REVIEW OF THE NATIONAL HEALTH SECTOR RESPONSE TO HIV IN THE REPUBLIC OF INDONESIA

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REPORT
2017

Joint External TB Monitoring Mission
Country Review on HIV Response
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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral treatment
ANC	Antenatal care
APBD	Anggaran Pendapatandan Belanja Daerah, National budget
APCOM	Asia Pacific Coalition on Male Sexual Health
APBN	Anggaran Pendapatan dan Belanja Negara, Provincial/district/city budget
ARV	Antiretroviral (drug)
ARVFAST	Antireroviral Forecasting and Supply Planning Tool
Bappenas	Badan Perencanaan Pembangunan Nasional, National Development Planning Agency
BNN	Badan Narkotika Nasional, National Narcotics Agency
BPJS	Badan Penyelenggara Jaminan Sosial, Social Insurance Administration Agency
BPPSDM	Badan Pemberdayaan dan Pengembangan Sumber Daya Manusia, Agency for the Development and Empowerment of Human Resources, Ministry of Health
CCM	Country Coordinating Mechanism
Cd4	Cluster of Differentiation 4
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPT	Cotrimoxazole preventive therapy
CSO	Civil society organisation
CST	Care, support and treatment
DHO	District health office
DKI	Daerah Khusus Ibukota, Special Capital City Region (Jakarta)
EID	Early Infant Diagnosis
EQA	External quality assessment
Fokus Muda	Forum Populasi Kunci Usia Muda, National Network of Young Key Affected Populations
FSW	Female sex worker
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GWL-INA	Gaya Warna Lentera Indonesia, national network of gay and transgender communities
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
HTC	HIV counselling and testing
IBBS	Integrated Biological and Behavioural Survey
INA-CBG	Indonesia Case-Based Groups
IPPI	Ikatan Perempuan Positif Indonesia, Indonesian Positive Women's Network
IPT	Isoniazid preventive therapy
JEMM TB	Joint External Monitoring Mission for Tuberculosis
JKN	Jaminan Kesehatan Nasional, National Health Insurance

KAP	Key affected population(s)
LGBT	Lesbian, Gay, Bisexual andTransgender
LKB	Layanan Komprehensif Berkelanjutan, Continuum of Care
M&E	Monitoring and evaluation
MMT	Methadone maintenance therapy
MNCH	Maternal, newborn and child health
MOH	Ministry of HealthMSMMen who have sex with men
MSS	Minimum Service Standards
NAP	National AIDS programme
NAC	National AIDS Commission
NGO	Nongovernmental organisation
NSP	Needle and syringe programme
NTP	National Tuberculosis Programme
OI	Opportunistic Infection
OPSI	Organisasi Perubahan Sosial Indonesia, National Network of Sex Workers
PEP	Post-exposure prophylaxis
PHO	Provincial health office
PICT	Provider-initiated Counselling and Testing
PITC	Provider-initiated Testing and CounsellingPLHIVPerson/people living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
POC	Point of carePrEPPre-exposure prophylaxis
PSM	Procurement and supply chain management
Pusdatin	Pusat Data & Informasi Kementerian Kesehatan Republik Indonesia
Puskesmas	Pusat Kesehatan Masyarakat, primary health care facility
PWID	Person/people who inject drugs
PWUD	Person/people who use drugs
RDT	Rapid diagnostic test
SIHA	Sistem Informasi HIV/AIDS, HIV/AIDS Information System
STI	Sexually transmitted infection
SUFA	Strategic Use of ARV
TB	Tuberculosis
UHC	Universal health coverage
UNAIDS	Joint United Nations Programme on AIDS
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WHO	World Health Organization
YKAP	Young key affected populations

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Executive Summary

The Ministry of Health of the Republic of Indonesia sought the cooperation of the World Health Organization to conduct a Review of the National Health Sector Response to HIV, from 16 to 27 January, 2017. The most recent review had taken place in 2011. The present review took stock of the implementation of the 2011 recommendations and, through a variety of methods, examined progress achieved since the last review, opportunities for further progress and barriers faced by Indonesia towards achieving its medium-term goals of effectively scaling up HIV prevention, care, treatment and support (i.e. by 2020, 90% of PLHIV will be aware of their HIV status; 90% of these will be on treatment; and 90% of those on treatment will have achieved viral elimination). The longer-term goal of the Indonesian response to HIV is to eliminate transmission of HIV by 2030.

Accordingly, a large team consisting of 25 national and external members was deployed to selected parts of the country, met with a large number of institutions and held individual meetings with a series of government officials as well as focus group discussions involving public service personnel, private sector practitioners, national human rights institutions, members of civil society, non-governmental organisations and representatives of multilateral and bilateral official development assistance agencies. UNAIDS and USAID provided particular support for the enabling environment, civil society and prevention aspects of the Review.

The objectives of the 2017 Review are:

1. **To review the status of the HIV/AIDS epidemic,** including a review of the relevance and adequacy of the strategic plan of the National Action Plan focusing on the health sector response to HIV/AIDS;
2. **To assess the adequacy of the national response,** including policies and programmes for HIV prevention, care and treatment. This will include an assessment of the progress and effectiveness of HIV prevention, care/treatment and support activities and identification of the constraints on programme implementation; and
3. **To provide recommendations** for refining the programmatic and technical aspects of HIV/AIDS prevention, care and treatment, including recommendations on the way forward for policy formulation and programme planning, implementation and collaboration among partners.

Conveniently, an analysis of the HIV epidemiological situation and impact in Indonesia had been conducted in Yogyakarta in November-December 2016 by a team of Indonesian epidemiologists with support from WHO and UNAIDS. The findings from this activity fed into the operational and management review of January 2017. The HIV Review also coincided with a large-scale monitoring exercise of the National TB Programme. Fruitful interaction between the HIV and the TB Review Teams resulted from joint discussions, the exchange and analysis of data and well-coordinated recommendations. Preliminary outcomes of both Reviews were presented jointly by the HIV and TB teams to H.E. the Minister of Health, the Representative of WHO in Indonesia, the Director of Communicable Disease Prevention and Control, an assembly of senior and other Ministry of Health staff, and numerous other stakeholders on the last day of the Reviews.

The HIV epidemic in Indonesia

Indonesia presents a complex and dynamic epidemic in a country that is very large, not only in terms of land and number of islands, but in population as well. The country also has a dynamic demography that has become increasingly urbanized over the last decade. In Indonesia, as in many countries in Asia, there is considerable heterogeneity in the epidemic context as well as in the levels of HIV prevalence among key populations.

There were an estimated 630,000 persons living with HIV (PLHIV) in Indonesia in 2015. As in other Asia-Pacific countries, HIV and AIDS in Indonesia remains concentrated in sub-populations that are exposed to an elevated risk of HIV transmission due to their behaviours, and this is compounded by persisting stigma and discrimination exerted towards them. These people are commonly referred to as “key affected populations” or “key populations”, and include sex workers, people who inject drugs (PWID), men who have sex with men (MSM), and transgendered persons (waria). The Review also examined the needs of, and services accessible to, at risk and vulnerable populations. These terms are defined in the body of the report.

The national HIV prevalence rate among people aged 15 years and above was estimated at 0.3% in 2015. Provincial estimates of HIV prevalence range from 0.1% to over 2.0%. Tanah Papua (comprising the provinces of Papua and West Papua) is an exception to the regional norm, with an estimated HIV prevalence of 2.3% in the general population in 2013.

As noted above, the epidemic in Indonesia is mostly concentrated in key populations, who display variable prevalence levels and trends across the provinces. The situation is different in Tanah Papua, which has a low-level generalised epidemic with more women than men living with HIV. Absolute numbers of PLHIV are highest in Jakarta and in the highly populated provinces of Java, as well as in Papua and West Papua. Although driven in earlier years by needle sharing among PWID, sexual transmission is now the primary mode of transmission of HIV, disproportionately affecting men having sex with men.

Indonesia has made tremendous progress in increasing the number of people tested for HIV. In addition, the number of people on antiretroviral therapy (ART) has increased to over 73,000 as of September 2016 from a just a few thousand in early 2011. This coverage is, however, insufficient to achieve the 2020 goals.

This report highlights successes and shortcomings of the national health sector response to HIV. The intensive decentralization process in Indonesia creates new opportunities for scaling up responses to HIV. Yet the insufficient clarity about the roles of actors at various levels of the health system and the relative lack of alignment of policies, laws, financing, strategic design and implementation practices between central and peripheral levels, hampers the efficiency and effectiveness of the fragmented response to HIV.entral and peripheral levels, hampers the efficiency and effectiveness of the fragmented response to HIV.

Key recommendations

Based on the findings of the joint Indonesian and international Review Team, this Review recommends that:

1. Given the characteristics of the epidemics in Indonesia, the concept of risk and harm reduction should be extended to all key populations, and safe sex behaviours should be promoted to the general public.
2. The Government of Indonesia, through the Ministry of Health, in collaboration with the Ministry of Home Affairs, should consider finalising an integrated policy and plan for a comprehensive national response to HIV. The national policy and plan should clarify the distribution of tasks and responsibilities among central, provincial, and district governments, including the elements of the health system. This recommendation calls for strengthened collaboration between the Ministry of Health and other Ministries, including the Ministry of Home Affairs, Ministry of Social Affairs and the Ministry of Rural Areas, Development of Disadvantaged Areas and Transmigration.
3. The Ministry of Health should consider facilitating the meaningful involvement of community service organisations and other civil society organisations in all facets and at every stage of programme design, planning, implementation and M&E of the HIV response, while facilitating their access to resources.
4. The Ministry of Health, in collaboration with the Ministry of Home Affairs, should consider comprehensive efforts to eliminate the stigma and discrimination experienced by PLHIV, key populations and women, first and foremost in the health sector, and apply a rights-based response to HIV in conformity with the policies, laws and regulations supporting the national health sector response to HIV.
5. The Ministry of Health should consider expanding eligibility for ART to all people living with HIV, regardless of CD4 count.
6. The Ministry of Health should consider shaping a more cost-effective and resilient supply chain, starting with procurement, as the costs of ARV and other HIV-related commodities represent highly disproportionate amounts of the annual expenditures of the national AIDS programme. This will be key to ensure the financial sustainability of the programme for years to come.
7. The Ministry of Health should consider ensuring that the specific tests used in the HIV testing algorithm are consistent and streamlined across all health care facilities throughout the country, as determined by the national AIDS programme. Laboratory tests, including CD4 and viral load, should be free of charge for all PLHIV, not only for those with health insurance or residents of the district or province, but also for those from outside that district or province.
8. Districts with a significant HIV/TB burden should formulate integrated plans and budgets, covering all sources of funds at district level, to ensure adequate financial support. Further, this Review recommends that provinces and districts assess the level and patterns of their epidemics based on their knowledge of the local situation and data related to HIV and TB.
9. While it is recognised that expanding voluntary HIV testing may be problematic among "hard-to-reach populations", such is not the case for people who are already clients of health facilities, in particular TB patients and pregnant women. This report details specific recommendations and suggested actions for

rapidly scaling up voluntary HIV testing, with informed consent, in these populations.

10. In accordance with state obligations under the international treaties subscribed to by the Government of Indonesia, the government should consider taking steps to reform national and sub-national policies and practices that hinder the effective implementation of the HIV response. These steps, which could be promoted within the Government of Indonesia, should include documenting the impact of both enabling laws and legal barriers to the HIV response, and initiating dialogue with the affected communities and other key stakeholders, such as parliamentarians, the National Human Rights Commission, and national experts.

These recommendations are spelled our further in the report and supported by practical action points, along with responsibilities, time frame and, where appropriate, indicators of progress.

Introduction

Contextual information

Indonesia, as a developing country with a population of 240 million spread across 514 cities and districts, faces specific challenges in its response to HIV. Although the national poverty level has decreased to 10.7%,[1] there is growing trend of economic inequality, as the Gini ratio indicates.[2] Indonesia is currently enjoying a demographic dividend, with an increase in young people of working age that is expected to peak in 2030, coinciding with the deadline of the Sustainable Development Goals.[3,4]

Indonesia is one of the few countries to have experienced an increase in maternal mortality in recent years after enjoying the lowest rate recorded in 2007 (228 per 100,000 live births), as documented by the most recent survey conducted in 2014.[5] There were an estimated 630,000 people living with HIV and AIDS (PLHIV) in 2015, while just 9% were on antiretroviral therapy (ART), a low figure for the Southeast Asia region, where the average coverage is 39%.[6,7,8] With regard to tuberculosis (TB), the most common opportunistic infection among people living with HIV, the high levels of TB and HIV coinfection and the increase in multi-drug resistant TB in Indonesia are causes for concern. There were an estimated 78,000 new cases of TB/HIV in 2015.[9]

HIV prevalence among adults (15-49 years old) reached 0.3% in 2015.[10] The data indicate that the proportion of cases among men who have sex with men (MSM) has increased almost fivefold since 2011, to 10%. Nevertheless, new cases continued to be predominantly associated with heterosexual transmission (76%) up to the 3rd quarter of 2016.[11]

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[1] Statistics Indonesia. Jumlah dan Persentase Penduduk Miskin, Garis Kemiskinan, Indeks Kedalaman Kemiskinan (P1), dan Indeks Keparahan Kemiskinan (P2) Menurut Provinsi, September 2012. (Number and Percentage of Poor People, the Poverty Line, Poverty Gap Index (P1), and Poverty Severity Index (P2) by province, September 2012). [Internet]. Jakarta: Badan Pusat Statistik; 2013 [cited 24 Jan 2017]. Available from: https://www.bps.go.id/linkTabelStatis/view/id/1489

[2] Statistics Indonesia. Gini Ratio by Province 1996, 1999, 2002, 2005, 2007-2013. [Internet]. Jakarta: Badan Pusat Statistik; 2017 [cited 24 Jan 2017]. Available from: http://www.bps.go.id/linkTabelStatis/view/id/1493

[3] Hayes A, Setyonaluri D. Taking Advantage of the Demographic Dividend in Indonesia: a Brief Introduction to Theory and Practice. Jakarta: United Nations Population Fund; 2015.

[4] United Nations General Assembly. Transforming Our World: The 2030 Agenda for Sustainable Development. A/RES/70/1 (21 Oct 2015); 2015.

[5] Ministry of Health of the Republic of Indonesia. 2015. Profil Kesehatan Indonesia Tahun 2015. (Indonesia Health Profile 2015). Jakarta: Ministry of Health of the Republic of Indonesia; 2016.

[6] WHO. Progress Report on HIV in the WHO South-East Asia Region. New Delhi: WHO Regional Office for South-East Asia; 2016. p. 27.

[7] Assessment of the Implementation of the Regional Health Sector Strategy on HIV 2011-2015. New Delhi: WHO Regional Office for South-East Asia; 2016. p. 13.

[8] For a detailed epidemiological analysis of the status and trends of the HIV epidemics in Indonesia, readers are encouraged to refer to the recent epidemiological review: Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[9] WHO. Global Tuberculosis Report 2016. Geneva: World Health Organization (WHO); 2016.

[10] Ministry of Health of the Republic of Indonesia. Estimates and Projection of HIV/AIDS in Indonesia 2015-2020. Jakarta: Directorate General of Disease Control and Prevention, Ministry of Health; 2017.

[11] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (*HIV, AIDS and STI Report, 3rd Quarter 2016*). Jakarta: Ministry of Health; 2016.

Since the last review in 2011,[12] there have been a number of new developments that have had a systemic impact on the health sector. One of them was the launch of the national health insurance scheme (JKN) in 2014 as a form of universal health coverage. Since 2013, national spending on HIV and AIDS has exceeded 50% of the total (national and external) HIV/AIDS expenditure, with treatment accounting for the largest share.[13] With the advent of the Global Fund's New Funding Model in 2016, outreach by peer workers was intensified for each key population. Renewed efforts were made to strengthen civil society and community-based organisations. Care, Support and Treatment (CST) services were decentralized to primary health care facilities and supply logistics were strengthened in preparation for the greater regional autonomy. The paradigm of early initiation of antiretroviral treatment was integrated into the guidelines for health care staff[14] within the Continuum of Care (LKB) framework, which spans all levels of care from diagnosis to long-term retention in treatment.[15,16]

The period since 2011 has also set new challenges for HIV prevention programs. The closure of sex work venues,[17] changing patterns of drug use,[18] and the criminalization of the LGBT discourse have impacted the HIV response.[19] The identification of more specific target groups within the heterosexual population is supporting the development of more selective interventions. In terms of funding, increased spending on HIV and AIDS at the macro level is not yet being matched by similar increases in spending on important program components at the province or city/district levels.[20] This is the backdrop against which this Review of the health sector response to HIV took place.

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[12] Ministry of Health of the Republic of Indonesia. Review of the Health Sector Response to HIV and AIDS in Indonesia 2011. Jakarta: Ministry of Health and World Health Organization; 2011.

[13] National AIDS Commission. Roles of Cross-Sectoral Collaboration on Critical Enablers, Factors to Accelerate AIDS Control in Indonesia: Performances and Challenges. Jakarta: National AIDS Commission; 2017.

[14] Minister of Health of the Republic of Indonesia Regulation no. 87/2014 on the Antiretroviral Treatment Guidelines.

[15] Ministry of Health of the Republic of Indonesia. Roadmap Mengurangi Kesakitan dan Kematian Terkait HIV, dan Memaksimalkan Manfaat Perluasan Akses ARV sebagai Pencegahan HIV. (*Roadmap for Reducing HIV-related Morbidity and Mortality, and Maximising the Benefits of Expanding Access to ARV for HIV Prevention*). Jakarta: Ministry of Health; 2013.

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[18] Nevendorff L, Praptoraharjo I. Crystal-Meth Use and HIV-Related Risk Behaviors in Indonesia: Study Report [Internet]. Jakarta: AIDS Research Center Atma Jaya Catholic University of Indonesia; 2016 [cited 21 Jan 2017]. Available from: http://mainline-eng.blogbird.nl/uploads/mainline-eng/Mainlines_sober_facts_on_chrystal_meth_use_in_Indonesia1.pdf.

[19] BBC. Kaum LGBT Indonesia Alami Diskriminasi (*LGBT Community in Indonesia experiences discrimination*). BBC [online daily]. 14 Aug 2014 [cited 24 Jan 2017]. Available from: http://www.bbc.com/indonesia/berita_indonesia/2014/08/140814 _lgbt_indonesia. Further development in more recent times sees ongoing attempts to prosecute LGBT and criminalize their sexual behaviour. See, Human Rights Watch. Indonesia: Court Reviews Anti-LGBT Law [Internet]. New York: Human Rights Watch; 2016 [cited 1 Feb 2017]. Available from: https://www.hrw.org/news/2016/08/23/indonesia-court-reviews-anti-lgbt-law

[20] National AIDS Commission. Roles of Cross-Sectoral Collaboration on Critical Enablers, Factors to Accelerate AIDS Control in Indonesia: Performances and Challenges. Jakarta: National AIDS Commission; 2017.

Objectives of the Review

The period between the last external review of Indonesia's health sector response to HIV and AIDS in 2011 and this current Review has seen tremendous change, both in the nature of the epidemic and in the scope and scale of the response. The Review Team performed a systematic review of the extent to which the 2011 review recommendations had been implemented (see Annex 4).

The objectives of the 2017 Review were:

1. To review the status of the HIV/AIDS epidemic, including a review of the relevance and adequacy of the strategic plan of the National Action Plan focusing on the health sector response to HIV/AIDS;
2. To assess the adequacy of the national response, including policies and programmes for HIV prevention, care and treatment. This will include an assessment of the progress and effectiveness of HIV prevention, care/treatment and support activities and identification of the constraints on programme implementation;
3. To provide recommendations for refining the programmatic and technical aspects of HIV/AIDS prevention, care and treatment, including recommendations on the way forward for programme planning, implementation and collaboration among partners.

The Review was expected to benefit the country on multiple levels. The findings and recommendations will help programme planners and implementers to improve the effectiveness of the National AIDS Programme. Secondly, by raising awareness about the current situation of the HIV/AIDS epidemic in the country, it will also be an important tool in reinforcing political commitment to the response. Finally, the Review was expected to contribute to promoting partnerships between the Government of Indonesia, NGOs and civil society, the private sector and international partners, including donors.

In the immediate term, the findings of the Review will also inform the strategic direction of the Global Fund support in the 2018-2020 period for the country's HIV/AIDS response.

Preparation and conduct of the Review

The actual Review took place between Sunday 15 January and Friday 27 January 2017. The team consisted of 25 national and external experts (see Annex 2), one of whom was nominated as a Team Leader by a joint Ministry of Health/WHO decision. Team members were selected by the Jakarta-based WHO staff engaged in HIV and their Ministry of Health counterparts, and comprised members of civil society, medical practitioners, health economists, policy and law specialists, logisticians, laboratory and strategic information specialists and other reviewers with expertise in HIV prevention, care, treatment and support.

Most members were fluent in English, others in Indonesian, and some in both languages. Two writers fluent in both English and Indonesian added to the strength of the team, while staff from the Ministry of Health were constantly on call to facilitate access to information and help interpret the documents made available to the team. Conveniently, the Review of the national response to HIV had been preceded by an analysis of the epidemiological situation in Indonesia conducted by an expert committee that had met in December 2016. The epidemiological analysis report was made available to the review team at the outset of their work. The HIV Review was implemented simultaneously with a monitoring activity of the national TB programme. Several

opportunities were secured to exchange information and views between the HIV and the TB Review Teams. Both the opening session of the Review and the presentation of provisional findings of the HIV and TB Reviews were presented jointly to HE the Minister of Health, the Director of Communicable Disease Prevention and Control, the Representative of WHO to Indonesia, and senior Ministry of Health officers as well as lay personnel and external partners working on HIV, TB or both.

Prior to the Review, attempts had been made to reduce the extremely broad scope of the assessment and focus primarily on what local and external actors considered as the major questions that should be addressed by the Review in order to enhance the performance of the national response to HIV, with a focus on the health sector. These attempts were not as successful as was hoped, however. As a result, the agenda and schedule of the Review were heavily loaded, occasionally exceeding the team members' capacity. To frame the Review and create a common understanding among reviewers as to what was expected from them, an instrument had been produced prior to the start of the Review. During a pre-review briefing of team members, sub-teams were tasked to review portions of the review instrument with a view to adjusting it based on their specialized experience and knowledge. This instrument proved to be quite useful as it enabled members of the Review Team to explore issues both within and outside their respective specialty. The Review began with a series of very valuable presentations given by leaders of the HIV and TB programmes and their staff. A schedule and division of labour for Review Team members and logistic arrangements were worked out jointly with the local WHO and Ministry of Health staff. The team was split into several sub-teams according to their respective schedules. Additionally, specialists in technical areas were nominated to provide direct input to the analysis of data collected by all sub-teams, with a view to ensuring the technical accuracy of a number of reports, travel notes and reference documents setting norms and standards as recommended by international agencies (WHO in particular) and adapted by the Indonesian authorities.

It is hard to overstate the complexity of the Review exercise, which had to take into account the strongly decentralized nature of the national response to HIV and the way in which this impacts on all its aspects, including the policy and legal variations across provinces, regions, districts/cities and more peripheral entities such as puskesmas (primary health care facilities). To appreciate both the value and the constraints imposed by this decentralization, sub-sets of the Review Team were assigned to make enquiries with institutions (e.g. ministries, hospitals, NGOs and panels of provincial delegates, or a combination of these, in Jakarta and during field visits to three provinces or special administrative regions, including Jakarta (DKI), West Kalimantan, and Maluku. Delegations from Bali, Papua, West Java and Aceh were interviewed in Jakarta. Focus group discussions were held with delegates from provinces, districts/cities, key populations and other stakeholders. Face-to-face interviews with key actors and higher authorities complemented the information collected by the team. In selecting the sites for the field visits and local delegations, the following criteria were considered: (1) areas with a relatively high epidemic and a strong response (Jakarta, Bali); (2) areas with a relatively high epidemic and a less robust response (West Kalimantan, Papua, West Papua and West Java); and (3) areas with a developing epidemic (Maluku, Aceh).

Written contributions to the overall Review report relevant to each topic were received by an Editorial Committee composed by the Review Team Leader, a national Associate Team Leader, the head of the central HIV Health Office, Jakarta-based WHO international staff and a clinician from Yogyakarta. Throughout the exercise and the collection and validation of data, national staff from the Ministry of Health and others attached to the WHO Representative Office were instrumental in ensuring the completeness and quality of the information analysed by the Review Team. Subsequently, draft contributions were worked on by the two

writers and, after a lengthy exchange between the writing team and the original contributors, sections of the report were assembled in what is presented here. Considering the wide scope of the Review, this length of this report exceeds what was anticipated. Thus, a decision was made to not expand its size further but to upload annexes and other reference materials to a website managed by WHO and to which access can be granted to interested readers.

The recommendations arising from this Review appear at the end of each section and are collated in Annex 1. Recommendations are as succinct as possible, and presented in the form of action points, in the hope that these will be helpful in the re-planning of the national response to HIV.

Review focus on key populations and other at-risk and vulnerable populations

A strong focus of this report is placed on key populations, at-risk populations and vulnerable populations as they are at a disproportionate risk of acquiring or living with HIV, while also constituting a critical resource for responding comprehensively to the epidemics in the country. In addition to people living with HIV (PLHIV), **key populations** comprise sex workers, people who inject drugs (PWID), female transgender (waria), and men who have sex with men (MSM); a**t-risk populations** comprise prison inmates, pregnant women, TB patients, migrants, clients of sex workers and partners of PLHIV.[21] **Vulnerable populations** are understood in this report as people who, for any social, economic, environmental, cultural, personal or other reasons may become prone to becoming exposed to a risk of acquiring HIV infection. These include young people.

The pattern of HIV spread in Papua somewhat differs from that in other parts of the country: there is a low-level generalised epidemic, with more women than men living with HIV. Accordingly, consideration has been given by the Review Team to differentiating the response to HIV in Papua (see Chapter 4).

The Ministry of Health has mobilized a large amount of its human and financial resources to bring the HIV epidemics under control. It is doing so through a matrix management system with a strong focus in the Directorate of Communicable Diseases with links to a number of other central and sub-national health entities. This structure has received strong guidance from the National AIDS Commission. Yet Indonesia, unlike most other countries, has not established a formally named "National AIDS Programme". For clarity and simplicity, this report will refer to the assembly of national and sub-national actors in the field of HIV in Indonesia by its generic denomination: the national AIDS programme (NAP).

Deliverables

Provisional recommendations were presented to HE the Minister of Health, the Representative of the World Health Organization in Indonesia, a panel of senior officials and other participants on 25 January 2017. A summary of provisional recommendations was made available in early February 2017 to drafters of a grant application to the Global Fund to inform their work. Meanwhile, this report was reviewed by section contributors and revised on multiple occasions, and ultimately constructed in a pre-final version for submission to WHO and, through WHO, to the Ministry of Health. The authors of this report express their pride in having been invited to conduct this Review. The Review Team apologizes for any errors this report may contain and invites readers to bring any needed correction or misinterpretation to its attention.

[21] Minister of Health of the Republic of Indonesia Regulation no. 74/2014 on the Implementation Guidelines for HIV Counselling and Testing: Chapter I, page 9; and other documents from the National AIDS Commission.

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1. Government system for HIV programmes and delivery: improving the implementation of decentralization in health

Introduction

The governmental system of the Republic of Indonesia changed in 1999 from centralized to a decentralized structures, roles and responsibilities, under the first decentralization law.[1] This law was amended by Law No. 32/2004 on Local Government, which was then superseded by Law No. 23/2014 on Local Government.

This chapter will highlight the main features of this law and of the ministerial regulations that have guided its implementation as they relate to the national response to HIV.

The most recent and comprehensive regulation on HIV was the Minister of Health Regulation No. 21/2013 on HIV and AIDS Control, which preceded the enactment of the 2014 Local Government law and has not been updated since. Since that time, the profiles of the HIV epidemics in Indonesia have evolved and, while progress has been achieved within multiple facets of the response, a number of prior governance issues persist while new ones have emerged. The achievement of the 90-90-90 targets by 2020[2] and the goal of ending the HIV epidemic by 2030[3] call for structural adjustments, including streamlining of the management of the HIV response, policy, regulations, division of tasks and responsibilities, and financing. Among the most critical and complex barriers to an effective, coordinated response to HIV are the interpretation of policies and regulations; the enactment of local bylaws; and governance and management by the Ministry of Health, provincial and district/city health offices, and communities.

Decentralization in Indonesia and the response to the HIV epidemic

Decentralization in Indonesia

Geopolitical decentralization was the nation's choice in 1999, following the beginning of the "reform" era in 1998. Prior to this time, governance had been highly centralized.[4] Decentralization, grounded in the 1999 law and its subsequent revisions (2004 and 2014), was aimed at bringing public service delivery closer to the

[1] Law of the Republic of Indonesia No. 22/1999 on Local Government.

[2] UNAIDS. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic. Geneva: Joint United Nations Programme on AIDS (UNAIDS); 2014.

[3] UNAIDS. Fast-Track - Ending the AIDS Epidemic by 2030. Geneva: Joint United Nations Programme on AIDS (UNAIDS); 2014.

[4] Rasyid MR. Regional Autonomy and Local Politics in Indonesia. Dalam: Aspinall E, Fealy G. Local Power and Politics in Indonesia: Decentralisation and Democratisation. Singapore: Institute of Southeast Asian Studies; 2003. p. 63-71.

people, and with more specific services. Today, Indonesia is composed of 34 provinces (**Figure 1.1**) made up of districts[5] or regencies (*kabupaten*) and cities (*kota*).[6]

Figure 1.1 Provinces of Indonesia

The national government retains exclusive responsibility for foreign policy, defence, the legal system and monetary policy. Since 2005, heads of local government (governors, regents, mayors[7] and village heads) have been directly elected by popular election. Below the provincial level, districts, cities and, below them, sub-districts, enjoy greater autonomy than the provincial government, including over the provision of public schools and public health facilities. Five of the 34 provinces have special status: the Jakarta Special Capital Region, and the Special Regions of Aceh, Yogyakarta, Papua and West Papua. This special status confers these provinces autonomy over their own governance systems, with Aceh, Papua and West Papua also having 'Special Autonomy'.

Decentralization and regional autonomy in Indonesia applies to both the provincial and district/city levels. Provinces do not have direct authority over districts, but can act on behalf of the national government in coordinating and supervisory functions.[8] Of the three principal powers of the state, namely judicial (the Supreme Court), executive (the President), and legislative (Parliament), only executive power can be decentralized and/or delegated.

[5] Kabupaten (3rd level administrative units, at the same level as *kota*/cities) are sometimes referred to as 'regencies', with the term 'district' used for 4th level administrative units (*kecamatan*). In this report, *kabupaten* are referred to as districts and *kecamatan* as sub-districts.

[6] Ministry of Home Affairs of the Republic of Indonesia. Rekapitulasi Jumlah PPID Pemerintah Daerah Januari 2017 (*Recapitulation of the Number of Local Government Information & Documentation Management Officers January 2017*) [Internet]. Jakarta: Ministry of Home Affairs; 2017 [cited 10 Feb 2017]. Available from: http://www.kemendagri.go.id/media/filemanager/2017/01/20/4/_/4._rekapitulasi_jumlah_ppid_provkabkota_kedua.pdf

[7] Districts (*kabupaten)* are headed by regents and cities (*kota)* by mayors.

[8] Law of the Republic of Indonesia No. 23/2014 on Local Government.

The President can delegate some of his or her power to the ministries and to local (provincial and district/city) governments. There are two main categories of national affairs, namely “absolute” and “concurrent” affairs.

Absolute affairs are the domain of the central government, and include national security and safety, monetary affairs, foreign affairs and religious affairs. Concurrent affairs are dealt with concurrently by central government (through the ministries) and provincial and/or district/city governments. Concurrent affairs are further divided into “mandatory” affairs and “optional” affairs. Mandatory affairs cover goods and services that provincial and/or district/city governments are required to provide. Within the category of mandatory affairs, a further distinction is made between affairs that are related to the provision of basic services (such as health, education, housing, etc.) and affairs that are not related to basic service provision (including labour, food and land).

Health is one of the affairs that must be managed concurrently by central government (the ministry) and local governments, and concerns basic health services for the people.[9] Accordingly, the Ministry of Health, as the representative of the central government in this case, is required to develop guidance documents on how aspects of health, including services related to HIV, are managed and delivered by the three levels of government. Such guidance documents, as stated in Law No. 23/2014, should consist of Norms, Standards, Procedures, and Criteria. In the case of HIV, these should include the elements and functions of the management of all programmes and activities relating to HIV, such as surveillance, prevention, care, treatment and support.

The guidance document is intended to assign authority to local governments to formally allocate local budgets for HIV and to conduct HIV programmes and activities in accordance with national standards, and at standardised levels of delivery throughout Indonesia. Furthermore, this document is expected to identify all the stakeholders involved in the formulation, management and monitoring of HIV programmes; strengthen local AIDS commissions; and ensure the involvement of NGOs/CSOs at all stages of programme development and implementation.

Unfortunately, the Ministry of Health has not followed up Law No. 23/2014 by developing and disseminating these guidance documents, leaving the interpretation and application of the law up to each provincial, district and city authority. Unavoidably, therefore, responses to HIV by local governments have remained fragmented and variable across the country. This diversity affects the focus, intensity and effectiveness of HIV-related work, the level of funding allocated for HIV work, and the extent to which CSOs and NGOs can access part of this funding.

Laws and regulations enacted by local governments are not always aligned with national guidance, and can create barriers to HIV prevention, care, treatment and support.[10] As of 2017, a national, normative guidance document is still awaited. Two strategic plans on HIV were drafted in 2015: one by the Ministry of Health: National Action Plan for HIV and AIDS in the Health Sector 2015-2019,[11] and the other by the National AIDS Commission: the National HIV and AIDS Strategy and Action Plan 2015-2019 (see **Box 1.1**).[12] Neither had been formally approved at the time of this Review.

[9] Law of the Republic of Indonesia No.23/2014 on Local Government includes HIV (and tuberculosis) services as one of the basic service types, with an emphasis on prevention and testing.

[10] For a review and case studies of discriminatory regulations in several areas, see Asa S. Kriminalisasi dalam Peraturan Daerah: Studi terhadap Perda Penanggulangan HIV & AIDS (*Criminalisation in Local Regulations: A study of Local Regulations on the AHIV & AIDS Response*). Yogyakarta: Lintang Books; 2015.

[11] Ministry of Health of the Republic of Indonesia. Rencana Aksi Nasional Pengendalian HIV dan AIDS Bidang Kesehatan 2015-2019 (*National Action Plan for HIV and AIDS in the Health Sector 2015-2019*). Draft per April 2015.

[12] National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

Box 1.1. Draft national HIV strategy and action planning documents

It should be noted that the Ministry of Health does not exercise direct authority over local authorities regarding health matters. These authorities are responsible to the Ministry of Home Affairs for all matters concerning local government, with the Ministry of Health acting as a technical adviser to local health authorities.

The following section highlights the evolving roles of the National AIDS Commission and of the AIDS and STI Sub-Directorate of the Ministry of Health, which is leading the health sector response to HIV.

Country responses to the epidemic

The Government of Indonesia responded to the epidemic in 1994 with the establishment of the National AIDS Commission.[13] The position and activities of the National AIDS Commission were later strengthened by Presidential Regulation No. 75/2006. A year later, the Ministry of Home Affairs issued Ministerial Regulation No. 20/2007 on the General Guidelines for the formation of local AIDS Commissions.

In 2002 the Ministry of Health issued guidelines on the control of HIV and STI,[14] which were revised by Ministerial Regulation No. 21/2013. This was followed by many other ministerial regulations on such specific

[13] Keputusan Presiden Republik Indonesia Nomor 36/1994 tentang Komisi Penanggulangan AIDS (*Decree of the President of the Republic of Indonesia No. 36/1994 on the AIDS Commission*), revised by Peraturan Presiden Republik Indonesia Nomor 75/2006 tentang Komisi Penanggulangan AIDS Nasional (*Regulation of the President of the Republic of Indonesia No. 75/2006 on the National AIDS Commission*).

[14] Keputusan Menteri Kesehatan Republik Indonesia Nomor 1285/2002 tentang Pedoman Penanggulangan HIV-AIDS dan Penyakit Menular Seksu (*Minister of Health Decree No. 43/2016 on the Guidelines for the Control of HIV-AIDS and Sexually Transmitted Infections*).

topics as HIV counselling and testing,[15] the prevention of mother-to-child transmission of HIV,[16] laboratory testing for HIV and opportunistic infections,[17] and others. **Figure 1.2** shows the key HIV and AIDS-related policies and regulations issued since Indonesia become a grant recipient of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) in 2003.[18]

With the issuance of Government Regulation No. 18/2016 on Regional Level Public Officials, the sole executor of government affairs in the health sector is the Health Office. Other stakeholders, including the AIDS commissions, will be functionally under the oversight of health offices. At the time of writing of this report, the Review Team learned that the National AIDS Commission will be dissolved by a Presidential Decree by the end of 2017, and replaced by a Technical Advisory Group under the national AIDS programme at the Ministry of Health.[19] Although the Review Team was not able to verify this information or fully explore its implications, such a structural change would reduce the risk of overlapping roles and actions, as has been documented during the Review, while preserving the independence of this body. The anticipated structural change should guarantee that the advice and guidance offered by the National AIDS Commission in its new form are not adversely influenced by the executive branch of the national AIDS programme, and that its guidance is informed by scientific evidence and recognized best HIV practice.

The number of HIV service facilities has increased dramatically in the years 2015-2017. To date, national and local governments operate 2,681 HIV counselling and testing sites; 655 ART centres; 1,574 centres for STI services; 238 PMTCT centres; 233 TB/HIV sites; 92 methadone sites; and various programmes in prisons and detention centres.[20] These achievements are commendable, given the lack of streamlined governance and coherence in the country response to HIV. However, the present Review triggered major concerns as a result of the observed diversity of local policies, regulations and resource allocations, the uneven adherence to national norms and standards and the inequitable access to and use of services across the country. Some illustrations of the fragmentation of the response to HIV in Indonesia are provided below.

The field visits and focus group discussions conducted by the Review Team[21] demonstrated the variation in the existence of local regulations on HIV in the form of Gubernatorial regulations (in provinces), Regent's

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[15] Peraturan Menteri Kesehatan Republik Indonesia Nomor 74/2014 tentang Pedoman Pelaksanaan Konseling dan Tes HIV (*Minister of Health Regulation No. 74/2014 on the Guidelines for HIV Counselling and Testing*).

[16] Peraturan Menteri Kesehatan Republik Indonesia Nomor 51/2013 tentang Pedoman Pencegahan Penularan HIV dari Ibu ke Anak (*Minister of Health Regulation No. 51/2013 on the Guidelines for the Prevention of Mother-to-Child Transmission of HIV*).

[17] Peraturan Menteri Kesehatan Republik Indonesia Nomor 15/2015 tentang Pelayanan Laboratorium Pemeriksa HIV dan Infeksi Oportunistik (*Minister of Health Regulation No. 15/2015 on Laboratory Testing Services for HIV and Opportunistic Infections*).

[18] Pusat Komunikasi Publik. Menkes Saksikan Penandatanganan Grant Agreement Global Fund (*Minister of Health Witnesses the Signing of the Global Fund Grant Agreement*) [Internet]. Jakarta: Pusat Komunikasi Publik, Secretariat General of the Ministry of Health of the Republic of Indonesia. 23 June 2010 [cited 3 Feb 2017]. Available from: http://www.depkes.go.id/article/print/1118/menkes-saksikan-penandatanganan--grant-agreement-global-fund.html

[19] Peraturan Presiden Republik Indonesia Nomor 124/2016 tentang Perubahan atas Peraturan Presiden Nomor 75 Tahun 2006 tentang Komisi Penanggulangan AIDS Nasional (*Regulation of the President of the Republic of Indonesia No. 124/2016 on the Amendment of Presidential Regulation No.75/2006 on the National AIDS Commission*).

[20] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016 (*HIV, AIDS & STI Report, 3rd Quarter 2016*). Jakarta: Ministry of Health; 2016.

[21] Field visits to Jakarta, West Kalimantan and Maluku, 18-20 January 2017, and discussions with representatives from health offices, health facilities and AIDS Commissions from Aceh, West Java, Bali and Papua.

regulations (in districts) or Mayoral regulations (in cities). Differences were also apparent in the funding available for HIV, which seems adequate in some areas and inadequate in others. The main sources of funding for local health offices is the national budget (APBN), local budgets (APBD), and financing from the Global Fund or other official development assistance agencies. Health offices also follow different procedures for budgeting. In earlier years, local AIDS commissions planned and requested their own funding from their respective local government, but in the past three years, funding for local AIDS commissions has been integrated with the budget of the local health office, and the allocation determined at that level. The effectiveness of the implementation of funding for HIV services through the national health insurance scheme is also variable, as is the level of coverage.

At the service delivery level, the provision of TB/HIV services is still inadequate, as is the provision of isoniazid preventive therapy (IPT). Outreach workers are mostly funded by non-government sources, mainly from the Global Fund. There are no regulations on local budget allocations for outreach, the funding of which is left to the arbitrary decision of local governments.

Figure 1.2. Key policies and regulations on HIV and AIDS in Indonesia since 2006

Year	Subject	Regulation/policy, institution
2006	Institutional strengthening of the National AIDS Commission	Presidential Decree RI No. 75/2006
	Harm reduction guidelines	Minister of Health Decree No. 567/2006
	Provision of care, support and treatment services at referral hospitals*	Minister of Health Decree No. 832/2006
2007	Establishment of local AIDS commissions	Minister of Home Affairs Regulation No. 20/2007
	Harm reduction as part of the HIV/AIDS response	Coordinating Minister for Welfare Regulation No. 2/2007
	National HIV and AIDS Strategy 2007-2010	National AIDS Commission
2008	Provision of methadone services at hospitals and satellite clinics	Minister of Health Decree No. 350/2008
2010	Acceleration of the achievement of the MDGs, including HIV/AIDS targets	Presidential Instruction No. 3/2010 on Socially Just Development Programs
	National HIV and AIDS Strategy Action Plan 2010-2014	Coordinating Minister for Welfare Regulation No. 8/2010
2012	Guidelines on the Prevention of Sexual Transmission of HIV	National AIDS Commission
	Guidelines on comprehensive Continuum of Care services for HIV and STI	Ministry of Health of the Republic of Indonesia
2013	Start of ART initiation irrespective of CD4 count for specific populations	Minister of Health Circular No. 129/2013

Year	Subject	Regulation/policy, institution
2013	Implementation of PMTCT Option B+†	Minister of Health Regulation No. 51/2013 on the Guidelines for the Prevention of Mother-to-Child Transmission of HIV
2014	Launch of the national health insurance scheme	Social Security Agency (BPJS) for Health
	Implementation of the Strategic Use of Anti-retrovirals (SUFA) in the revised/consolidated guidelines on ART for adults, children and PMTCT‡	Minister of Health Regulation No. 87/2014 on the Guidelines for Antiretroviral Treatment
2015	National HIV and AIDS Strategy and Action Plan 2015-2019 (draft)	National AIDS Commission

* Revised several times up to 2012.

† Initiation of all HIV-positive pregnant women on ART for life with ARVs for babies born to HIV-positive mothers from birth up to 4-6 weeks.

‡ First released in 2004 (for adults) and subsequently revised, up their consolidation in this regulation.

Challenges and opportunities for the HIV programme and service delivery

Challenges

- The implementation of decentralization from central to local governments is still weak. The laws on Local Government have not been consistently interpreted and followed at all levels of government.[22]
- There are two ministries involved in the decentralized implementation of the HIV programme, namely the Ministry of Health for technical matters and the Ministry of Home Affairs for governance aspects. Provincial and district/city health offices are governed by the policies of the local province/district/city government, and are accountable to the Governor, Regent or Mayor, respectively. These multiple lines of authority and accountability severely hamper coordination between the Ministry of Health and local health offices.
- There is no appropriate managerial guidance for local government on the delivery of HIV programmes and services. The guidance document that should have been issued by the Ministry of Health and the Ministry of Home Affairs, containing the Norms, Standards, Procedures and Criteria for delivering these services, is still awaited. Without this document, there is growing variation in the way HIV programmes are implemented, at both management and service levels.
- There seems to be poor coordination between different Directorates General in the Ministry of Home Affairs, which impacts on HIV programme performance at the district/city level.
- There is poor coordination and communication between the central government (Ministry of Health) and provincial and district health actors.

[22] This applies even to Law of the Republic of Indonesia No.32/2004 on Local Government, which was revised by Law of the Republic of Indonesia No. 23/2014 on Local Government.

- Until 2016, HIV was not included in the Minimum Service Standards (MSS) for health (Minister of Health Regulation no. 741/2008). Consequently, HIV was not a mandatory programme for local governments.[23]
- Through field visits and focus group discussions,[24] the Review Team documented wide variation across provinces and districts with regard to the implementation and quality of HIV programmes and activities. The managerial ability of health offices to respond to the epidemic is weak, with little planning and monitoring capacity, and project development at these levels is commonly donor-driven.
- Gaps remain in the regulations governing the implementation of HIV and ART services at health facilities, one of which is the absence of standards and criteria to regulate payments and subsidies for the procurement of goods and services.
- There is still uncertainty regarding HIV and ART norms, standards and procedures for the delivery of services. No gap analysis has been conducted at the puskesmas (primary health facility) level regarding the extent and quality of their HIV-related services and supervision and monitoring capacity, on the one hand, and on the other, the human and financial resources needed to perform these functions optimally.
- There are multiple stakeholders involved in the HIV response which sometimes have overlapping responsibilities, tasks and programs. Coordination between these actors, which include the national and local AIDS commissions, CSOs and other NGOs, other ministries and the private health sector, is poor.

Opportunities

- The revised Local Government law[25] provides a window of opportunity for the Ministry of Health to revise and strengthen the health system and care delivery system, in consultation with the Ministry of Home Affairs.
- There is growing coordination and communication between the Ministry of Health and the Ministry of Home Affairs, with both recognizing the complementarities of their mandates.
- HIV is included in the new Minimum Service Standards document,[26] which implies that all districts in Indonesia should prioritize the delivery of HIV services, given that HIV has been reported by more than 300 districts in Indonesia.

Recommendation 1

1.1 *In compliance with Law of the Republic of Indonesia No. 23/2014 on Local Government, the Ministry of Health should, by the end of 2017, develop and publish norms, standards, procedures, and criteria related to HIV and AIDS. To this end, the government should:*

1.1.1 Set norms and standards for quality and equitable services that reach the most at-risk and most vulnerable populations.

[23] Peraturan Menteri Kesehatan Republik Indonesia Nomor 741/2008 tentang Standar Pelayanan Minimal Bidang Kesehatan di Kabupaten/Kota (*Minister of Health Regulation No. 741/2008 on Minimum Service Standards for Health in Districts/Cities*). This regulation was later revised by Peraturan Menteri Kesehatan Republik Indonesia Nomor 43/2016 tentang Standar Pelayanan Minimal Bidang Kesehatan (*Minister of Health Regulation No. 43/2016 on Minimum Service Standards for Health*).

[24] Field visits to Maluku and West Kalimantan on 18-20 January 2017, and discussions with representatives from the provinces of Jakarta, West Java, Bali, and Papua on 18 January 2017 in Jakarta.

[25] Law of the Republic of Indonesia No. 23/2014 on Local Government.

[26] Peraturan Menteri Kesehatan Republik Indonesia Nomor 43/2016 tentang Standar Pelayanan Minimal Bidang Kesehatan (*Minister of Health Regulation Number 43/2016 on Minimum Service Standards for Health*).

1.1.2 Give guidance on the separation of authority, chain of command and accountability, including managerial responsibilities (human resources, financial resources, procurement and supply, equipment and other goods, methods of implementation) and functions (planning, budgeting, organizing, actuating, supervising and accounting) between central, provincial, and district governments in the implementation of programmes and activities related to HIV, such as prevention and care, treatment, and support.

1.1.3 Develop the norms, standards, procedures, and criteria document on the basis of Minister of Health Regulation No. 21/2013 on HIV and AIDS Control. All other relevant regulations related to HIV and AIDS can also be incorporated in or annexed to the document.

1.1.4 Convene Technical Advisory Groups, calling as necessary on external partners to ensure that the norms, standards, procedures, and criteria document abides by best practice principles, norms and standards.

1.2 The Ministry of Health should further strengthen its collaboration with the Ministry of Home Affairs to overcome local barriers to the responses to HIV, such as human resources for health. To this end, the two Ministries should consider:

1.2.1 Jointly undertaking, in early 2018, an assessment of human and financial capacities at the local level to respond more effectively to the epidemics they are confronting.

1.2.2 On the basis of their findings, jointly developing a human resources development, deployment and supervision plan, inclusive of partners from CSOs and other NGOs.

1.2.3 Jointly developing training for health offices to strengthen their capacity and competencies to manage the response to HIV epidemics and address other health problems relevant to local health facilities.

1.2.4 Improving the coordination and synchronization between different Directorates General within the Ministry of Home Affairs, particularly to address TB/HIV and HIV in mothers and children, which involve more than one Directorate General.

1.2.5 This recommendation calls for extending the collaboration between the Ministry of Health and the Ministry of Home Affairs to the Ministry of Rural Development and Transmigration.

1.3 The Ministry of Health should be vigilant about any legislation related to HIV and AIDS issued by other ministries and agencies to ensure that such laws and regulations are informed by, and aligned with, the existing national legislation and regulations, as well as with the norms, standards, procedures, and criteria document once it is formally approved by the government. To this end:

1.3.1 By the end of 2018, the Ministry of Health should develop and update an inventory of all pre-existing and new laws and regulations relevant to HIV across all sectors of government (e.g. Home Affairs, Defence, Labour, Tourism and other sectors).

1.3.2 The Ministry of Health should analyze these laws and regulations against the principles, norms and standards entrenched in the Constitution, existing laws, decrees and regulations and international human rights.

2. Legal and policy environment: Enablers and constraints in the HIV programme

Introduction

Virtually all the chapters of this report underscore the value of shaping the national response to HIV in the Republic of Indonesia according to the Constitution of the Republic of Indonesia and key principles, policies, regulations and laws enacted to enhance prevention, care, support and treatment. Some of these have resulted in progress in the understanding of the HIV epidemics in the country and demonstrated that, when combined interventions are appropriately brought to bear on the spread and impacts of the epidemics, progress is achieved for the benefit of people living with HIV, affected populations, and public health as a whole. However, major improvements are needed to ensure that the technical soundness of HIV work in the country is appropriate and that it is adapted to local needs and circumstances, scaled up at a more rapid pace than currently documented, and that, importantly, it occurs within a supportive structural environment consisting of policies, regulations, laws, financing and accountability across all sectors of economic and social development.

Investment in an environment that enables the effective implementation of HIV prevention, services, and care is critical for an effective HIV response.[1] The enabling environment strategy should focus on the promotion and protection of human rights, and one part of this is through the review and reform of legislation that may create barriers to access, or reinforce stigma and discrimination against people living with HIV and key populations.[2]

The 2017 Review identified a wide array of normative instructions and guidance formulated at the national level, including numerous regulations aimed at creating a policy environment for evidence- and rights-based responses to HIV that have been passed since the 2011 review.[3] Some important programmes to create an enabling environment, including reducing stigma and discrimination, were also identified by this Review. However, this Review concluded that there remained a number of gaps or weaknesses in the efforts to create an enabling environment. These can be broadly summarised in three areas:[4]

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[1] UNAIDS. Human Rights and the Law: Guidance Note. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014 [cited 26 Jan 2017]. Available from: http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_humanrightsandthelaw_en.pdf.

[2] United Nations General Assembly. Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, para 63b. A/RES/70/266; 2016.

[3] Ministry of Health of the Republic of Indonesia. Review of the Health Sector Response to HIV and AIDS in Indonesia 2011. Jakarta: Ministry of Health; 2011.

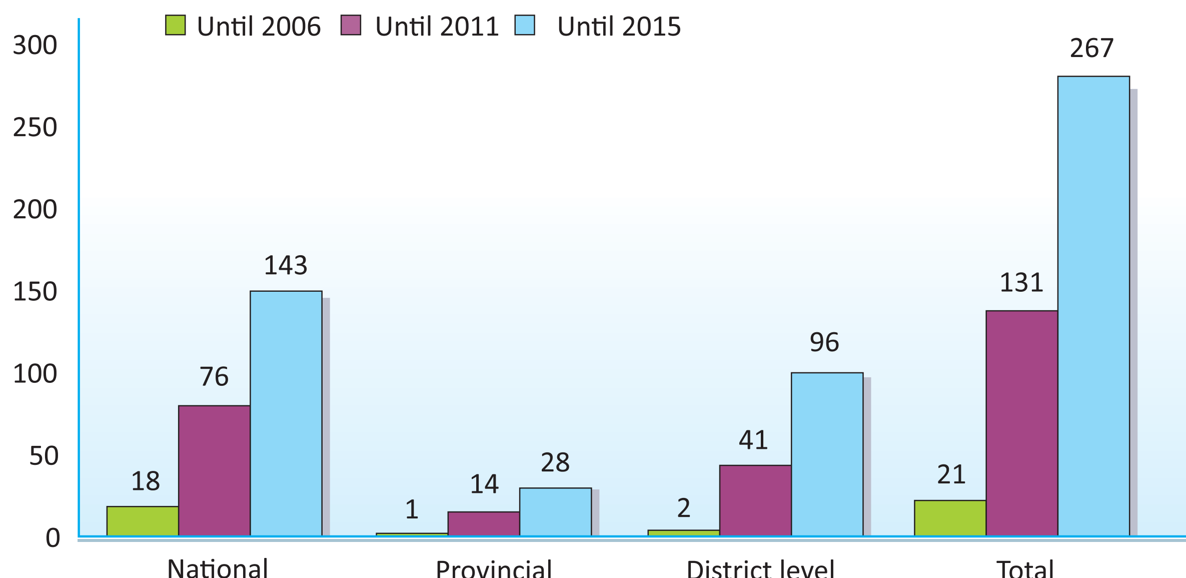
[4] Ibid.

1. The HIV response programme lacks a clear strategy and mechanisms for ensuring full implementation of human rights standards at national, provincial, district and more peripheral levels. This results in inconsistent, non-harmonised implementation of regulations that enable effective HIV response, as well as discriminatory regulations, policies and practices.
2. Continuing stigma and discrimination experienced by PLHIV and key populations, hindering timely access to HIV services. Incidents of discrimination most commonly do not result in any remedial action- an important aspect of ensuring full implementation of human rights standards.
3. Gaps in access to affordable HIV services for those who need them, caused by barriers to access to the universal health coverage (UHC) system and gaps in coverage.

Key areas of progress since the 2011 Review

Since 2011, the central government has developed a large number of laws and regulations, establishing a framework that serves as an important policy and legal foundation for the HIV response (see **Figure 2.1**).

Figure 2.1. Number of HIV and AIDS-related policies 2006-2015



Some of these regulations contain provisions that are important advances in creating a more enabling environment for evidence- and rights-based responses to HIV. Take for example, at the national level, the Minister of Health Regulation No. 21/2013, which prohibits discrimination in the provision of health care and requires health programmes to actively engage key populations while adhering to the principles of respect for human dignity, justice, and gender equality.[5] Minister of Health Regulation No. 43/2016 regarding Minimum Service Standards for Health ensures that HIV services are part of the minimum standard of services that need to be available and delivered throughout the country, thus ensuring the funding resources for such services. However, some of the regulations are also problematic, in a way that hinders an effective HIV response, which

[5] Minister of Health of the Republic of Indonesia Regulation no. 21/2013 on HIV and AIDS Control.

will be explained later in this chapter.

The National HIV and AIDS Strategy and Action Plan 2015-2019[7] represents an opportunity for progress in this area as it is built around the goal of ending AIDS as a public health threat by 2030[8] and achieving the "three zeros:" zero new infections, zero discrimination and zero AIDS-related deaths.[9] The National Strategy and Action Plan recognises and prioritises the creation of an enabling environment for an effective HIV response, upholding human rights, empowering civil society and reducing stigma and discrimination, as one of six strategic priority areas in achieving the goal. Programmes to create an enabling environment and address stigma and discrimination are also included under the interventions detailed in the National Strategy and Action Plan for prevention and for treatment, care and support.[10] Taken together, the proposed activities largely cover the seven key programmes for reducing HIV-related stigma and discrimination and increasing access to justice recommended by UNAIDS (see **Box 2.1**). Similarly, there are programmes within the National Strategy and Action Plan that address the four essential strategies for creating an enabling environment as described in the WHO 2014 Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations.[11]

However, while some of the relevant interventions from the National HIV and AIDS Strategy and Action Plan are being implemented as part of the national HIV response (see **Box 2.1**), the scale of implementation appears to be limited and they appear to be supported largely by external donors. Unfortunately, the Review Team was unable to obtain more detailed information on the extent to which the interventions proposed in the National Strategy and Action Plan are being implemented, or the extent of support through the national budget. Additionally, the Review observed a lack of systems to monitor and document the implementation, outcomes and impact of the interventions proposed in the National Strategy and Action Plan.

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[5] Minister of Health of the Republic of Indonesia Regulation no.21/2013 on HIV and AIDS Control.

[6] Minister of Health of the Republic of Indonesia Regulation no.43/2016 on Minimum Service Standards for Health.

[7] National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

[8] UNAIDS. Fast-Track-Ending the AIDS Epidemic by 2030. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014 [cited 5 Feb 2017]. Available from: http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report.

[9] UNAIDS. Getting to Zero: 2011-2015 UNAIDS Strategy. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2010.

[10] National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

[11] WHO uses the following four strategies: (1) Supportive legislation, policy and financial commitment, including decriminalization of certain behaviours of key populations; (2) Addressing stigma and discrimination; (3) Community empowerment; (4) Addressing violence against people from key populations. See WHO. Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations. Geneva: World Health Organization (WHO); 2014 [cited 14 Feb 2017]. Available from: http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1.

Box 2.1. Package of key programmes to reduce stigma and discrimination

Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice, UNAIDS 2011.[12]	Examples of interventions identified by the Review that represent progress in implementation of relevant programmes from the National Strategy and Action Plan
1. Stigma and discrimination reduction	Practical Guidance for the Media (National AIDS Commission); provincial level programmes with journalists (provincial AIDS Commissions); PLHIV Stigma Index to be conducted in 2017.
2. HIV-related legal services	Paralegal programmes delivered by CSOs and some key population networks (e.g. people who use drugs, sex workers).
3. Monitoring and reforming laws, regulations and policies (including community-based monitoring and documentation, NHRIs)	National Consultation on Legal and Policy Barriers to Access to HIV Services;[13] Minorities desk at the National Human Rights Commission (covering LGBT); legal audit and review of national regulations.[14]
4. Legal literacy ("know your rights")	Community-run programmes.
5. Sensitization of lawmakers and law enforcement agents (including judges)	Symposium for law enforcement agencies and judges (to be implemented by civil society in 2017), education on SOGIEB (sexual orientation, gender identity and expression and body) for key stakeholders in collaboration with the key population communities (National AIDS Commission);
6. Training for health care providers on human rights and medical ethics	Stigma reduction training for healthcare workers (and communities) as part of a programme to develop MSM-friendly centres; youth-friendly "Lolipop" programme.
7. Addressing gender and equity - reducing gender-based discrimination and violence (GBV and other harmful gender norms)	Research conducted by communities and government on violence against sex workers; integration of Gender-Based Violence (GBV) programme into the Prevention of Sexual Transmission programme.

[12] UNAIDS. Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses: Guidance Note. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2012 [cited 12 Feb 2017]. Available from: http://www.unaids.org/sites/default/files/media_asset/Key_Human_Rights_Programmes_en_May2012_0.pdf

[13] National AIDS Commission. National Consultation on Legal and Policy Barriers to HIV in Indonesia. Jakarta: National AIDS Commission; 2015 [cited 13 Feb 2017]. Available from http://www.aidsdatahub.org/sites/default/files/publication/rbap-hhd-2015-national-consultation-legal-policy-barriers-hiv-indonesia.pdf.

[14] Singgi ADD, Polhaupessy DC, Aotari F. Tinjauan Peraturan Perundang-Undangan Indonesia terkait HIV Berdasarkan Standar Hak Asasi Manusia Internasional. (*Review of HIV-related Legislation in Indonesia based on International Human Rights Standards*). Jakarta: Lembaga Bantuan Hukum Masyarakat; 2016 [cited 13 Feb 2017]. Available from: http://lbhmasyarakat.org/wp-content/uploads/2016/04/140416_Compile-HIV-Legal-Audit.pdf.

The National Strategy and Action Plan identifies several indicators for tracking progress on the enabling environment pillar of the strategy,[15] but it appeared to the Review Team that no progress had been made in developing appropriate tools or systems for collecting and analysing the necessary data.

In terms of regulations, the Review Team was pleased to see that in some districts, the local governments, together with civil society, have put efforts into creating an enabling environment. In Lombok Barat, the Lombok Barat District Regulation No. 47/2014 was designed to enable key populations to access HIV treatment and services. There is no criminalisation of transmission, exposure and non-disclosure, and the patient's right to decide the types of services that they will accept after being fully informed about those services is protected.[16] Everyone, including healthcare workers, is prohibited from stigmatising and discriminating PLHIV.[17] To protect PLHIV from stigma and discrimination, the Lombok Barat District Regulation 47/2014 guarantees the provision of social assistance, advocacy, as well as legal aid.[18] Where there are such positive advances towards creating an enabling environment, the impact of these should be closely monitored, including through baseline surveys and testimony from PLHIV and beneficiaries of HIV services, in order to assess the impact of the legislation. It is also important to promote such legislation so that other districts can follow these good practices.

Key findings from the 2017 Review

Selected indicators of the lack of enabling environment

In addition to the many barriers to access to HIV prevention, care, support and treatment services identified in the preceding chapter, the Review notes that low CD4 counts and high loss to follow up are indicators of the presence of significant social and structural barriers to the uptake of offered services.

Although Indonesia has a problematic dearth of strategic information on stigma, discrimination and violence to inform the programme (addressed further below), there are some data that were noted by the Review Team.

- Since the last review in 2011, CSOs have consistently rated the efforts of the government on implementing human rights in the context of HIV as 2 out of 10 (with 0 being the worst on a scale of 0-10).[19]
- In the 2012 Demographic and Health survey (DHS), only 9.3% of respondents expressed accepting attitudes towards people living with HIV/AIDS.[20] For example, less than a third of respondents indicated

[15] National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

[16] Lombok Barat District Regulation Number 47 Year 2014, Article 7. (*Peraturan Bupati Lombok Barat Nomor 47 Tahun 2014 tentang Pencegahan dan Penanggulangan AIDS, Pasal 7*).

[17] Lombok Barat District Regulation Number 47 Year 2014, Article 35, 36 Para 1. (*Peraturan Bupati Lombok Barat Nomor 47 Tahun 2014 tentang Pencegahan dan Penanggulangan AIDS, Pasal 35 dan 36(1).*)

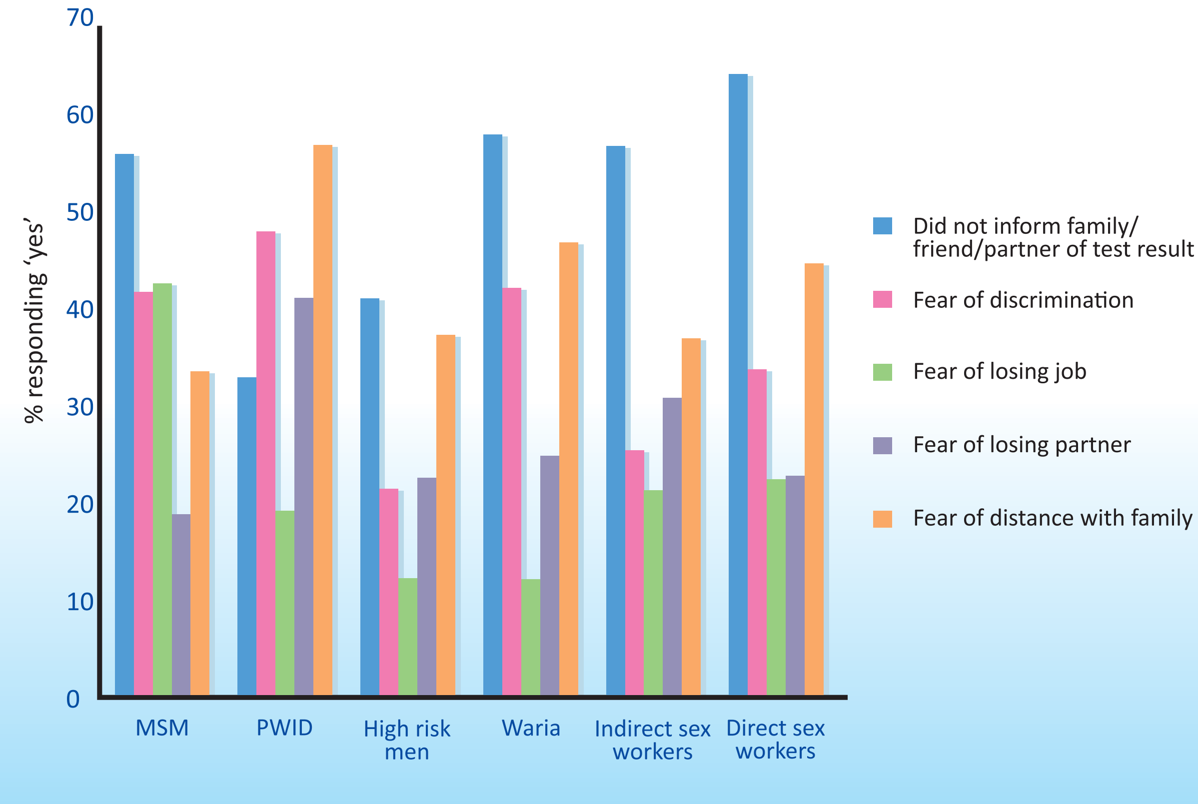
[18] Lombok Barat District Regulation Number 47 Year 2014, Article 33. (*Peraturan Bupati Lombok Barat Nomor 47 Tahun 2014 tentang Pencegahan dan Penanggulangan AIDS, Pasal 33*).

[19] National AIDS Commission. Roles of Cross-Sectoral Collaborations on Critical Enablers, Factors to Accelerate AIDS Control in Indonesia: Performances and Challenges. Booklet presented to the 2017 HIV Review on 23 January 2017 in Jakarta, citing National Composite Policy Index (NCPI) data from 2011, 2013 and 2015.

[20] Badan Pusat Statistik, BKKBN, Ministry of Health of the Republic of Indonesia, ICF International. Survei Demografi dan Kesehatan Indonesia 2012. (*Indonesia Demographic and Health Survey 2012*). Jakarta: Badan Pusat Statistik, Badan Kependudukan dan Keluarga Berencana Nasional, Kementerian Kesehatan Republik Indonesia and ICF Internasional; 2013 [cited 13 Feb 2017]. Available from: https://dhsprogram.com/pubs/pdf/FR275/FR275.pdf.

- they would buy fresh vegetables from someone living with HIV/AIDS.[21]
- Key populations also face stigma, discrimination and violence that increase vulnerability to HIV. For example, 2015 IBBS data showed high levels of forced sex experienced by key populations in the last 12 months (ranging from 12.6% to 86.5%), indicating extreme vulnerability to violence and HIV.[22] The same survey data also showed high levels of involuntary HIV testing (ranging from 3.8% to 22.2%), indicating a lack of respect for the rights of key populations in the context of HIV programming.[23] Fears of discrimination were widely cited by key populations as the reason for not disclosing HIV test results to family, friends and/or permanent partners (**Figure 2.2**).

Figure 2.2. Reasons given for reported non-disclosure of HIV test results[24]



Gaps and challenges in the response: regulatory barriers

Despite the progress mentioned above, the Review found that there are still critical weaknesses with regard to an enabling regulatory framework for effective programming. Firstly, the understanding of enabling regulations is not disseminated comprehensively to local healthcare workers in urban and rural areas. In some sub-districts, local healthcare workers are unaware of the existence of both national and local regulations, or have never read the regulations they do know about.[25] As an example, a doctor reported hearing about Minister of

[21] Ibid.

[22] Ministry of Health of the Republic of Indonesia. Integrated Biological and Behavioural Survey (IBBS) 2015.

[23] Ibid.

[24] Ibid.

[25] Based on focus group discussions with stakeholders from Aceh and West Java, 18 January 2017, in Jakarta.

Health Regulation No. 21/2013 just a few months ago, when she was seeking advice regarding a case in the primary health centre where she works.[26]

The lack of understanding of regulations by local healthcare workers impacts the quality of their services as it leads to a partial understanding of which services are allowed and prohibited and how a service should be delivered. The Review Team noted multiple reports that pregnant women are required to take an HIV test and are not fully informed of their right to refuse the test. Such practice is not in line with Minister of Health Regulation No. 21/2013 and Law No. 36/2009 regarding Health, which state that prior to every medical treatment, the patient must be given comprehensive information about such treatment so that s/he can give informed consent.[27]

Further, Minister of Health Regulation No. 43/2016 regarding the Minimum Service Standards for Health states that pregnant women, as one of the groups that are at risk of HIV infection, should receive standardized HIV testing, and to that end, healthcare workers must actively offer HIV testing to pregnant women. Appropriately, this does not authorise mandatory HIV testing for pregnant women, nor does it create an exception to the need to obtain informed consent prior to conducting such tests.[28]

The Review also observed different practices in different sites in relation to informed consent, which illustrated a lack of understanding of the requirements of the regulation. With regard to this, the Review Team would like to highlight that informed consent requires more than just information about the services, but also a clear explanation of the risks and benefits of such services. Consequently, it requires healthcare workers to understand what informed consent involves, and to deliver it consistently.

With regard to women living with HIV, the Review Team did not uncover any cases of forced sterilisation from the field visits and focus group discussions. However, the Review takes note of the lack of any system in place to capture experiences of stigma and discrimination in healthcare settings. To ensure that the government has successfully eliminated such practices and protects HIV-positive women's informed reproductive choices, a monitoring system should be put in place.

The Review noted that some provincial and local regulations or policies are inconsistent with international human rights obligations and national regulations. For example, the Review Team heard reports of mandatory HIV testing in the army and as a pre-marital requirement in some provinces,[29] despite Minister of Health Regulation No. 21/2013 which clearly states that HIV testing must be performed with the patient's consent.[30] The Review also heard reports of mandatory testing in the context of employment. This practice is not in line with the Minister of Manpower and Transmigration Decree No.68/Men/IV/2004 regarding HIV Prevention and Control in the workplace, which prohibits mandatory testing. In some districts HIV transmission, exposure and

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[26] Based on findings from a field visit to Maluku, 18-20 January 2017.

[27] Minister of Health of the Republic of Indonesia Regulation Number 21/2013 on HIV and AIDS Control, Article 8. (*Peraturan Menteri Kesehatan Republik Indonesia Nomor 21 tahun 2013 tentang Penanggulangan HIV dan AIDS, Pasal 8*).

[28] See annex to the Minister of Health Regulation No. 43/2016 on Minimum Service Standards for Health.

[29] For example, Bogor District Regulation No. 4/2016, Article 13 (*Peraturan Daerah Kota Bogor Nomor 4 Tahun 2016 tentang Pencegahan dan Penanggulangan Human Immunodeficiency Virus dan Acquired Immuni Deficiency Sindrome [sic], Pasal 13*), and Cilacap District Regulation No. 2/2015, Article 20 (*Peraturan Daerah Kabupaten Cilacap Nomor 2 Tahun 2015 tentang Penanggulangan HIV dan AIDS di Kabupaten Cilacap, Pasal 20*).

[30] Minister of Health of the Republic of Indonesia Regulation No. 21/2013 on HIV and AIDS Control, Article 22 Paragraph 2.

[31] See Bali Provincial Regulation Number 3/2006, Article 27 (*Peraturan Daerah Provinsi Bali Nomor 3 Tahun 2006 tentang Penanggulangan HIV/AIDS, Pasal 27*), and Cilacap District Regulation 2/2015, Article 21.

non-disclosure is criminalised by local regulations[31] (see Chapter 6 on knowing your HIV status). In West Java, a case is currently under investigation under one such law. A legal advisory CSO is helping in teasing out arguments put forward by the plaintiff and weighing possible evidence relevant to this case, illustrating the complexity of implementing an ill-conceived law.[32] Laws that discriminate against people living with HIV contribute to the stigma that undermines effective HIV responses. The Review Team also notes with concern the attitude of some stakeholders who support and even defend such regulations as necessary to protect the so-called 'innocent victims', indicating a critical lack of understanding of HIV issues.

An effective HIV response has become part of the national strategic programme. As regulated under Law No. 23/2014 regarding Local Government, local governments must implement the national strategic programme as part of their local programme.[33] To this end, they must take urgent action to review, amend, or repeal regulations that are not in line with an effective and rights-based HIV response (such as regulations that allow for mandatory HIV testing and criminalisation of HIV transmission, exposure, and non-disclosure). Otherwise, it can be concluded that the local government in question is not implementing the national strategic programme, and that sanctions may therefore be applied against it.[34]

Secondly, the Review Team also noted that many local regulations criminalise sex work.[35] These regulations have high potential to impede an effective HIV response, as they tend to push sex workers and clients underground and limit their access to sexual health services, condoms, and other related services. In addition, the criminalisation of sex work is not in line with Indonesia's commitment to human rights, as demonstrated by the country's ratification of many international human rights treaties, declarations and documents (see **Table 2.1**).[36] Recommendations to repeal such regulations were included as one of the critical enablers in the 2015-2019 National Strategy and Action Plan, but no advocacy work has been undertaken since then.

Another barrier found by the Review is the limitation on the age of consent for access to health services. The United Nations Committee on the Rights of the Child has argued that underage persons (i.e. below 18 years old)[37] who are able to demonstrate sufficient understanding should be entitled to give or refuse consent.[38,39] However, the Review Team found that there is a mandatory requirement of parental consent for underage persons when accessing medical interventions, including HIV testing, treatment and services.[40] According to

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[32] Based on reports from a FGD with stakeholders from West Java, 18 January 2017, in Jakarta.

[33] Law of the Republic of Indonesia No. 23/2014 on Local Government (*Undang-Undang Nomor 23 Tahun 2014 tentang Pemerintahan Daerah*).

[34] Law of the Republic of Indonesia No. 23/2014 on Local Government, Article 68.

[35] Two examples are the DKI Jakarta Provincial Regulation No. 8 Year 2007 regarding Public Order (*Peraturan Daerah Khusus Ibukota Jakarta Nomor 8 Tahun 2007 tentang Ketertiban Umum)* and Tangerang District Regulation No. 8 Year 2005 regarding Prohibition of Prostitution (*Peraturan Daerah Kota Tangerang Nomor 8 Tahun 2005 tentang Pelarangan Pelacuran*).

[36] UNDP. Sex Work and the Law in Asia and the Pacific. Laws, HIV and Human Rights in the Context of Sex Work, p. 21. Bangkok: United Nations Development Programme (UNDP); 2012 [cited 27 Jan 2017]. Available from: http://www.aidsdatahub.org/sites/default/files/documents/HIV_2012_SexWorkAndLaw.pdf

[37] Regulated in various acts, including Law No. 12/2006 on Citizenship of the Republic of Indonesia, Article 4 (h), and Law No. 23/2002 on the Protection of Children, Article 1 Para 1.

[38] See United Nations Convention on the Rights of the Child. General Comment No. 12: The Right of the Child to be Heard. CRC/C/GC/12 (1 Jul 2009); 2009.

[39] United Nations General Assembly: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. A/HRC/32/32 4 (4 April 2016); 2016.

[40] Based on findings from the field visit to Maluku, 18-20 January 2017.

the Minister of Health Regulation No. 290/2008 regarding Consent for Medical Interventions, consent is given by a competent patient, which refers to an adult patient.[41] This restriction prevents underage persons from accessing HIV services in circumstances where they cannot or do not wish to seek parental consent.[42]

Gaps and challenges in the response: stigma and discrimination

Indonesia has ratified or signed a wide array of international human rights treaties (**Table 2.1**), thereby subscribing to state obligations to respect, protect and fulfil human rights. While progress has been achieved in recent years in this direction, it is evident to national and international observers that several acute problems exist which directly or indirectly hamper the response to HIV. There are also some concerning developments that foreshadow the establishment of further barriers if action is not taken.

The Review found that stigma and discrimination against PLHIV persists, with people continuing to keep their status hidden from family members and community due to fears of being judged and discriminated against. PLHIV interviewed by the Review Team reported significant stigma (including self-stigma), with even some who are leading/engaged with community support groups keeping their status hidden from family members for many years. While some provincial/city level health staff reported that stigma is decreasing in areas with HIV services and information, education and counselling,[43] they also observed that the issue remains a concern. Moreover, there is persistent high stigma in areas where there is limited understanding of HIV (e.g. Maluku Tenggara).[44] However, these trends cannot be objectively verified as the government has not implemented any systematic measure of levels of stigma in the community or in healthcare services since the previous Review. This Review supports the plan in the National Strategy and Action Plan to implement the PLHIV Stigma Index. These data need to be collected on a regular basis, and supplemented with additional information from other sources so as to ensure a comprehensive monitoring system to inform programme design and track progress of efforts.

Examples given of stigma and discrimination by communities against PLHIV include: houses of PLHIV being set on fire (Maluku), children being banished to the forest by the village when their parents die of AIDS (Papua); a young person being locked in his room by parents and fed through a door (Aceh); a woman who was beaten by her husband after disclosing her HIV result following ANC testing (West Java); community rejection and refusal to bury PLHIV locally (Maluku Tenggara). Reports of such discrimination remain largely unverified due to the absence of coordinated systems for documentation and reporting discrimination. Programmes for access to legal services, paralegals and community documentation of rights violations-which are currently being implemented in selected cities with support from external donors-should be part of a national system for addressing stigma and discrimination that would ensure the data and outcomes generated by such programmes inform the national response.

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[41] This includes a married underage person as s/he is considered as an adult according to Indonesian law. Minister of Health Regulation Number 290/2008 on Consent to Medical Interventions, Article 13 jo. 1 (7). *(Peraturan Menteri Kesehatan Republik Indonesia Nomor 290 Tahun 2008 tentang Persetujuan Tindakan Kedokteran).*

[42] United Nations General Assembly: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. para. 59.

[43] Focus group discussions with stakeholders from Aceh and Provincial AIDS Commissions, 18 and 19 January 2017, in Jakarta.

[44] Field visit to Maluku, 18-20 January 2017.

Moreover, the Review found that discrimination against PLHIV in healthcare settings remains an issue in Indonesia. Citing from the Australian review of the HIV response:

> "A 2013 study on Community Access to Treatment Services (CATS) in Indonesia found that nearly one-fifth (18%) of PLHIV respondents experienced unpleasant treatment, stigma and discrimination due to their HIV status. In addition, women living with HIV are twice as likely to experience stigma and discrimination. Perpetrators of stigma and discrimination vary and could even be the health workers. Surprisingly, respondents in Jakarta reported, 10% of perpetrators of stigma and discrimination were health workers who denied providing health services to PLWHA."[45]

Table 2.1 International human rights treaties to which the Government of Indonesia is a state party

Treaty	Signature Date	Ratification Date
Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment	23 Oct 1985	28 Oct 1998
Optional Protocol of the Convention against Torture		
International Covenant on Civil and Political Rights		23 Feb 2006 (accession)
Second Optional Protocol to the International Covenant on Civil and Political Rights aiming at the abolition of the death penalty		
Convention for the Protection of All Persons from Enforced Disappearance	27 Sept 2010	
Convention on the Elimination of All Forms of Discrimination against Women[46]	29 Jul 1990	13 Sept 1984
International Covenant on Economic, Social and Cultural Rights		23 Feb 2006 (a)
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	22 Sept 2004	31 May 2012
Convention on the Rights of the Child	26 Jan 1990	5 Sep 19902
Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	24 Sep 2001	4 Sep 2012
Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography	24 Sep 2001	24 Sep 2012
Convention on the Rights of Persons with Disabilities	30 Mar 2007	30 Nov 2011

[45] Suharni M, Praptoraharjo I, Safika I, Retno S, Dewi EH, Hersumpana I et al. HIV-AIDS Policy and Health System in Indonesia: A Document Review. Yogyakarta: Center for Health Policy and Management, Universitas Gadjah Mada; 2016 [cited 13 Feb 2017]. Available from: http://www.kebijakanaidsindonesia.net/jdownloads/Penelitian Research/ hiv-aids_policy_and_health_system_in_indonesia_-_a_document_review.pdf.

In addition to high levels of stigma against people living with and affected by HIV, a lack of tolerance by certain provincial and district authorities towards key populations as well as abuses perpetrated outside the law by law enforcement agencies,[47,48] create major obstacles to timely access to HIV services. Comprehensive programmes are required to address punitive and discriminatory attitudes and practices relating to key populations, failing which rejection, fear or denial of services will create insurmountable barriers between the authorities and those who could willingly and enthusiastically engage in the response to the epidemics.

While regulations and services are in place to enable HIV services specifically for key populations,[49] regulations at national and sub-national levels were found that create barriers to access to these services. For example, the political debates and increasingly restrictive laws and regulations relating to expression of sexual orientation and gender identity[50] are contributing to increasing stigma and violence against men who have sex with men and transgender people,[51] as well as directly impeding programmes designed to ensure their access to HIV information and services.[52] Shrinking space for civil society to advocate for their needs and rights poses a problem for the HIV response and for sustainable development in Indonesia more broadly, and needs to be closely monitored.

An extreme situation has developed in the province of Aceh since the last review, where the amended local criminal code passed in 2014 incorporates certain principles of Shariah law, including provisions that criminalise consensual same-sex sexual acts as well as all *zina* (sexual relations outside of marriage). It prohibits *liwath* (sodomy) and *musahaqah* (lesbianism), and permits as punishment up to 100 lashes and up to 100 months in prison for consensual same-sex sex acts.[53] The Review Team does not feel sufficiently well equipped to analyze the historical, political, religious or cultural roots of the legal developments. It expresses its deep concern, however, about the impact that such a body of laws has on the response to HIV.[54] In Aceh, even before

[46] Indonesia also ratified the CEDAW-OP (the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women), accepting the individual complaints for Indonesia, in February 2000.

[47] See, for example, Forum Korban NAPZA, Paguyuban Korban NAPZA Bandung, Performa, East Java Action. Monitoring & Documentation Report of Police Abuse against People Who Use Drugs in Indonesia, 4 Provinces in Java, 2007-2011. New York: International Harm Reduction Development – Open Society Foundation; 2012 [cited 27 Jan 2017]. Available from: http://www.aidsdatahub.org/sites/default/files/documents/Indonesia_Police_Abuse_Report_2012.pdf

[48] See also: Manjima Bhattacharjya, et al. The Right(s) Evidence: Sex Work, Violence and HIV in Asia, A Multi-Country Qualitative Study. Bangkok: United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP) and Asia-Pacific Network of Sex Workers (APNSW); 2015 [cited 24 Jan 2017]. Available from http://www.aidsdatahub.org/sites/default/files/documents/new/Rights-Evidence-Report-2015-final.pdf; UNDP. Sex Work and the Law in Asia and the Pacific: Laws, HIV and Human Rights in the Context of Sex Work. Bangkok: United Nations Development Programme (UNDP); 2012.

[49] Refer to the list of regulations on harm reduction, Suharni M, Praptoraharjo I, Safika I, Retno S, Dewi EH, Hersumpana I. et al. HIV-AIDS Policy and Health System in Indonesia: A Document Review, page 65.

[50] For example, the prohibition on broadcasting impersonations of LGBT and on deviant sexual behaviour.

[51] Rustinawati Y, Arifin A, Korbarri RJ, Dave, Gurning A, Purba Y. Research, Documentation and Monitoring on the Situation of Human Rights and Access to Justice for LGBTI Group in Indonesia. Jakarta: Arus Pelangi; 2017 [cited 14 Feb 2017]. Available from: https://app.box.com/s/mruhlv2ekgocq7bubr39yqtmj1ji6hlx.

[52] See, for example, Rachmi Farmita. 'Pesta' Gay Surabaya, Panitia: Hanya Sosialisasi HIV/AIDS. (Surabaya Gay 'Festival', Committee: Only Creating Awareness About HIV/AIDS). Jakarta: Tempo.co, 8 February 2016 [cited 24 Jan 2017]. Available from: https://m.tempo.co/read/news/2016/02/08/058743050/pesta-gay-surabaya-panitia-hanya-sosialisasi-hiv-aids.

[53] Johnson C. Indonesia: Aceh Province Law Expands Caning Punishment to Adultery and Homosexual Acts [Online]. Washington: Library of Congress; 28 October 2015 [cited 31 Jan 2017]. Available from: http://www.loc.gov/law/foreign-news/article/indonesia-aceh-province-law-expands-caning-punishment-to-adultery-and-homosexual-acts/.

[54] Such laws are reported to exist in South Sumatra and six other districts. See Adam Harvey. Indonesia's Constitutional Court Considers Criminalising Adultery and Gay Sex. Sydney: ABC News, 14 September 2016 [cited 1 Feb 2017]. Available from: http://www.abc.net.au/news/2016-09-14/push-to-ban-casual-and-gay-sex-in-indonesia/7804822.

the legislation entered into force in October 2015, repressive actions were being taken by the local police and judicial system against those who were seen as violating key Shariah principles but also against those who were seen to not conform to such moral principles as dressing in conformity with one's biological sex.[55] Such instances have been well documented by groups specializing in documenting human rights violations[56] and the local and international media.[57],[58] From an HIV perspective, the attainment of the highest standard of physical and mental health, non-discrimination and the protection against torture and other cruel inhuman or degrading treatment or punishment are human rights falling under the obligation of the state to respect, protect and fulfil rights. The evidence accumulated through this Review strongly suggests that the national response to HIV will not succeed if the Government of Indonesia does not meet its obligations under international human rights treaties it has ratified.

The Review is also concerned regarding the current petition before the Constitutional Court seeking criminalization of consensual same-sex conduct and sex out of wedlock,[59] and the proposed revisions to the Criminal Code that include limits on the distribution of contraceptive supplies, and control the provision of information about contraception.[60] Any one of these legal developments would present a very significant barrier to access to essential HIV services for populations that need them. Indonesia needs human rights-based legal responses that are grounded in evidence-based public health measures if it is to achieve the goals of the "90-90-90 by 2020"[61] described in earlier sections of this report, ending AIDS by 2030,[62] achieving universal health coverage and other Sustainable Development Goals. While the Ministry of Law and Human Rights has indicated that the proposed laws are inappropriate, the Ministry of Health has yet to speak publicly on these concerning developments.

In Indonesia, while there are no national prohibitions on sex work *per se*, the Criminal Code prohibits trading in women and living on the earnings of a female sex worker, and sex workers can be detained in rehabilitation centres for up to six months.[63,64] Some local laws regulate quasi-legal brothels (*lokalisasi*). Some provinces or

55 Human Rights Watch. Human Rights Watch Complaint on the Rights of LGBT People in Indonesia's Aceh Province [Online]. New York: Human Rights Watch; 2016 [cited 1 Feb 2017]. Available from: https://www.hrw.org/news/2016/03/29/human-rights-watch-complaint-rights-lgbt-people-indonesias-aceh-province.

56 Rustinawati Y, Arifin A, Korbarri RJ, Dave, Gurning A, Purba Y. Research, Documentation and Monitoring on the Situation of Human Rights and Access to Justice for LGBTI Group in Indonesia Op. cit.

57 The Jakarta Post. Aceh Clamps Down on LGBT People, Threatens Caning [Online]. Jakarta: The Jakarta Post, 15 March 2016 [cited 3 Feb 2017]. Available from: http://www.thejakartapost.com/news/2016/03/15/aceh-clamps-down-lgbt-people-threatens-caning.html.

58 Kennedy R. Caning Law Pushes Aceh's LGBT Further Underground [Online]. Doha: Al Jazeera, 5 December 2015 [cited 15 Feb 2017]. Available from: http://www.aljazeera.com/news/2015/12/caning-law-pushes-aceh-lgbt-underground-151205110810340.html.

59 Human Rights Watch. Indonesia: Court Reviews Anti-LGBT Law [Online]. New York: Human Rights Watch; 2016 [cited 1 Feb 2017]. Available from: https://www.hrw.org/news/2016/08/23/indonesia-court-reviews-anti-lgbt-law.

60 Widagdo C. Legislative Changes in Indonesia will Limit Access to Contraception and Breach Rights [Online]. New York: Health and Human Rights Journal 16 January 2017 [cited 3 Feb 2017]. Available from: https://www.hhrjournal.org/2017/01/ legislative-changes-in-indonesia-will-limit-access-to-contraception-and-breach-rights/.

61 UNAIDS. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic.

62 UNAIDS. Fast-Track - Ending the AIDS Epidemic by 2030.

63 UNDP. HIV and the Law in South-East Asia [Internet]. Bangkok: United Nations Development Programme (UNDP); 2015 [cited 15 Feb 2017]. Available from: http://www.asia-pacific.undp.org/ content/dam/rbap/docs/Research & Publications/hiv_aids/rbap-hhd-2015-hiv-and-the-law-in-south-east-asia.pdf.

64 Alvin. 2015. Rakornas Penanganan Prostitusi dan Gelandangan Pengemis Hasilkan 6 Kesepakatan Penanganan Tuna Susila dan 11 Kesepakatan Penanganan Gelandangan Pengemis. (*National Coordination Meeting on Prostitution and Homelessness Agrees 6 Resolutions on Addressing Prostitution and 11 Resolutions on Addressing Homelessness*). Jakarta: Ministry of Social Affairs of the Republic of Indonesia: 2015 [cited 24 Jan 2017]. Available from: http://www.kemsos.go.id/modules.php?ame=News&file =article&sid=18618.

districts prohibit sex work under local regulations.[65] Condoms are still used as evidence of sex work in several provinces.[66] Criminalisation of sex work creates well-documented barriers to health for sex workers and their clients, including difficulties in accessing HIV and gender-based violence (GBV) services, fear of condoms being used as evidence of crimes and increased vulnerability to violence and other rights violations.[67]

Moreover, the Review notes with concern the government's policy of eliminating brothels in Indonesia by 2019,[68] and the subsequent local efforts to close sex work zones and crack down on the sale of sex. There is no evidence to suggest that such efforts have a sustained impact in reducing the prevalence of the sale of sex. The evidence gathered by the Review,[69,70,71] found in most cases that the sex work business returns, though often more underground, making sex workers and their clients more difficult to reach with HIV services. Research conducted by CSOs and academic institutions in six cities in Indonesia found impediments to community outreach, disruptions in access to condoms and other HIV services by sex workers and disruption of access to ART. Importantly, the national network of sex workers (OPSI) and the National AIDS Commission are currently jointly conducting research in four cities on the impact of this policy on HIV responses.

Similarly, the environment of criminalization of drug use and drug possession presents real and serious barriers to access to HIV services for people who use drugs. The Review Team heard reports of people who use drugs not wanting to participate in needle and syringe exchange programmes due to fear of being caught by the police in possession of needles. There is also limited access to HIV testing and services in prisons, and over half of the people in prisons in Indonesia are there for drug-related offences.[72] Access to services in drug treatment centres run by the National Narcotics Agency (BNN) is also very limited. There have also been instances where people who use drugs have been excluded from services or engaging in policy development processes that directly affect them because of their status as criminals or requirements to prove that they are drug-free.[73]

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[65] For example, Garut Regulation No. 2 /2008 on Anti Immoral Acts, West Java. See: Institut Perempuan. Discrimination against Women in Local Regulation ("Perda") in West Java. Jakarta: Institut Perempuan; 2015 [cited 28 Jan 2017]. Available from: http://www.institutperempuan.or.id/?p=358

[66] Focus group discussions with stakeholders from Aceh, 18 January 2017, in Jakarta.

[67] Bhattacharjya M, Fulu E, Murthy L, Seshu MS, Cabassi J, Vallejo-Mestres M. The Right(s) Evidence: Sex Work, Violence and HIV in Asia: A Multi-Country Qualitative Study; UNDP. Sex Work and the Law in Asia and the Pacific: Laws, HIV and Human Rights in the Context of Sex Work.

[68] Novia DRM, Ucu KR. Pemerintah Targetkan Indonesia Bebas Kawasan Prostitusi pada 2019 (*Government Targets Prostitution Zone-Free Indonesia in 2019*). Jakarta: Republika, 5 April 2016 [cited 24 Jan 2017]. Available from: http://nasional.republika.co.id/berita/nasional/umum/16/04/05/ o554f3282-pemerintah-targetkan-indonesia-bebas-lokalisasi-prostitusi-pada-2019; Fajerial E. Indonesia will be Brothel-Area Free by 2019: Minister Khofifah [Online]. Jakarta: Tempo.co, 4 March 2016 [cited 24 Jan 2017]. Available from: https://nasional.tempo.co/read/news/2016/03/04/173750572/menteri-khofifah-2019-indonesia-bebas-lokalisasi; Alvin. Rakornas Penanganan Prostitusi dan Gelandangan Pengemis Hasilkan 6 Kesepakatan Penanganan Tuna Susila dan 11 Kesepakatan Penanganan Gelandangan Pengemis. (*National Coordination Meeting on Prostitution and Homelessness Agrees 6 Resolutions on Addressing Prostitution and 11 Resolutions on Addressing Homelessness*).

[69] OPSI Laporan Penelitian Penutupan Lokalisasi Gondang Legi Kota Malang dan Payosigadung Jambi (*Research Report on the Closure of Sex Work Zones in Gondang Legi, Malang and Payosigadung, Jambi*), page 11-13. Jakarta: Organisasi Perubahan Sosial Indonesia (OPSI); 2016.

[70] Praptorahardjo I, Sukmaningrum E, Nevendorff L, Widihastuti A, Apriana K, Sihaloho BS, et al. Studi Kualitatif Dampak Penutupan Lokalisasi di Empat Kota (*Qualitative Study on the Impact of the Closure of Sex Work Zones in Four Cities*), page 91. Jakarta: Pusat Penelitian HIV/AIDS Universitas Katolik Atma Jaya; 2016.

[71] Discussions with representatives of the Papua and West Java provincial AIDS commissions, 19 January 2017, in Jakarta.

[72] Tarigan M. Setengah Penghuni Penjara Indonesia Terpidana Kasus Narkoba (*Half of Indonesia's Prison Inmates Were Convicted on Drugs Offences*). Jakarta: Tempo.co, 28 March 2016 [cited 27 Jan 2017]. Available from: https://nasional.tempo.co/read/news/2016/03/28/063757367/setengah-penghuni-penjara-indonesia-terpidana-kasus-narkoba.

[73] Field visit to Maluku, 18-20 January 2917, and a key informant interview with the Coordinator of PKNI (*Persaudaraan Korban NAPZA Indonesia/Indonesian Drug Users Network*), 23 January 2017, in Jakarta.

Documentation of rights violations by CSOs, and to a lesser extent, by the National Commission on Human Rights[74,75] and the National Commission on Violence Against Women, has started to generate evidence on the impact of punitive laws on access to services for key populations in Indonesia. Such evidence is being used to inform public and 'behind the scenes' advocacy aimed at increasing the right to health of key populations.[76] However, opportunities for dialogue with the government to discuss solutions to systemic issues are limited, and leadership from the health sector (the Ministry of Health, the National AIDS Commission and their provincial- and district-level counterparts) to facilitate and, where appropriate, support community advocacy for reform is reportedly lacking. Whilst the National AIDS Commission has willingly engaged in collaborating with partners on the implementation of programmes to address stigma and discrimination,[77] there is no systematic effort to coordinate and scale up such programmes, or to monitor the impact of such programmes on access to appropriate services by PLHIV and key populations. Moreover, the Review Team was only able to identify limited examples of where the National AIDS Commission or Ministry of Health has shown leadership in engaging on the reform of regulations that contribute to stigma or discrimination experienced by PLHIV or key populations.[78] The Review Team appreciates that this sometimes involves sensitive issues, but it is an appropriate and important role for the Ministry of Health and the National AIDS Commission to document and share the impact that such laws have on public health and sustainable development.

The National AIDS Commission acknowledges the challenges posed by stigma and discrimination experienced by PLHIV and key populations, and shared information with the Review Team on programmes it has implemented in partnership with other stakeholders, including training public order officers on transgender and MSM issues, engaging religious officials, capacity building for key population networks and stigma reduction training for healthcare workers.[79,80] However, it also acknowledged that the coverage of such efforts is low:

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[74] National Commission on Human Rights. Siaran Pers: Komisi Nasional Hak Asasi Manusia tentang LGBT (*Press Release: National Commission on Human Rights on LGBT*). Jakarta: National Commission on Human Rights, 29 January 2016 [cited 26 Jan 2017]. Available from: https://www.komnasham.go.id/files/ 20160206-siaran-pers-pernyataan-sikap-komnas-$QOLWZ.pdf;

[75] National Commission on Human Rights. 2016. Keterangan Pers Nomor 014/Humas-KH/VI/2016 tentang Launching Laporan Pelapor Khusus untuk Hak-Hak Minoritas "Upaya Negara Menjamin Hak-Hak Kelompok Minoritas di Indonesia" (*Press Release on the Launch of the Report of the Special Rapporteur for Minority Rights "State Efforts to Guarantee the Rights of Minority Groups in Indonesia"*). Jakarta: National Commission on Human Rights, 1 June 2016; 2016 [cited 26 Jan 2017]. Available from: https://www.komnasham.go.id/files/20160601-keterangan-pers-tentang-launching-$A8FW.pdf.

[76] The National Commission on Human Rights (*Komnas HAM*) now specifically covers the rights of LGBT persons under the mandate of the Special Rapporteur on the Rights of Minorities, established by National Commission on Human Rights in 2012.

[77] National AIDS Commission. Roles of Cross-Sectoral Collaboration on Critical Enablers, Factors to Accelerate AIDS Control in Indonesia: Performances and Challenges.

[78] Recommendations for reform developed in 2013 in consultation with civil society and development partners have not been taken forward: see National AIDS Commission, National Consultation on Legal and Policy Barriers to HIV in Indonesia.

[79] “The Time Has Come” training package was adapted and implemented with a core group of trainers (DHO, Puskesmas, LGBT community) from 17 provinces in 2015 with support from UNDP and WHO. After the training, each province is expected to do “echo” training, which can be in-house training or implementation within puskesmas, or training of other puskesmas within the district. Further rollout is taking place in 2016/17 with funding from the Global Fund. One indicator suggested for the post-training evaluation/monitoring system is the number of MSM/ waria visiting puskesmas, which can be measured in the HIV and AIDS online reporting system (SIHA). In April 2016, the training material was incorporated into the updated HIV and STI Comprehensive Training package, and provincial health office staff from 34 provinces have been trained. (Source: key informant interview with the Ministry of Health, 23 January 2017). See also UNDP. "The Time Has Come": Enhancing HIV, STI and Other Sexual Health Services for MSM and Transgender People in Asia and the Pacific. Facilitator Training Manual [Internet]. Bangkok: United Nations Development Programme; 2013 [cited 15 Feb 2017]. Available from: http://www.asia-pacific.undp.org/content/rbap/en/home/library/democratic_governance/ hiv_aids/the-time-has-come.html

[80] National AIDS Commission. Roles of Cross-Sectoral Collaboration on Critical Enablers, Factors to Accelerate AIDS Control in Indonesia: Performances and Challenges.

> "In terms of the work on stigma reduction: we have the pattern, the model, but the problem is that the places where [we] are doing this are still limited."[81]

With a limited (undisclosed) domestic budget for these activities and less than 0.2% of the Global Fund HIV grant for 2015-2017 allocated to programmes designed to remove legal barriers to access to services and community systems strengthening, there is a clear need for the government to increase its investment-leadership and financial-in creating an enabling environment.

Access to affordable HIV services

Universal health coverage is defined as ensuring that all people have access to needed promotion, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. In Indonesia, Minister of Health Regulation No. 21/2013 on HIV and AIDS Control states that care and treatment costs for people living with HIV who are poor are to be borne by the state, and health services are prohibited from refusing treatment and care to people living with HIV.[82]

The government has made significant progress in developing and rolling out a national health insurance scheme with a view to ensuring universal health coverage, including access to affordable HIV services for people who need them, since the last review, which included several recommendations relating to expanding insurance coverage for HIV services and taking steps to include HIV and AIDS benefits packages in the national scheme (which was under development at the time of this Review).

Four specific objectives of the national health insurance scheme (Jaminan Kesehatan Nasional, or JKN) are:[83]

- To enable people to access healthcare services without financial hardship.
- To deliver cost-contained and quality controlled healthcare services.
- To strengthen healthcare services at primary and referral health facilities.
- To prioritize preventive and promotive measures in rendering healthcare services to reduce the prevalence of disease and lower the number of sick people through efficient healthcare services.

The JKN represents an important policy development for advancing the right to health for all in Indonesia and for ending AIDS by 2030. As a relatively new policy and system, it is to be expected that close monitoring of the implementation of the policy will be needed to ensure that it is meeting its objectives.

The Review Team repeatedly heard in focus group discussions and key informant interviews that people living with HIV and key populations who are entitled to access services under the government-subsidised universal healthcare scheme in Indonesia if they are 'poor' are unable to claim those benefits due to practical and regulatory barriers. These included: lack of possession of a valid ID card (noted as problematic for transgender people, for people under the age of 17, or for those included on a family card but no longer living with family); not being registered in the relevant district or province of the site providing the service sought; not following the regulation process in terms of accessing health facilities;[84] being in prison or other forms of detention.

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[81] Key informant interview with representatives of the National AIDS Commission, 23 January 2017, in Jakarta.

[82] Minister of Health of the Republic of Indonesia Regulation No. 21/2013 on HIV and AIDS Control, Articles 46 and 30(1).

[83] WHO. Universal Health Coverage and Health Care Financing Indonesia [Online]. Jakarta: World Health Organization (WHO); 2015 [cited 28 Jan 2017]. Available from: http://www.searo.who.int/indonesia/topics/hs-uhc/en/.

[84] Reports from a field visit in Jakarta, 20 January 2017, note that 95% of outpatients are ineligible for insurance because they come directly to the health facility, rather than being referred.

Access to affordable services is extremely important for scaling up HIV treatment and services.[85] As a lifelong disease, PLHIV requires sustained and continuous HIV treatment and services. Ensuring that PLHIV can access the treatment and services they need is in itself a means of preventing further transmission. The earlier they get into treatment, the more effective a prevention measure it can be. Therefore, it is critical for key populations to be able to obtain early diagnosis of their status, and for PLHIV to stay on treatment in order to reduce the possibility of HIV transmission.

Recommendation 2

Taking into account the progress, gaps, and challenges in the implementation of effective HIV response, the Review Team encourages the Government of Indonesia to implement the recommendations below.

2.1 *In accordance with state obligations under the international treaties subscribed to by the Government of Indonesia, and in order to address barriers to access to HIV services for PLHIV, key populations and young people that impede progress towards ending AIDS by 2030,[86] the Government of Indonesia should take steps to reform national and sub-national policies and practices that hinder the effective implementation of the HIV response. To this end, the Ministry of Health should:*

2.1.1 Ensure that by the end of 2017 that local service providers and stakeholders (e.g. the National AIDS Commission, health offices and communities) are aware of human rights principles and have a clear and comprehensive understanding of relevant regulations so as to ensure the correct implementation of national policies impacting on HIV response.

2.1.2 Together with other relevant ministries, including the Ministry of Law and Human Rights and the Ministry of Home Affairs, document the impact of punitive regulations on the HIV response and amend or repeal national and local regulations that restrict access to HIV services for those who need them, before the development of the next national strategy on HIV.

2.1.3 Identify and develop enabling regulations and policies at national and local level, document their impact on HIV response and promote such regulations as good practices. The documentation of good practices should be finalized by the end of 2018, together with a plan for strategic promotion thereof.

2.2 *The Review recommends that the Government of Indonesia accelerate efforts to eliminate the stigma and discrimination experienced by PLHIV, key populations and women and ensure accountability for the implementation of a rights-based response to HIV. To this end, Ministry of Health should:*

2.2.1 By 2018, implement at scale a comprehensive package of programmes to create an enabling environment, including eliminating stigma, discrimination and gender-based violence, as referred to in the National Strategy and Action Plan and relevant human rights documents, with an effective and transparent oversight mechanism operational by end 2017 and a comprehensive monitoring system in place by end 2018.

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[85] United Nations General Assembly. Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight Against HIV and to End the AIDS Epidemic by 2030, Para. 37. 2016.

86 UNAIDS. Fast -Track - Ending the AIDS Epidemic by 2030. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014.

2.2.2 In a sustained and continuous fashion, and in consultation with civil society, engage in joint efforts and advocacy, where necessary, with key stakeholders such as parliamentarians, other ministries, the national human rights commissions, and national and international experts for the reform of policies and practices that hinder an effective HIV response.

3.3 The Review recommends that the Government of Indonesia ensure that PLHIV, key populations, young people and women are able to access affordable HIV services including HIV prevention, testing, treatment and care. To this end, the Review recommends that:

2.3.1 The government address key barriers faced by PLHIV and key populations in accessing benefits under the UHC system, including the JKN, such as ID card requirements, location of registration and coverage in prisons and other detention settings.

2.3.2 By the end of 2017, the Ministry of Health should revise the guidelines for the standard HIV service package under UHC to ensure full coverage for essential HIV-related services, such as STI care, hepatitis C testing and treatment, opportunistic infections, CD4 and viral load testing, and travel to health services. Revised guidelines should be rolled out at the beginning of 2018.

2.3.3 The Ministry of Health and other concerned ministries should undertake training and retraining of national and local authorities engaged in the response to HIV so as to ensure their understanding, capacity and accountability with regard to the rationale for comprehensive, rights-based strategies aimed at bringing the HIV epidemics under control and mitigating their impact. By the end of 2018, all public service personnel involved in the responses to HIV should have participated in at least one day of knowledge and skills building appropriate for their function within and outside the health system. Civil society representatives should be meaningfully engaged in the design and implementation of these activities.

3. The role of civil society organisations the response to HIV: Leadership, governance and management

Progress since the 2011 Review

It is widely recognised that the government cannot solve the country's HIV epidemics alone. Reaching National Strategic Plan[1] and Fast Track[2] objectives will require fast and sustained scale-up of programmes and rigorous implementation of key interventions following national and global good practices. A strong and genuine partnership with civil society is required to reach the targets and implement key interventions successfully. However, the potential to partner and co-design effective responses to HIV is not supported by strong institutional links between the Ministry of Health and civil society organisations (CSOs), including networks of key affected populations (KAP). This lack of mechanisms for engaging and financially enabling CSOs in the Ministry of Health's programme planning, coordination and monitoring is a rate limiting step, limiting the potential timeliness for achieving programme targets. It is also impeding the development and sustainability of CSOs, the agents most likely to be able to identify and reach KAP, in particular the youth within this population. CSOs need to be engaged and enabled so they can design innovative prevention interventions, link KAP to the health system, support adherence to HIV treatment as well as propose models for strengthening community and health systems and build the links between them. Both the CSOs and the Ministry of Health require rules, regulations and mechanisms that facilitate the meaningful involvement of CSOs in all facets and at every stage of the national response to HIV.

There are many examples of good practice that demonstrate a willingness by civil society to work with the Ministry of Health, other partners and with each other to lead a strong and effective response to HIV. The examples are available at national, provincial, district and sub-district level. They are also evident in efforts by networks of sex workers, men who have sex with men (MSM), transgender people, drug users, people living with HIV (PLHIV) and youth to be proactively engaged in developing solutions and partnering with international development partners, universities and local authorities.

The 2011 Review found that "Civil society organisation (CSO) involvement is not strong enough, particularly at sub-national and service delivery levels. Current Government of Indonesia laws and regulations do not facilitate funding to CSOs."[3] The National HIV and AIDS Strategy and Action Plan 2015-2019 acknowledges that "sustained support for communities, however, has been a constant challenge as the cuts in foreign funding have taken effect."[4] The 2017 Review found that this situation remained unchanged.

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[1] National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

[2] UNAIDS. Fast-Track - Ending the AIDS Epidemic by 2030. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014 [cited 5 Feb 2017]. Available from: http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report.

[3] Ministry of Health of the Republic of Indonesia. 2011. Review of the Health Sector Response to HIV and AIDS in Indonesia 2011. Jakarta: Ministry of Health and World Health Organization.

[4] National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

In relation to CSO engagement in service delivery, the 2011 Review noted that "PLHIV peer support groups continue to expand in number. However, there is a need for further involvement of PLHIV and other CSOs in care, support and treatment in the continuum of care." The Review went on to recommend that:

- "At provincial and district level, local health authorities should strengthen collaboration with the CSO sector to improve the coverage and quality of service provision."
- "More must be done to ensure the meaningful participation of groups representing the interests of male and female PLHIV, people who inject drugs (PWID), MSM and waria (transgender) in developing policies, programmes and in implementation.
- PLHIV should be effectively and actively involved in all aspects of care, support and treatment, including the development of policy, strategy and guidelines, planning, and provision of services. Capacity should be strengthened accordingly."

These recommendations continue to apply.

The need for greater involvement of CSOs, strengthened collaboration across all partners in the response and meaningful participation of KAP is now more critical than ever if Indonesia is to reach, test and enrol in treatment the numbers required to gain control of the epidemic. Robust mechanisms to facilitate meaningful participation that results in co-design and monitoring by CSOs and their public and private partners, along with mutual accountability, remains to be fully addressed.

However, several avenues for cooperation on HIV between the governmental programme and CSOs do exist and some progress since 2011 is noted in 2017. The CSO role in the HIV programme is facilitated via membership of the National AIDS Commission, and civil society is actively represented on Indonesia's Country Coordinating Mechanism (CCM Indonesia). CSOs participate in country dialogue as stipulated in the Global Fund's New Funding Model and by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and through service provision for the prevention and control of HIV and treatment support in collaboration with the Ministry of Health and the provincial health offices. These mechanisms provide an avenue for consultation and dialogue. This secures CSOs a voice in planning and monitoring forums, especially since Yayasan Spiritia, a peer-led organisation for people affected by HIV, became a Global Fund principal recipient. However, focus group discussions with CSOs indicated that they were not systematically consulted or invited to scheduled meetings with provincial or district authorities and that, if they were able to participate, their input was often not reflected in final decisions made at these levels.

Increased engagement of KAP in networks, activities and service delivery

Since 2011 there has been increased participation by CSOs in networks, activities and service delivery. Over 22,000 people are engaged in peer support groups that link to networks advocating for greater programme effectiveness.[5] Networks of KAP, including PLHIV and positive women's groups, are now well established at the

[5] Mardhiati R, Handayani S. Peran Dukungan Sebaya terhadap Peningkatan Mutu Hidup ODHA di Indonesia Tahun 2011 (*The Role of Peer Support in Improving the Quality of Life of PLHIV in Indonesia in 2011*) [Internet]. Jakarta: Lembaga Penelitian dan Pengembangan Universitas Muhammadiyah Prof. DR. Hamka; 2011 [cited 10 Feb 2017]. Available from: http://spiritia.or.id/dokumen/laporan-penelitian-peran-dukungan-sebaya.pdf.

national level,[6] and their reach extends across many provinces,[7] as documented elsewhere in this report. All the networks report increasing membership, despite the criminalisation of and/or hardening of policy against homosexuality,[8] drug use,[9] sex work[10] and, in Aceh, the vilification of and punishment for same-sex sex, social encounters between unmarried couples, penalization of sex outside marriage, and other actions not conducive to community engagement.

The CSOs and networks are demanding a greater role in planning and service delivery, and they actively monitor engagement in the HIV response and draw attention to any related challenges. For example, Gaya Warna Lentera Indonesia (GWL-INA), the national network of gay and transgender communities, collaborated with a research partner to publish a report documenting the involvement of the network members in the Global Fund's New Funding Model process.[11] This 2016 report found that the involvement of representatives of the MSM and transgender community, including young people, brought sufficient knowledge of the issues and experiences from the community to make a significant contribution to the Global Fund Concept Note. However it also found that the representation and involvement of transgender communities in the concept note development process was limited compared to that of the MSM community, and this resulted in less than optimal consideration of their specific needs in formulating a country plan.

Young key affected populations (YKAP) have increased their engagement in networks, activities and service delivery. This has been largely assisted by the Forum Populasi Kunci Usia Muda (the National Network of Young Key Affected Populations), known as 'Fokus Muda', which was established by a consortium in 2012 to increase the engagement of YKAP and advocate for responses addressing the needs of young key populations. In 2015 the LOLIPOP project in Bandung was initiated to increase access to health facilities and HIV services for young people aged 15–24. Through this programme, Fokus Muda collaborated with the Burnet Institute, the National AIDS Commission, a local university and the Ministry of Health. Fokus Muda reviewed practices and policies affecting YKAP access to prevention, testing and treatment in Bandung, developed a module for training outreach workers, and trained outreach workers for primary health centres (puskesmas) in Bali, Surabaya, and

[6] The 2011 Review noted that the National AIDS Commission has provided operational and programme funding for five national networks of key affected populations, including PLHIV. See Ministry of Health of the Republic of Indonesia. Review of the Health Sector Response to HIV and AIDS in Indonesia, 2011.

[7] For example, IPPI (Ikatan Perempuan Positif Indonesia/Indonesian Positive Women's Network) has 18 provincial offices, Gaya Warna Lentera Indonesia (GWA LINA) is active in 30 districts, OPSI (national sex worker network) is active in 22 provinces and PKNI (Persaudaraan Korban NAPZA Indonesia, the national drug user network) reports that they are active in 17 provinces with 25 local network groups, up from 22 in 2015.

[8] Since 2015, public discourse has frequently been coloured by accusations against LGBT groups, leading to sporadic attacks and a demand for the inclusion of same-sex sex in the Criminal Code, which is now being assessed by the Constitutional Court. See Kwok Y. LGBT Rights in Indonesia are coming under 'Unprecedented Attack.' Time [online daily]. 11 Aug 2016 [cited 10 Feb 2017]. Available from: http://time.com/4447819/indonesia-lgbt-rights-islam-muslim-gay-bi-transgender/

[9] Drug users were among the first groups to be marginalised when President Joko Widodo declared a “drug emergency” and announced unrealistic targets for getting people into rehabilitation, which led to mandatory treatment and human rights violations. See Irwanto, Wirawan DN, Praptoraharjo I, Irianto S, Mulia SM. Evidence-Informed Response to Illicit Drugs in Indonesia. Lancet. 2015;385(9984):2249-50. doi:10.1016/S0140-6736(15)61058-3.

[10] In 2015 the Ministry of Social Affairs launched the “Prostitution/Sex Work Zone-Free Indonesia by 2019” movement, which resulted in the closure of several sex work zones; these zones had, in fact, facilitated health interventions. See Fajerial E. Indonesia will be Brothel-Area Free by 2019: Minister Kholifah.

[11] Apcom. The Involvement of the MSM and Transgender Community with the Global Fund New Funding Model in the Country Processes - Indonesia [Internet]. Bangkok: apcom.org; 2016 [cited 11 Feb 2017]. Available from: https://apcom.org/2016/12/08/apcom-report-finds-involvement-indonesias-msm-transgender-community-global-fund-new-funding-model-need-strengthened/

Bandung so that they are skilled at identifying, reaching and supporting YKAP.[12,13,14] The project also set up a website providing HIV information for YKAP. This website was described by YKAP as being very useful because it provides them with information about 'taboo' topics that they cannot get elsewhere.[15]

When providing services to minors who are already engaged in high risk behaviours, CSOs report being genuinely worried about contravening the Child Protection Act.[16] They are reluctant to report contact with very young KAP because when information is shared with funders and government institutions they fear possible legal consequences arising from not reporting at-risk minors to the authorities.[17]

Advocacy activities are well supported by research undertaken by networks and other CSOs. The CSOs are no longer reliant on evidence produced by government or international development partners, and have the confidence and capacity to initiate, implement and internationally disseminate their research. For example, Yayasan Spiritia produced a report with researchers documenting the role of peer support in improving the lives of PLHIV.[18] Likewise the sex worker network, Organisasi Perubahan Sosial Indonesia (OPSI), conducted research into the impact of brothel closures in two cities and initiated further research in four additional cities, which was carried out by Atma Jaya University.[19] The findings of this and similar research are informing work in collaboration with the Independent Journalists Association (AJI) to improve the reporting of sex work zone closures.[20]

CSOs have extended their leadership in areas of interest to KAP beyond health service delivery. Ikatan Perempuan Positif Indonesia or IPPI (the Indonesian Positive Women's Network), for example, is a partner of the national commission on violence against women (KOMNAS Perempuan), as well as a member of the CEDAW Working Group Indonesia (CWGI). In these forums IPPI has been able to promote the integration of violence against women services and HIV services and the issue of gender-based violence in HIV forums. IPPI conducted peer-based research among 122 women living with HIV in eight provinces to draw attention to violence against positive women, and in 2012 they used the results to highlight the forced sterilisation of HIV-positive women in the CEDAW (Convention on the Elimination of Discrimination Against Women) Shadow Report and other forums, including the National AIDS Commission's Gender Taskforce.[21,22,23]

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[12] Burnet Institute, Universitas Padjadjaran, UNICEF. Demonstration Site of Friendly HIV Services for Young Key Populations in Bandung: Baseline Evaluation. Melbourne: Center for International Health & Centre for Population Health Burnet Institute, Faculty of Psychology & Department for TB-HIV Universitas Padjadjaran, United Nations Children's Fund (UNICEF); 2015.

[13] UNICEF. All In to End Adolescent AIDS in Indonesia: UNICEF Report to MAC AIDS Foundation. Jakarta: United Nations Children's Fund (UNICEF); 2017.

[14] Key informant interview with a representative of the United Nations Population Fund (UNFPA), 25 January 2017, in Jakarta.

[15] Parnell B. Demonstration Site of Friendly HIV Services: LOLIPOP Mid-Term Review Report. Melbourne: Burnet Institute; 2016.

[16] Law of the Republic of Indonesia No. 35/2014 on the Amendment of Law No. 23/2002 on Child Protection.

[17] Focus group discussions with stakeholders from West Java and community representatives, 18 and 20 January 2017, in Jakarta; and focus group discussion with representatives of YKAP communities, 25 January 2017, in Jakarta.

[18] Mardhiati R, Handayani S. Peran Dukungan Sebaya terhadap Peningkatan Mutu Hidup ODHA di Indonesia Tahun 2011 (The Role of Peer Support in Improving the Quality of Life of PLHIV in Indonesia in 2011).

[19] Praptorahardjo I, Sukmaningrum E, Nevendorff L, Widihastuti A, Apriana K, Sihaloho BS. et al. Studi Kualitatif Dampak Penutupan Lokalisasi di Empat Kota (Qualitative Study on the Impact of the Closure of Sex Work Zones in Four Cities), page 91. Jakarta: Pusat Penelitian HIV/AIDS Universitas Katolik Atma Jaya; 2016.

[20] Key informant interview with representatives of Organisasi Perubahan Sosial Indonesia (OPSI), 24 January 2017, in Jakarta.

[21] Rivona B, Mukuan O. Global Mechanism, Regional Solution: Ending Forced Sterilisation [Internet]. London: openDemocracy; 4 Dec 2012 [cited 9 Feb 2017]. Available from: https://www.opendemocracy.net/5050/baby-rivona-oldri-mukuan/global-mechanism-regional -solution-ending-forced-sterilisation.

[22] Commission on the Status of Women. Caregiving in the Context of HIV/AIDS and Recognizing and Valuing Unpaid Care Work. E/CN.6/2013/CRP.8 (19 Mar 2013); 2013.

[23] Key informant interview with representatives of IPPI, 24 January 2017, in Jakarta.

Increased participation in governance

Recognition of the specific needs of and barriers to engagement by KAP and YKAP has increased since 2011. The draft National Strategy and Action Plan acknowledged the need to ensure the meaningful engagement of young people from key populations in multisectoral dialogues and noted that YKAP had lower participation rates in HIV testing and other prevention initiatives. It also acknowledges the need for community system strengthening, social mobilization and strengthening inclusive and participatory programme planning and monitoring.[24]

The networks of KAP are active members of the National AIDS Commission and are involved the policy and planning process. Increased participation in governance is evidenced by the expansion of participation in the Global Fund Country Coordinating Mechanism (CCM), which has increased from two community members in 2011 to six members in 2016 (three full members and three alternates). CSOs demanded and secured participation in this country Review, and used their networks and influence to ensure that the Review Team met with national and sub-national representatives of all KAP.[25] Very keen to meet this request, the Review Team held a series of focus group discussions and interviews specifically with CSO representatives in Jakarta (for example with Global Fund and PEPFAR-funded community representatives on 20 January 2017 and a focus group discussion with YKAP in Jakarta on 25 January 2017). Review Team members met with KAP in Maluku and West Kalimantan during field site visits, and with KAP participating in provincial delegations from Aceh, Bali, Papua, West Java and Jakarta.

The establishment and resourcing of Fokus Muda has increased the participation of YKAP in governance. This CSO represents YKAP at high-level forums and on the HIV working groups sponsored by the Ministry of Health, the National AIDS Commission, PEPFAR and the CCM Indonesia.[26] In addition, the CCM Indonesia introduced a mechanism for ensuring that the CSO can communicate with YKAP and secure their input into the country dialogue. These actions have increased influence and expanded collaborations.[27] For example, the CSO reports that they used programme data to demonstrate that YKAP were not accessing the health facilities for HIV and therefore required additional programming consideration, which has been acknowledged in the draft National Strategy and Action Plan 2015-2019.[28,29,30]

Program management achievements

The involvement of CSOs in programme management has expanded with the appointment of Yayasan Spiritia as a national principal recipient for the Global Fund. The integrated programme provides prevention and care, support and treatment services.

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24 National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

25 Focus group discussions with community representatives and young KAP, 20 and 25 January 2017, in Jakarta.

26 Fokus Muda. Promoting Young Key Populations Responds [sic] in HIV-SRHR Strategies [Internet]. DKI Jakarta: Forum Populasi Kunci Muda (Fokus Muda); 2014 [cited 9 Feb 2017]. Available from: http://fokusmuda.weebly.com.

27 Focus group discussion with community representatives on the Country Coordinating Mechanism, 18 January 2017, in Jakarta.

28 National AIDS Commission. Rencana Aksi Nasional untuk Orang Muda Berisiko, Usia 15-24 Tahun 2010-2014 (National Action Plan for Young People (aged 15-24) at Risk, 2010-2014). Jakarta: National AIDS Commission; 2010.

29 National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

30 Focus group discussion with CCM Indonesia members from key populations, 18 January 2017, in Jakarta.

Current issues

Limited mechanisms to facilitate meaningful participation that results in co-design and monitoring by CSOs

An effective strategic response in Indonesia demands engagement by government, policy makers and service providers with KAP and CSO. The role of CSOs in designing effective programmes and promoting accountability and transparency or influencing policy is currently sub-optimal and not perceived as valued by Ministry of Health decision makers. During the focus group discussions, CSOs stated that they are often invited to validate plans before they are officially released rather than contributing to their design.

There is an **absence of regulations that require the Ministry of Health, KAP and primary and tertiary health care services to work closely together** to co-design appropriate and effective programmes and ensure that CSOS participate meaningfully in all aspects of the programme. There are a number of examples that demonstrate CSO willingness and capacity to participate in an effective response. For example, the Global Fund HIV concept notes are developed and co-designed with high levels of CSO involvement. However, the most recent sectoral Ministry of Health HIV plan[31] was developed largely in isolation from other partners. Therefore the HIV health programmes are unable to consistently manage, implement and monitor interventions and set or achieve targets that will drive a reduction in the epidemics among KAP.

Where the international development partners have supported CSOs to design their own approaches and implement community services, there are many examples of increasing reach among KAP. However, increased reach must result in increased retention across the cascade and reduced incidence among KAP, especially among YKAP, to achieve the national targets. This young population is often more vulnerable and routinely excluded from the services and not enabled to adopt health protective behaviours at the time when they are forming lifelong habits.

Where mechanisms and opportunities exist for CSO participation in programme aspects other than service delivery, most **CSOs perceive that their input is not welcome or acted upon**. CSO representatives interviewed for the national Review stated that, in general, they think that their perspectives are welcomed when they provide input related to service delivery. However, when they identify systemic problems, or critique policy, their input is not welcomed or elevated for action. For example, when CSOs draw attention to laws that inhibit KAP from accessing HIV services, or the actions of law enforcement that make it difficult to reach and serve KAP, or laws that criminalise homosexuality or sex work, the input of CSOs is not acted upon and does not result in changes.[32]

CSOs and networks of KAP working in Jakarta at the national level report more opportunities to engage and have their input actioned than those at the provincial and local levels. The absence of mechanisms requiring provincial and district health offices to engage with CSOs and community-based services has resulted in sporadic engagement, with effort directed at solving local problems for individuals. There were no documented examples of services for PMTCT programmes or HIV treatment provision in hospitals where the programme

[31] Ministry of Health of the Republic of Indonesia. National Action Plan for HIV and AIDS in the Health Sector 2015-2019.

[32] Key informant interview with representatives of Komnas Perempuan, Lembaga Bantuan Hukum Masyarakat (Community Legal Aid Institute), and OPSI, 24 January 2017, in Jakarta.

managers are required to include the expressed needs of their clients in service design and monitoring. Many hospitals report facilitating patient satisfaction surveys and meetings; however, KAP community members are not visible in these meetings. Fears of stigma and discrimination keep them hidden.

The **mechanisms for engaging CSOs are also absent in other sectors** such as within the Ministries of Social Affairs or Home Affairs, or the Police. Limited mechanisms are in place for receiving government financial support, unless it is for one-off charity or for the rehabilitation of sex workers or homosexuals. CSOs, especially the networks of KAP, need ongoing strengthening and running costs for sustainability and to support their engagement in HIV policy, planning and evaluation forums. CSOs report that they want to be seen as partnering the Ministry of Health in the HIV response, not as opponents wanting to criticize it. This position puts them at odds with NGOs in other sectors (e.g. human rights or climate change activism groups) who do not want to accept government funding because they see this as compromising their independence and freedom.[33]

Stigma and discrimination limits KAP and CSO involvement in the response

Stigma and discrimination limits KAP and CSO involvement, which reduces the speed at which national targets can be achieved. Stigma and discrimination keeps KAP hidden and undermines KAP trust in government, which in turn influences their willingness to be identified, to present for testing and demand quality health services. This is especially true for young (including underage) KAP.[34,35]

The primary concerns of community members as expressed during their participation in focus group discussions during the 2017 Review are: reducing the pervasive stigma associated with living with HIV or being a KAP, and combating discrimination by health professionals. However, there is no strategic plan with a monitoring framework and targets for actively and strategically achieving reductions in stigma and discrimination.

KAP describe being referred to during events, on banners and in HIV forums by stigmatising language, for example, as a group that 'spreads HIV'. The stigma that is directed at KAP by family members, friends and the community in general as well as by health professionals, affects their trust in strangers and willingness to be identified as members of KAP. This in turn impacts on their engagement in CSOs and deprives the programme of the deep understanding and innovative solutions they could offer.

Without safe and respectful opportunities to be involved, KAP, including YKAP, will continue to be left behind in the HIV response. Ultimately, the goal is to cultivate an HIV response that fosters an environment where key population-led organisations are respected and included as partners by both officials and service providers.[36] KAP are generally insufficiently informed about their legal and human rights, and the same lack of awareness prevails among health care providers, law enforcement agencies and, reportedly, the judicial system. Targeted

[33] Key informant interviews/focus group discussions with CCM Indonesia members from key populations, 18 January 2017, and with representatives of IPPI, Lembaga Bantuan Hukum Masyarakat, and OPSI, 24 January 2017, in Jakarta.

[34] Focus group discussion with CCM Indonesia members from key populations, 18 January 2017 in Jakarta; see also Fokus Muda website (http://fokusmuda.weebly.com/)

[35] WHO. HIV and Young People Who Sell Sex: A Technical Brief [Internet]. Geneva: World Health Organization (WHO); 2015 [cited 11 Feb 2017]. Available from: http://www.unaids.org/sites/default/files/media_asset/2015_young_people_who_sell_sex_en.pdf.

[36] World Health Organization, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, Global Network of Sex Work Projects, The World Bank. Implementing Comprehensive HIV/STI Programmes with Sex Workers: Practical Approaches from Collaborative Interventions [Internet]. Geneva: World Health Organization; 2013 [cited 11 Feb 2017]. Available from: http://apps.who.int/iris/bitstream/10665/90000/1/9789241506182_eng. pdf.

efforts to inform, educate and establish complaints and redress mechanisms for KAPs are being performed by some legal aid entities and CSOs.[37]

Both GWL-INA and IPPI stated that although the network memberships are growing, the stigma and fear makes people afraid to join the networks in case they are publicly identified. Joining the network benefits KAP because they learn about their rights, services and support available, but it also benefits the HIV programme, because it enables their lived experience and expertise, understanding of barriers and enablers to inform programme development and implementation.

The Ministry of Health has made efforts to ensure that a small number of puskesmas are "MSM friendly" by implementing sensitisation training in cities and clinics recommended by CSOs. This could be expanded beyond being MSM friendly to include other KAP, including YKAP, as was piloted in Bandung in 2015, using the same approach. KAP networks indicated a willingness to co-design and partner with the Ministry of Health to deliver the training required to ensure that puskesmas work effectively to serve sex workers and people who use drugs.[38,39,40]

The Ministry of Health has not secured the enduring partnerships with CSOs needed to achieve an effective response

The Ministry of Health has not yet developed with CSOs, including the KAP networks, the relationships that are necessary to secure them as enduring partners with the capacity to help Indonesia achieve an effective response to HIV. These relationships could also be leveraged to reduce the associated burden of disease from other sexually transmitted infections, blood-borne viruses and TB.

One reason the Ministry of Health has not secured enduring partnerships is because **CSO groups and activities are largely funded from external sources** and at the national level. The forming and sustaining of self-help groups and effective empowerment of KAP at sub-national level is hindered by limited access to funding, limited health and legal literacy (although this is growing), and a perception that their role is or should be limited to service delivery. Efforts by Ministry of Health to manage and deliver effective programmes and ensure the meaningful participation of CSOs in all facets and at every stage of the HIV programme will require the Ministry of Health to develop enduring partnerships and facilitate CSO access to government resources. This will enable CSOs to build organisational and technical capacity, resulting in their ability to help the Ministry of Health achieve positive and sustainable programme results. Facilitating access to government resources, including funding, will enable the Ministry of Health to establish the kind of relationships with CSOs that have been established by the external agencies. In 2015, the government explored options for funding CSOs to enable them to participate in the national response to HIV. Senior government staff from the Ministries of Finance and National Development Planning visited Australia and Malaysia, then developed a policy discussion paper.[41]

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[37] Burnet Institute, Universitas Padjadjaran, UNICEF. Demonstration Site of Friendly HIV Services for Young Key Populations in Bandung: Baseline Evaluation. Centre for International Health & Centre for Population Health, Burnet Institute; Universitas Padjadjaran; UNICEF; 2015.

[38] Ibid.

[39] Parnell B. Demonstration Site of Friendly HIV Services: LOLIPOP Mid-Term Review Report. Burnet Institute; 2016.

[40] Focus group discussion with representatives of Yayasan Spiritia and their sub-recipients, 20 January 2017, and representatives of IPPI, 24 January 2017, in Jakarta.

[41] Burnet Institute. Bruce Parnell | Burnet Institute [Internet]. Melbourne: Burnet Institute; 2017 [cited 11 Feb 2017]. Available from: https://www.burnet.edu.au/people/49_bruce_parnell.

Emphasis on projects at the expense of ongoing strengthening of technical and organisational capacity

Where resources are provided to CSOs the **emphasis is on implementing projects and delivering services**. This comes at the expense of developing the organisational and technical capacity of CSOs. Only the largest KAP networks and CSOs can engage in activities other than service delivery, because they do not have the resources or technical capacity to address system failures and limitations. CSOs have very little knowledge of or access to national reporting and financial data. Nor do they have the technical capacity to make use of the data to inform planning, improve implementation or monitor impact.

The paucity of resources for developing and sustaining organisational capacity **hinders leadership development, effective reporting and governance**. The dependence on project funding also impacts on the ability of CSOs to attract and retain skilled staff and build on a solid corporate history and memory. These things provide a platform for programme effectiveness and innovation. Strengthening organisational capacity and leadership can be expected to strengthen respect for and understanding of the roles and responsibilities of government and community actors, the rights of individuals, and for the rights of differing groups to express their interests and opinion. Increased organisational capacity enables organisations to scale up and secure funding from multiple sources and achieve a level of independence. The paucity of technical capacity limits CSO understanding of the drivers of the epidemic, and capacity to assess the adapt good practices or innovate to improve impact and outcomes.

Many Ministry of Health staff working in puskesmas, hospitals, pharmacies and laboratories indicated that they appreciate the benefits of CSO involvement and would welcome the opportunity to share the role of mounting a comprehensive, successful response to HIV.[42] However, the limited technical capacity and knowledge of the many laws, policies decrees and regulations governing the actions of health care professionals limits the ability of CSOs to identify entry points where they could contribute to programme effectiveness.

To achieve an effective response, CSOs must be able to anticipate and respond effectively to policy and other contextual changes, and innovate to maintain momentum. For example, CSOs currently require financial support to develop the technical capacity to develop new outreach methods in response to changes in sex work practices and the cycle of drug use patterns. This is explored in more detail in Chapter 5. They must also be able to design interventions that succeed in linking PLHIV to self-help groups and other impact mitigation mechanisms, and engage even the most marginalized KAP and their partners in prevention efforts and understanding the benefits of knowing their status and accessing treatment early enough to protect their health.

Over time, efforts to reach PLHIV will yield diminishing returns, especially as community workers exhaust their own personal networks. There were some reports by puskesmas staff in West Java that they get frustrated because outreach workers claim to have reached a large number of KAP, but very few turn up for HIV counselling and testing.[43] As effective retention in the cascade is low across all KAP, and prevalence continues to rise among MSM, it becomes increasingly important to detect and interrupt ongoing HIV transmission within high-risk networks. Reaching hidden networks of marginalised, stigmatised and highly vulnerable individuals with effective interventions requires an environment where trust can be established, peer interventions can

[42] Burnet Institute, Universitas Padjadjaran, UNICEF. Demonstration Site of Friendly HIV Services for Young Key Populations in Bandung: Baseline Evaluation. 2015.

[43] Focus group discussions with stakeholders from West Java, 18 January 2017, in Jakarta.

operate openly and needed services of optimal quality can be accessed. This is dependent upon investing in building CSO technical capacity.

Proposed responses

Require mechanisms to facilitate CSO participation and monitor impact

Programme goals, design and targets are often set nationally and poorly understood at the sub-national level. To make the HIV programme more effective, the Ministry of Health, through the Minimum Service Standards or other mechanisms, **could establish mechanisms that facilitate and require CSO involvement in all facets and at every stage of the programme.** To promote acceptance and implementation of this requirement, it will be important to demonstrate the benefits of integrating community participation to programme managers and implementers. Existing initiatives that demonstrate how to do this could be scaled up. For example, in Makassar (Sulawesi) in 2015 the annual Capacity Building for HIV Program Staff programme integrated MSM and transgender representatives into the training team. They delivered material on sexual orientation and gender identity (SOGI) and inspired managers to make adjustments to primary care service delivery to make it more appropriate for MSM and transgender clients. These changes are described as making the puskesmas more MSM friendly; however, they also make the service more effective and better equipped to reach the targets. Review informants reported that after the training, presentations for HIV counselling and testing rose by 100% among MSM and transgender people, and of those testing positive, 100% of MSM and 90% of transgender people were connected to care and treatment services.[44]

Correspondingly, the Ministry of Health will need **to invest in building CSO capacity** so that they can inform the development and delivery of quality health programmes and services. To strengthen rapport and shape the mechanisms for CSO engagement, it would be useful for the Ministry of Health to host a dialogue to r**each a consensus with CSOs on what constitutes meaningful participation,** and **how its impact can be monitored and understood** by the health service providers and CSOs.

The co-designed programmes, training for health professionals and locally appropriate approaches for identifying, reaching and retaining KAP in the health system should lead to higher rates of testing and increased retention across the cascade. Community system strengthening programmes, supported by the Ministry of Health and linked to the health system, will require leadership and good management to ensure that efforts to work with the community do not result in further stigma or harm for community members. While working to change the stigmatising environment, health professionals must be cognisant of the trust placed in them by CSO and community members who provide input, share their knowledge and mobilise KAP to engage with health services.

The continuum of prevention, care and treatment approach at the district level provides for a monthly meeting of health service and CSO service providers. This could be utilised as a platform for building further collaboration, moving beyond consultation to co-design of interventions.

Develop and implement interventions to reduce stigma and combat discrimination in health care and other settings

[44] Focus group discussions with stakeholders from West Java, 18 January 2017, in Jakarta. See also Fokus Muda website: http://fokusmuda.weebly.com

The National Program proposes "Increasing IEC promotion" as a means of reducing stigma and discrimination. Given the impact of this barrier, this is inadequate, and a costed national action plan for reducing stigma and eradicating institutionalised and other discrimination and setting national and sub-national targets, underpinned by findings from a stigma index and other data sources, is therefore proposed. This could bring together the current disparate activities and focus attention on this issue. It could also mandate action to address critical enablers, including reducing stigma in advocacy, and guide efforts by the Ministry of Health to influence policies and regulations developed by the National AIDS Commission's partner Ministries to ensure they facilitate an effective HIV programme.

A baseline stigma index supported by Global Fund will be conducted by Yayasan Spiritia in late 2017.[45] It will assess stigma and human rights, but will only cover PLHIV. To document a holistic baseline that can inform both the development of the plan and progress monitoring, it is proposed that the Ministry of Health incorporate a robust assessment of stigma against all KAP into national integrated bio-behavioural surveillance (IBBS) and utilise the National Demographic and Health Survey or other appropriate instruments to establish HIV-related attitudes among the general public.

A costed plan could outline a comprehensive package of interventions to eliminate stigma and discrimination, and promote the protection of KAP rights and safety. The costed plan should be accompanied by efforts to implement a system to monitor stigma and discrimination experienced by PLHIV and other KAP in health care settings. This may require strengthening and scaling up the community-based stigma monitoring which currently occurs in 17 cities (funded by the Global Fund). The Ministry of Health could survey health care staff using community-based monitoring tools to understand the root causes and inform locally nuanced approaches to preventing stigma and discrimination.

The plan should provide non-punitive guidelines on interpreting the findings so that they can be acted on by the Ministry of Health to improve practices in health settings. It should outline mechanisms for identifying and responding to specific instances of discrimination or discriminatory practices.

Invest in building CSOs as sustainable allies and partners in an effective response

The effectiveness of the HIV programme could be increased through **an investment by the Ministry of Health in developing civil society** as diverse, sustainable, skilled and appropriately resourced partners in the response, who can both demand and participate in providing quality health care services. **This requires direct funding from the government** to be made available to CSOs.

Direct investment from the Ministry of Health would help to ensure that CSOs perceive themselves as partners in the national response to HIV rather than identifying with their funding source ('we manage a GF project', 'we are a USAID partner NGO'). CSOs require both technical assistance and organisational strengthening from the Ministry of Health and other Ministries to access resources, participate in governance, provide leadership and expand reach and coverage. Technical assistance must be scaled up to a point where effective coverage is reached.

The Ministry of Health is encouraged **to identify the mechanisms currently available** that allow them to provide CSOs with access to government resources, **explore avenues for optimising those mechanisms** and work with other Ministries to **establish or extend additional funding mechanisms**. This may require the

[45] Focus group discussion with Yayasan Spiritia and their sub-recipients, 17 January 2017, in Jakarta.

Ministry of Health to look beyond traditional means for funding health service delivery to include mechanisms and funding streams that facilitate organisational strengthening to improve governance and accountability.

Of course investment need not be limited to financial investment, and therefore the Ministry of Health is encouraged to **extend opportunities to CSOs to participate in technical capacity building** to improve programme design, innovation and monitoring. Existing programmes designed to promote community systems strengthening could be adopted by the Ministry of Health and scaled up.

Investment can be risky, and the Ministry of Health should therefore expect that growing capacity to support KAP to recognize and demand quality services in their communities may initially place additional demands on service providers across the cascade as well as resulting in some lessons learned. However, in the long term, an effective HIV programme will reduce the ongoing budget burdens that increasing prevalence and numbers of PLHIV place on the health system.

Recommendation 3

The Ministry of Health should consider facilitating the meaningful involvement of CSOs in all facets and at every stage of programme design, planning, implementation, and monitoring and evaluation of the HIV response, while facilitating their access to resources.

3.1 *To improve the leadership, governance and management of the response, the Review recommends the greater and more meaningful participation of civil society organisations at all levels (national, provincial, district and sub-district) of the health programme, and in other spheres as required, to establish and maintain an environment that facilitates and legitimises CSO participation.*

3.1.1 By December 2017, the Ministry of Health, in collaboration with Ministry of Home Affairs and the National AIDS Commission, should consider finalising an overall plan for a comprehensive national response to HIV, including the promotion of the active participation of CSOs at all stages of design, planning, implementation and implementation of the response.

3.1.2 By December 2017, the Ministry of Finance and the Ministry of National Development Planning should provide CSOs with access to sources of financing at national, provincial and district levels to strengthen their capacity to perform programme tasks, expand capacity to identify, reach, test and support KAP and be accountable to their constituents and local and national authorities in operational and financial terms.

3.1.3 By mid-2018, the National AIDS Commission should consider strengthening and supporting CSOs to contribute to all efforts to enhance the response to HIV and, in particular, eliminate discriminatory policies, laws, regulations and practices hampering the participation of civil society organisations in the response to HIV, for their benefits and the protection of public health.

3.2 *To strengthen and sustain capacity for the meaningful participation of CSOs and the community, the Review recommends that:*

3.2.1 Together, the Ministry of Health and CSOs should decide what constitutes meaningful involvement, and identify the forums, training and processes in which CSOs will be routinely invited to participate at each level of the programme.

3.2.2 By end 2018, a community monitoring mechanism should include key targets and indicators for documenting progress on increasing meaningful participation and advocacy activities in the community information management system, and display them using a dashboard.

3.3 *The Ministry of Health, in collaboration with the Ministry of Home Affairs, should consider taking steps to eliminate the stigma and discrimination experienced by people living with HIV and key populations, and apply a rights-based response to HIV in conformity with the objectives of the national AIDS programme.*

The Review recommends that the National AIDS Commission facilitate the meaningful involvement of CSOs in efforts to eliminate the stigma and discrimination experienced by PLHIV, key populations and women, and the monitoring of the implementation of a rights-based response to HIV, including:

3.3.1 By end 2017, the Ministry of Health and other relevant Ministries, in collaboration with CSOs and communities, should consider conducting a baseline stigma audit, and prepare a plan for addressing stigma and discrimination in areas critical to achieving programme objectives.

3.3.2 By end 2018, the National AIDS Commission should consider implementing at scale a comprehensive package of programmes, informed by CSOs, to eliminate stigma and discrimination.

3.3.3 The National AIDS Commission should consider facilitating CSO involvement in an effective and transparent oversight mechanism, operational by end 2017, and a comprehensive monitoring system, to be in place by end 2018.

3.3.4 The National AIDS Commission and the Ministry of Home Affairs should consider ensuring that CSOs are informed and engaged in the reform of national and local policies and practices that hinder effective implementation of the HIV response, including through documenting the impact of punitive laws on HIV responses, dialogue with key stakeholders such as parliamentarians and the national human rights commissions, and engaging support from national and international experts.

4. Differentiation: The HIV epidemic in Tanah Papua contrasts with the HIV epidemics in other regions of Indonesia

Background and findings

A focus group discussion involving government and non-governmental actors from Papua Province (the West Papua delegation was invited to take part in the Review in Jakarta but was unable to attend) resulted in the findings and recommendations listed below. The 2015-2019 strategic plan for Papua and West Papua were not available to the participants of this meeting. A further literature review[1] was undertaken to complement the focus group discussion.

Figure 5.1. Map of Papua

[1] Including: 1) CHAI. CHAI Indonesia Annual Report 2008. DKI Jakarta: Clinton Health Access Initiative (CHAI); 2009; 2) Ministry of Health of the Republic of Indonesia. IBBS 2011: Integrated Biological and Behavioural Survey; 3) CHAI. Rapidly Expanding Access to Care for HIV in Tanah Papua (REACH) Program Activity Completion Report. Jakarta: Clinton Health Access Initiative (CHAI); 2016; Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016 (*HIV, AIDS and STI Report, 3rd Quarter 2016*).

"Tanah Papua" (referring to both Papua and West Papua) presents unique and significant challenges with regard to its topography, complex socio-cultural environment, security issues, and fragile governance. Contrary to other provinces, Papua and West Papua are confronting a low-level generalised HIV epidemic: 2.3% HIV prevalence with higher number of women of reproductive age who are infected.[2] Although HIV has spread among men and women in the general population, commercial sex has contributed disproportionately to the epidemic in all areas of Tanah Papua. Female sex workers in Tanah Papua have higher HIV and sexually transmitted infection (STI) prevalence rates than their counterparts in other parts of Indonesia. In 2011, HIV prevalence among samples of sex workers was as high as 25%, with 31% to 56% of sex workers being infected with at least one STI.[3]

West Papua and Papua have the highest HIV case rates compared to other provinces, at nearly 8 and 15 times greater, respectively, than the national case rate.[4] HIV testing rates in Tanah Papua are low, with only 27,468 people ever diagnosed with HIV by September 2016, many of whom had already died.[5] In that same year, access to HIV treatment was particularly low, with only 6,343 people on ART. This represented just 21% of an estimated 24,293 people in need of treatment.[6] Most presented with late stage disease, making effective treatment more difficult and increasing stigma and dependency as they are unable to work.

Papuan sexual culture is perhaps less restrictive overall than in many other parts of Indonesia. Many of Papua's 250 cultural groups actively promote marriage at an early age for girls. Many Papuans maintain longstanding customs around sex and marriage, such as allowing premarital sex in some circumstances and maintaining polygamous households in others. In addition, for many migrants to Papua, the region is a frontier culture where sexual openness is perceived as more prevalent than elsewhere in Indonesia. Soldiers and police tend to be highly sexually active. Many indigenous Papuans and migrants take advantage of what they see as a "*seks bebas*" (free sex) culture in the province. The sex work industry thrives in Papua's frontier economy, with brothels, discos, street workers and other forms of sex work well established at resource extraction sites and in cities and towns.[7]

The prevention programme for key populations has been primarily targeted on brothels. The closure of the Tanjung Elmo brothel in Jayapura and female sex worker cafes in Jayawijaya district has caused sex workers to be dispersed and spread to other districts. Additionally, the closure of Dolly brothel in Surabaya has caused some displaced sex workers to move to Tanah Papua.

While women are more frequent users of health services than men, their access to health services can be reliant on male permission.

Over 60% of Tanah Papua's population of 4.3 million[8] lives in rural areas, where access to and quality of services is poor, stigma is high, and transportation is expensive. Of the two provinces, Papua province is the

[2] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[3] Calculated from the IBBS 2011 Indonesia Report. Ministry of Health of the Republic of Indonesia. IBBS 2011: Integrated Biological and Behavioural Survey. Jakarta: Ministry of Health, Directorate General of Disease Control and Environmental Health; 2011.

[4] Cumulative up to September 2016, Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (HIV, AIDS and STI Report, 3rd Quarter 2016). Jakarta: Ministry of Health; 2016, page 16.

[5] Cumulative up to September 2016, ibid., page 8.

[6] Ibid. page 126.

[7] Bennett L, Davies S. (Eds.). Sex and Sexualities in Contemporary Indonesia: Sexual Politics, Health, Diversity and Representations. London: Routledge; 2015. Page 113.

[8] According to Wikipedia, in 2014 the population of Papua was 3.5 million, and of West Papua, 877,437.

more difficult to access due to the almost impassable geographic terrain, necessitating the use of aircraft. Difficult accessibility is exacerbated by the fact that flight schedules are erratic, uncertain weather conditions cause many flight delays, and security issues cause further delays, as do issues around aircraft maintenance. Comparatively better conditions prevail in West Papua, with most districts accessible by car, although driving time ranges from eight to fourteen hours.

Human resource numbers and distribution, as well as requisite skill levels, are among the main challenges to scaling up HIV-related services in Tanah Papua. Most health facilities—particularly at the more basic level—suffer from chronic staffing-related issues with regard to both high attrition rates and rotation, which negatively affect the delivery of essential programmes and services. Sparse staffing is compounded by high levels of absenteeism.

One of the biggest issues facing health care delivery is one of accountability at the district level. Under the decentralized health system, the Ministry of Health in Jakarta and the two provincial health offices (PHO) in Tanah Papua have limited power to compel districts to meet their commitments to health, much less allocate additional funding for HIV and AIDS. Districts and health facilities are in general not held accountable for performance and results, nor for complete and timely reporting. Nine out of twenty-nine districts have not benefited from training on the HIV/AIDS Information System (SIHA).

Insufficient laboratory capacity and referral networks remain significant debilitating factors in the ability to roll out quality HIV related services on a larger scale in Tanah Papua. Laboratory technicians play a key role, with HIV diagnosis as the first step towards HIV care and treatment, and as such, the availability of skilled lab technicians is crucial but still largely lacking. Prevention of mother-to-child transmission (PMTCT) services are available in 15 districts, but only eleven infants received early infant diagnosis (EID) of HIV in 2016 due to the only PCR (Polymerase chain reaction) testing facility being located in Jayapura. Viral load testing is not available and there are reported cases of CD4 reagent stock-outs.

HIV services are available in one city and twenty districts in Papua. However, only fifteen are considered active. ART services are available in thirteen provincial and district hospitals and fourteen primary health centres (puskesmas).

There is an active advocacy group on Facebook comprising 35,000 members encouraging people not to take ART.

National health insurance (JKN) and Papua health insurance for those of Papuan origin (Kartu Papua Sehat) cannot be utilised optimally due to administrative barriers: many who try to access health services do not have a national citizen ID and/or family card.

Loss to follow up issues abound due to mistrust of medical treatment generally and particularly towards perceived ART side effects. From the perspective of the patient, stigma is still rampant. Lack of knowledge leads to poor adherence, exacerbated by at times poor provider responsiveness, and traditional methods of healing provide additional constraints to successful ART treatment and retention in Tanah Papua.

HIV/AIDS has never been discussed as a priority in the province and districts in the 'Musrenbang', a bottom-up participatory budgeting process. Civil society organisation (CSO) involvement so far is only to help government implement the HIV programme, but there is no participation of civil society in programme planning supported by local government budgets (APBD).

Programme planning based on the epidemic profile cannot be supported by the significantly reduced

budget allocation for HIV in Papua province (Rp. 400 million for 2017 against Rp. 1.6 billion in the previous year).

Overlapping area among international donors support is the main concern of the PHO's in dealing with disparities within and across the districts.

All recommendations presented in this report are equally relevant and applicable to Papua Tanah than to other high HIV burden provinces in Indonesia. However, considering the geopolitical, epidemiological, socio-cultural and structural specificity of Papua Tanah, the Review proposes the following the Additional Agenda for Action.

Proposed action for Tanah Papua

- Provincial and district health offices and CSOs should collaborate on developing a systematic prevention programme targeting both the general population and female sex workers (FSW), particularly with the recent dispersal due to the closure of brothels and FSW cafes. Use customary areas (Mamta, Saereri, Anim Ha, La Pago, Meepago) as a basis for specific prevention programmes, taking into consideration cultural variations, including partner relationships. The information, education and communication (IEC) plan should also include social media and SMS strategies.

- Considering the geographical and infrastructural constraints, the most effective way of increasing access to HIV treatment in Tanah Papua is to make quality treatment available closer to where infected people live. Consequently, the provincial and district health offices and partners should work on decentralising and expanding quality care at the primary health clinic (puskesmas) and rural private clinic levels. To maximise the impact of service delivery, it is necessary to simultaneously ensure availability of key commodities at these facilities.

- Special autonomy resources (OTSUS) should be strategically invested with 80% allocated to districts and 20% to provinces, to strengthen, incentivize and retain skilled human resources, especially care, support and treatment personnel and lab technicians, and build needed basic infrastructure (e.g. clean water, electricity, solid and fluid medical waste management, computers, internet) for health facilities in the districts. Working in remote and difficult areas (due to both geographic characteristics and potential insecurity), an official residence for employees is a major incentive to increase health staff's availability and retention.

- Data should inform and support advocacy. The purpose of monitoring and evaluation (M&E) is to provide data for better programme planning and advocacy. Some health facilities have successfully advocated to local government to support their HIV-related programmes. Puskesmas Ilekma in Jayawijaya district was allocated Rp. 200,000,000 per year from the local government budget starting in 2014. Tolikara District successfully advocated local government to approve an HIV programme budget amounting to Rp. 2,000,000,000 per year in 2015. In West Papua, Fakfak district provided an official residence to ensure health staff availability at the puskesmas level. Sorong city and Bintuni district successfully budgeted for the procurement of HIV test kits and reagents using local government funds.

- Facility-based training through in-house training (IHT) and on–the-job training (OJT) should be preferred to traditional one-time, didactic training approaches. This approach would be more cost-effective for health facilities and ensure that staff are not away from their posts for long stretches, thereby minimizing undue burdens on already understaffed facilities. In human resource limited sites, increase the skill sets

of midwives to task shift some of the responsibilities that normally fall to lab technicians, thereby addressing the chronic shortage of lab testing and delayed receipt of results for patients.

- Provincial-level governments in Papua and West Papua should leverage Law 23/2014 on Local Government, which mandates districts to ensure that minimum service standards for health are met as outlined by the Ministry of Health, as well as compliance with SIHA recording and reporting standards. This should go beyond delegating technical authority and include administrative authority.

- The active engagement of CSOs, including religious organisations as they have a significant footprint in Papua, should be enhanced through capacity strengthening and greater resource allocation to become advocates for local HIV policies and programmes, apart from being implementers. Support for scaling up HIV related services should ideally not be exclusively focused on health facilities. Community leaders, families, the private sector, and peer groups should be engaged as they play an important role in improving patients' access to health facilities.

- Since the national AIDS programme is still centralized in nature, in order to reduce disparity among districts in Tanah Papua, partnerships should be more effectively coordinated at the national level (including the Ministry of Health, the Global Fund, the National AIDS Commission, official development assistance agencies and donors).

- Given the generalized epidemic in Papua, the scale-up of PMTCT should be prioritized, including voluntary partner testing of positive people and for all pregnant women, with linkages to care and treatment. Additional support should be sought with expanded outreach to community and traditional tribal leaders and groups.

- The Papua strategic plan for HIV should be reviewed and updated.

Masalah dan Penanggulangannya
Welcome Team
JOINT EXTERNAL TB MONITORING MISSION (JEMM)
AND COUNTRY REVIEW ON HIV RESPONSES
AT RS. SUKANTO INDONESIA NATIONAL POLICE HOSPITAL
January, 19th 2017
Masalah dan Penanggulangannya

5. Understanding and responding to the epidemic in key populations

Epidemiological trends in key populations

TThe consultations and documentation provided to the Review Team have confirmed the consensus reached at the Epidemiological Review of 2016: that the HIV epidemic situation in Indonesia has experienced a dramatic change in the key populations affected and instrumental to the epidemic.[1]

The HIV epidemic for each key population is explained below, i.e. men who have sex with men (MSM) and transgender women or transwomen (known as waria), female sex workers (FSW), and people who inject drugs (PWID).

Men who have Sex with Men (MSM) and Waria (Transgender people)

Across Asia over the last 15 years, reported HIV infection rates among MSM have increased in large cities. In Indonesia, HIV infection among MSM has increased very significantly in recent years. The Integrated Biological Behavioural Survey (IBBS) data have unequivocally documented the upward trend in HIV and syphilis prevalence for MSM in all provinces surveyed in Indonesia since 2007 (**Figure 5.1**).[3,4,5]

Coverage of outreach activities for MSM (i.e., those who received the minimum package of prevention services) in 141 districts supported by the Global Fund for AIDS, TB and Malaria (GFATM), increased significantly to reach 167,689 in 2016, while for waria, coverage increased to 24,533 in 2016.[6] This contribution to the national prevention coverage for key populations (against the 2016 national population size estimation[7]) revealed high coverage for waria (66%) but very poor coverage for MSM (22%). Critically, reported HIV testing in the past 12 months (IBBS 2015) was 83% for waria, but only 61% for the MSM interviewed.[8]

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[1] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[2] Beyrer C, Baral SD, van Griensven F, Goodreau SM, Chariyalertsak S, Wirtz AL, et al. Global epidemiology of HIV infection in men who have sex with men. Lancet. 2012 [cited 27 Jan 2017]; 380:367–77. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3805037/pdf/nihms516957.pdf doi:10.1016/S0140-6736(12)60821-6.

[3] Mustikawati DE, Riono P, Sutrisna A, Siahaan T, Bambang AC, Priyono JB, et al. Analisis Kecenderungan Perilaku Berisiko terhadap HIV di Indonesia: Laporan Survei Terpadu Biologi dan Perilaku 2007 (*Analysis of HIV-related Risk Behaviour Trends in Indonesia: Report on the Integrated Biological and Behavioural Survey 2007*). Jakarta: Ministry of Health; 2009.

[4] Ministry of Health of the Republic of Indonesia. IBBS 2011: Integrated Biological and Behavioural Survey. Jakarta: Ministry of Health, Directorate General of Disease Control and Environmental Health; 2011.

[5] Ministry of Health of the Republic of Indonesia. Survei Terpadu Biologis dan Perilaku (STBP 2015) (*Integrated Biological and Behavioural Survey 2015*) [unpublished report]. Jakarta: Ministry of Health; 2015.

[6] GFATM programme in Indonesia: monitoring data 2014-2016 [unpublished data].

[7] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[8] Ministry of Health of the Republic of Indonesia. Survei Terpadu Biologis dan Perilaku (STBP 2015) (*Integrated Biological and Behavioural Survey 2015*) [unpublished report]. Jakarta: Ministry of Health; 2015.

Figure 5.1. HIV and syphilis prevalence among MSM and Waria

Female Sex Workers (FSW)

Amongst FSW the data remain essentially static, with HIV prevalence of less than 5% in the estimated 267,000 FSW across Indonesia. The Review did not follow the local distinction of direct versus indirect sex work since a comprehensive response to the HIV transmission risk of transactional sex applies regardless of that distinction (and also to waria or transgender women). Of particular concern in Indonesia is the greater than 15% HIV prevalence amongst FSW in Papua.[9]

People Who Inject Drugs (PWID)

In general, although the prevalence of HIV as measured in the IBBS remains high amongst PWID, there is good evidence that the drug market has changed and that the supply of illicit drugs over recent years has favoured the availability of crystal methamphetamine[10] (locally known as "sabu-sabu"), and that heroin has markedly decreased in purity and increased in price. As a consequence, the HIV risk associated with drug use (particularly heroin injection) has decreased, while the inhaling or smoking of methamphetamines has become common. Although most are occasional, it is estimated there are almost 800,000 people who use drugs (PWUD) nationally.[11] Injection of crystal methamphetamines is limited,[12] but it was found in some patients or PWID on methadone maintenance therapy (MMT) or amongst previous heroin injectors.[13]

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[9] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[10] United Nations Office on Drugs and Crime. World Drug Report 2016. p53. New York: UNODC; 2016 [cited 25 Jan 2017]. Available from: https://www.unodc.org/doc/wdr2016/WORLD_DRUG_REPORT_2016_web.pdf

[11] Badan Narkotika Nasional. Laporan Akhir Survei Nasional Perkembangan Penyalahguna Narