2015	5.73%
Share of public health expenditure in **total health expenditure**	2015	37.8%
Share of total health expenditure in **GDP**	2015	2.8%

Table 1: Essential data on Indonesia (World Bank, 2017)

As the largest economy in Southeast Asia, the world's 10th largest economy in terms of purchasing power parity and a member of the G-20, Indonesia's HIV expenditure reflects an increasing trend. With a population of 259 Million, Indonesia's health expenditure of USD 99.41 is the lowest among the SHIFT countries, and below the ASEAN average of USD 544. National and subnational spending is low relative to other countries with comparable income level, with a low national revenue collection. While the revenue collection for expenditure is centralised, the expenditure and service delivery are decentralised to the district level[21].

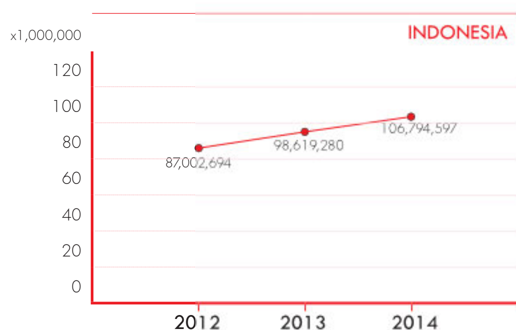


Figure 2: Trend in total HIV expenditure, Indonesia 2012-2014[22]

II. HIV Financing: Domestic vs. International

The latest NASA (2015) report indicates an increase in domestic financing, overtaking international and private sources. Domestic financing was proportionally greater than international funding at 52% for 2013 and 57% for 2014. In 2015, domestic financing sources were comprised of public funds from central government (80%), district level (15%) and 5% from Jaminan Kesehatan Nasional (National Health Insurance)[23].

III. Key Populations Epidemiology vs. HIV Expenditure

According to the 2014 HIV estimates and projections, there were 668,498 people living with HIV in Indonesia with 67,217 new infections in 2015. Without improved interventions, the HIV epidemic would continue to grow in Indonesia, increasing to 777,924 in 2019[24]. The estimates and projections suggest MSM remain the worst affected by the epidemic. In 2014, an estimated 22.1% of new infection occurred among MSM. This proportion is projected to increase to 29.4% in 2019[25].

Despite key population epidemiology, only 1% of total HIV spending is on key population prevention, as shown in Figure 3 below.

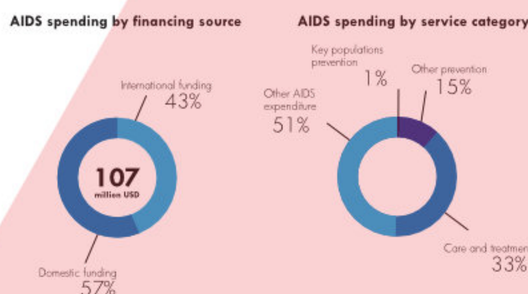


Figure 3: Proportion of HIV expenditure by financing source and service category, latest available data[26]

21. World Bank Group (2016). Indonesia Health Financing System Assessment: Spend More, Right and Better. https://openknowledge.worldbank.org/handle/10986/25363
22. UNAIDS (2017). AIDSinfoonline Key Population Atlas
23. NASA Indonesia (2015)
24. Ministry of Health of Indonesia, Estimates and Projections of HIV and AIDS in Indonesia. 2015.
25. Ministry of Health of Indonesia Estimates and Projections of HIV and AIDS in Indonesia. 2015.
26. UNAIDS Datahub (2017). Country Snapshot: Indonesia

Expenditure data when disaggregated to each key population shows MSM receiving 99.7% of their funding from international sources, sex workers with 57% and PWID with 7% (Figure 4). Looking at the share of domestic vs. international sources of funding, it is imperative to highlight the dependence especially of MSM on international donor funding, and the outlook for ongoing resourcing for HIV interventions for this population during transition. This is further complicated by the current context of anti-gay political sentiment and the policing of homosexuality in Indonesia, which does not bode well for a transition into full government support for MSM programmes. Lastly, there is a need for more up-to-date disaggregated financing information, as the latest data set presented here is from 2012.

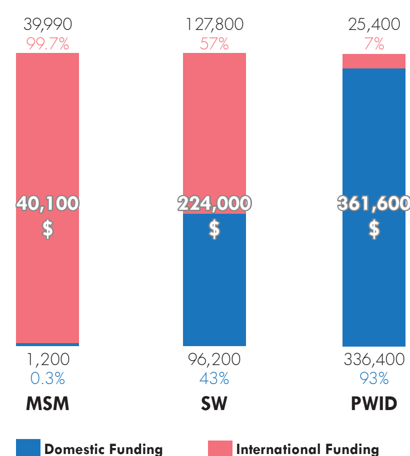


Figure 4: Share of HIV financing for Key Populations Programming in 2012[27]

IV. HIV Financing Mechanisms

Overview

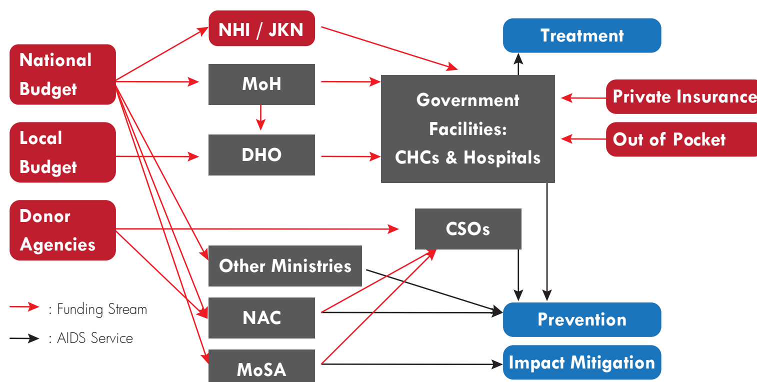


Figure 5: Indonesia's health financing sources and budget utilisation

Government health spending in Indonesia can be divided into two main categories:

- Direct central government expenditure (APBN)
- Transfer to sub-national expenditure (APBD)

In direct central government expenditure, the fund can flow through two main funding channels: (1) ministries and other government institutions and (2) other channels.

There are two functions covered by funding for ministries and other government institutions: core functions and non-core functions. Funding for core functions are designated to cover administrative structures of central and local government. Funding for non-core functions are channeled into three types of financing that can be used to support various health programmes at the provincial and district levels. These three are:

- De-concentration fund (Dekon): grant used for central government-sponsored activities. District should submit a proposal to receive the grant for implementing the activities. The proposal will be approved by provincial level based on the regulations determined by the Ministry of Health.
- Support Assignment Fund (Tugas Pembantuan): this type of grant is intended to support district government including health office for physical assets, infrastructure, and equipment. The allocation and use of these funds are approved by the central Ministry of Health.
- Grant for Operational Costs at Community Health Centre Level (Bantuan Operasional Kesehatan-BOK): supplemental funding directed for public health activities such as promotion, prevention and outreach activities. These funds cannot be used to support personnel or infrastructure.

Indonesia

Funding transferred to sub-national government is mainly used to finance subsidies on infrastructure, specific programmes or operational cost of health services.

Based on NASA 2015, central government spending was used predominantly to finance care, support and treatment for PLHIV by providing ART for free, reagents or medical equipment, while local government spends most of their funds for health promotion programmes targeting the general population. International partners usually focus on prevention programmes for key populations by providing direct funding to CSOs or CBOs. Other ministries spend their funds to support general community education, while the Ministry of Social Affairs (MOSA) provides a small amount of funding to support PLHIV or key populations.

Funding Sources

The main source of funding for health is increasingly domestic, with the central government expenditure (APBN) at 40%, sub-national expenditure (APBD) at 11% and national health insurance (JKN) at 6% in 2014[28].

The remaining funding comes from bilateral and multilateral sources (Global Fund, USAID, UN System) or foreign foundations. Global Fund remains the biggest international donor in 2014, accounting for 60% of international funding sources[29].

Other domestic resources came from the corporate sector through CSR or company contributions coordinated by IBCA (Indonesian Business Coalition on AIDS), standing at 0.02% of the total source.

At the national level, in addition to MOH's budget, there exists a budgetary allowance for HIV response from Ministry of Social Affairs, Ministry of National Education, and Ministry of Youth and Sports (NAC). However, the amount of budget of these ministries are dependent on political and moral consideration and hence is not seen as a sustainable source for key populations financing.

MINISTRY	TOTAL	
Ministry of Social Affairs	USD	1,534,687
Ministry of Defense		91,945
Ministry of Labour		69,364
Ministry of Justice		57,350

Table 2: HIV expenditure other than MOH in 2014 [30]

Health Budget Planning Processes

In the process of health financing, Ministry of Finance has a list of "indicative limits' usually called the financial note for budgeting processes developed by ministries and local governments (see Figure 6 below, right column). This budgeting process is a "top-down" mechanism where the ministry determines the budget items and limitation of these items.

On the other hand, the planning process is a "bottom-up" approach, started from sub-national level and finalised at the national level, with provision for participative engagement with civil society. Ideally, the two mechanisms should meet in the middle to discuss the financial note, but this is usually not the case. The Ministry of Finance would have already prepared the financial notes, and the proposed budget developed by the ministries are negotiated during the process by the National Development Planning Board (Bappenas). This essentially makes the budget planning mechanism a "top down" approach, a significant challenge for civil society to engage and effectively influence budget advocacy.

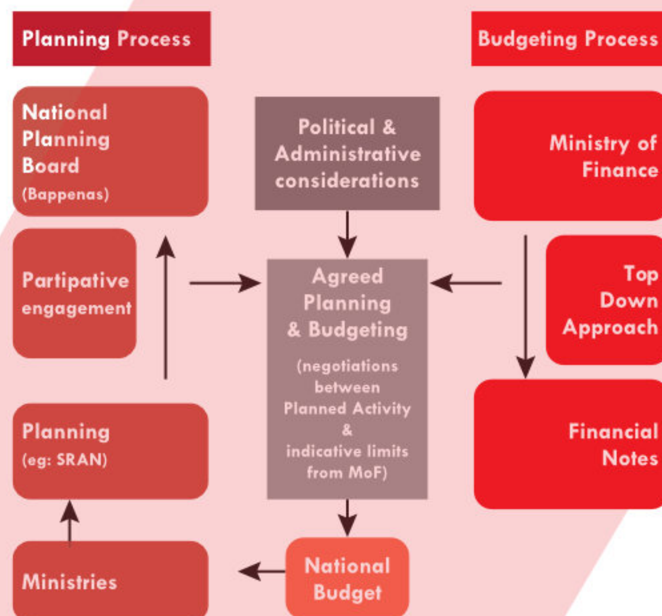


Figure 6: Budget planning process (based on interview with FITRA)

28. NASA Indonesia (2015)
29. NASA Indonesia (2015)
30. NASA Indonesia (2015)

V. National Budget Mechanisms

A flowchart of budgeting process on health as described in MOH's Regulation no. 7/2014 is shown above. This flowchart explains in detail the processes at each level (national and sub-national) and the timeline for each process to take place. However, civil society involvement is not indicated specifically, as seen in the budget cycle above. There is no document-based evidence that shows civil society's influence on the sub-national and national health budgeting process[31].

VI. Analysis

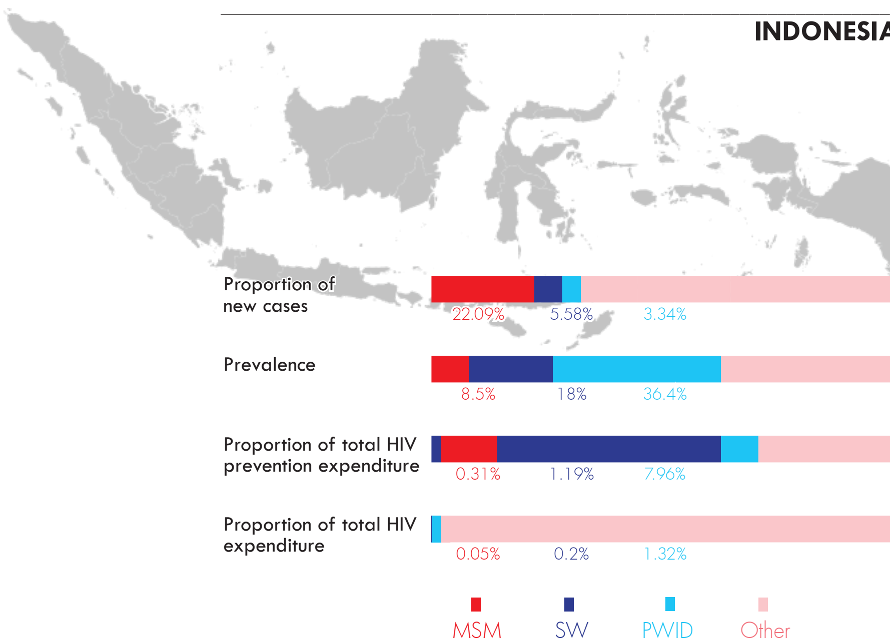


Figure 3: Key Populations Incidence and Prevalence vs Prevention and Total Spending, Indonesia 2014 [32]

With the 2014 data disaggregated further, MSM registered the highest in incidence rate at 23%, while receiving investments of only 0.3% of prevention and 0.05% of total HIV expenditure. Looking at prevalence, PWID is the largest with 36%, receiving more prevention investment than MSM at 8% and a total HIV expenditure of 1.3%.

An inference can be made that the bulk of funding for HIV prevention goes towards the general population (other). However, looking at the total HIV investment, which includes significant costs of care and treatment, the amount spent on the care and treatment for key populations is not as readily deduced, as treatment data for key populations are not routinely captured.

G-20 and Eligibility for Funding Support

As a member of the G-20, Indonesia now faces the risk of becoming ineligible for Global Fund support. According to the Global Fund Eligibility Policy: Upper-Middle Income Countries that are members of the Group of 20 (G-20) countries are not eligible to receive an allocation and apply for funding unless they have an 'extreme' disease burden. Currently Indonesia is a lower-middle income country[33] but approaching upper-middle income status.

It remains unclear when Indonesia's ineligibility will be recognised. In the event of full domestic financing, a significant paradigm shift needs to occur requiring domestic governments to absorb the cost entirely. Because the bulk of key populations programmes are funded externally, except for PWID, the impact on key populations could be considerable if the transition is not managed.

31. Seknas Fitra, 2012. Budgetary Reform in Indonesia. Budget Brief September 2012
32. AIDS Info Online (2017)
33. World Bank 2017, Country classification by income. http://www.piscomed.com/wp-content/uploads/2017/03/Income-classification.pdf

Indonesia

Recommendations for Further Areas of Research

The epidemiological and expenditure data presented requires further clarification, especially for use to inform advocacy measures, namely:

- How was key populations data collected for total HIV expenditure, considering care and treatment data does not differentiate routinely between key populations and general population. Would prevention spending be a better strategic information focus for advocacy purposes?
- What constitutes key populations in routine data collection? As evident from the 2015 NASA reporting, there are multiple categories, such as high-risk populations, other key populations, specific populations etc. With PLHIV (ODHA) and non-target groups (Kelompok Non-Target) receiving the majority (43% and 32%) of the total expenditure respectively, there is a need to clarify what populations and intervention makes up these grouping, and why they are classified this way. See Table 3 below:

	ODHA	Populasi Resiko Tinggi	Populasi Kunci Lainnya	Populasi Spesifik (yg ter jangkau)	Populasi Umum	Kelompok Non Target	Spesifik Populasi Target (tidak ada klasifikasi)	Total
2013	30,320,226	10,098,547	2,526,432	5,107,939	9,734,058	30,039,571	10,692,508	98,519,280
2014	43,685,105	12,929,314	1,000,001	4,998,581	6,684,083	31,208,039	6,289,474	106,794,597

Table 3: HIV expenditure by population, Indonesia 2013-2014 (USD Million), translation provided in footnotes[34]

Decision makers

One of the key decision makers in the process of AIDS budgeting is the Directorate General of Disease Control at the Ministry of Health. The institution decides on activity items in the budget, with the Director General a good ally for CSOs in advocating for HIV budgeting. Budget categories for HIV are included within the budget for infectious diseases at the Ministry of Health; they are not specific for HIV. The HIV budget is also only a small fraction of the total health budget, indicative of a potential ease in negotiating budgetary reconsiderations[35].

Since decentralisation, province-level health offices have mainly been responsible for training and coordination efforts as well as oversight of provincial hospitals, but they have limited resource allocation responsibilities. In contrast, districts have major responsibilities for delivering health services and allocating resources. By design, districts are now responsible for public service planning and budgeting, but their capacity to implement programmes are limited as they are not significantly involved in designing the AIDS response. As district level offices play a role in funding and administrative arrangements more than programme implementation, there is an opportunity to position CSOs as capable of complementing this work as programme implementers.

The National AIDS Commission (NAC) has pushed for the Ministry of Home Affairs to encourage provincial and district government to create local policies enabling provincial funding (APBD) for HIV responses at these administrative levels. However, the result has not been as expected. Only 98 districts out of about 500 districts have local HIV policies that enable funding from local government. It seems that there is a lack of clarity in interpreting what these policies mean in the implementation stage. This results in programmes that may not be appropriate for the HIV response at the provincial level.

34. NASA Indonesia (2015). Translation: ODHA (PLHIV), Populasi Risiko Tinggi (high risk populations), Populasi Kunci Lainnya (Other key populations), Populasi Umum (general population), Kelompok Non Target (non-targeted group), Spesifik Populasi Target "tidak ada klasifikasi" (non-classified specific target population).
35. Pers. Comms with Seknas Fitra (2017)

Innovative Financing Sources

A funding stream that has not been utilised optimally for supporting AIDS response especially by CSOs are grants or social assistance funds from Ministry of Home Affairs (MOHA) and local government. According to Law No. 17/2013 on Community Organisations, the government has the obligation to guide and strengthen the existing community organisations in Indonesia through policy facilitation, institutional capacity strengthening and strengthening for human resources in community organisations. These strategies are aimed to empower community organisations to be partners of the government in development process. Empowerment strategies include providing funds for the community organisations to implement their programmes (see Figure 7).

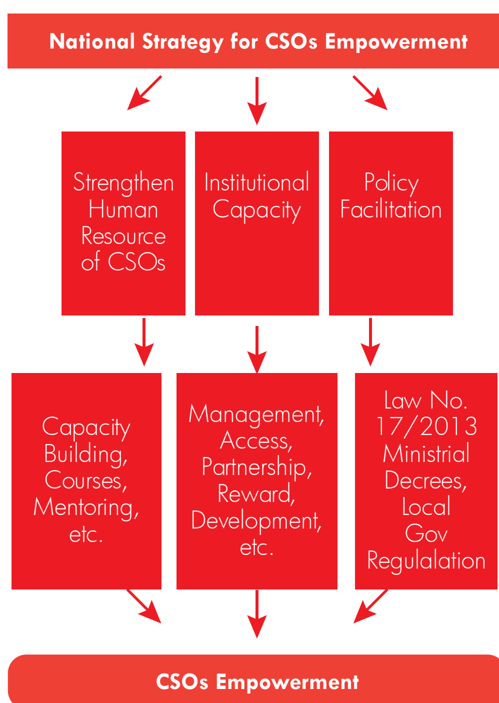


Figure 7: MOHA National Strategy for CSO Empowerment[36]

CSOs and CBOs working in the HIV response across Indonesia are eligible for receiving funding from MOHA or other ministries because they are mostly registered as community organisations at Ministry of Law and Human Rights or at local government office[37]. This legal status is the main pre-requisite to access the grants or social assistance. There is a clear procedure developed by MOHA to access this grant or social assistance fund (see Figure 8)[38].

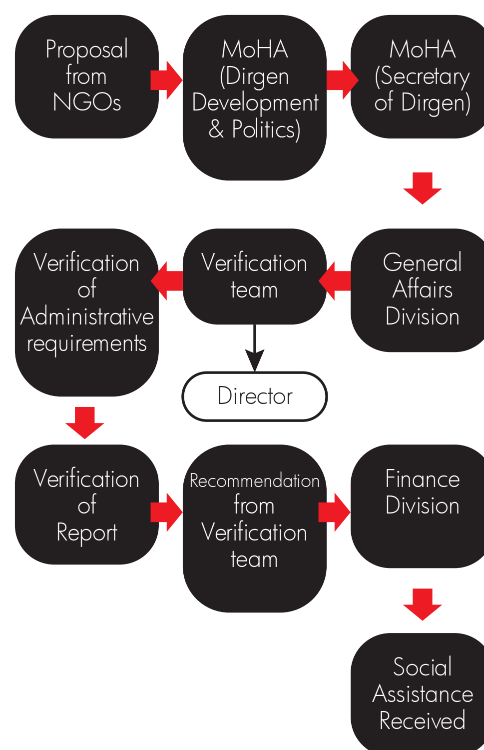


Figure 8: Procedure to Access Social Assistance based on Home Affairs' Ministerial Decree No.44/2009 and Home Affairs' Ministerial Regulation No.20/2013

36. MOHA (2015). Empowering Community Organisation based on Law No. 17/2013, presented at Indonesia Health Policy Forum, Padang, August 26, 2015
37. Koalisi Kebebasan Berserikat (2015). Monitoring Report 2nd Year of the Implementation of Act on Societal Base Organisation (Act Number 17/2013)
38. MOHA (2015). Empowering Community Organisation based on Law No. 17/2013, presented at Indonesia Health Policy Forum, Padang, August 26, 2015

Acknowledgements:

APCOM would like to acknowledge Min Fuh Teh, Strategic Information Officer, as the lead author of this report, as well as recognising the valuable contribution of peers at APCOM who provided feedback for this report: Inad Rendon, Senior Programme Manager, and Ryan Figueiredo, Deputy Director.

We would also like to acknowledge the Australia Federation of AIDS organisations (AFAO), the principal recipient of this project, for overseeing the SHIFT Programme. We recognise the valuable contribution of the staff at AFAO who reviewed and provided feedback for this report before publication: Rebecca Gupta-Lawrence, Programme Officer, Greg Gray, Technical Advisor, Jenny Xia, M&E Officer and Joselyn Pang, International Programme Manager.

We wish to acknowledge our SHIFT country partners - the Indonesian AIDS Coalition (IAC), the Malaysian AIDS Foundation (MAC), the Thai National AIDS Foundation (TNAF) and Action for Health Initiatives Inc. (ACHIEVE) in the Philippines, for their significant contribution, feedback and support in providing insights from a localised context.
A thank you to Sekretariat Nasional Forum Indonesia Untuk Transparasi Anggaran (Seknas Fitra) as well for the data support and technical input for the Indonesian section of this report.

A special thanks goes to the UNAIDS Data Hub Team, specifically Taoufik Bakkali, Technical Manager and Regional Programme Adviser, Dr. Khin Cho Win Htin, Lead Data Specialist, and Dr Ye Yu Shwe, Data Specialist for providing sources of data and technical input that were included in this report.

Finally, we would like to extend our sincere appreciation to all stakeholders for investing their trust in this project and for sharing their opinions, views, evidence, and data, ultimately making this report possible.

Lead Author: Min Fuh Teh
Design and layout: Andrey Tan, Philips Loh, and Vaness Silpakhon Kongsakul
Project Managers: Inad Rendon and Ryan Figuriedo

Map Disclaimer: The designations employed and the presentation of the material on this map do not imply the expression of any opinion whatsoever on the part of APCOM concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Every effort is made to ensure this map is free of errors but there is no warrant the map or its features are either spatially or temporally accurate or fit for a particular use.
This map is provided without any warranty of any kind whatsoever, either express or implied.

Regional Partners:

Country Partners: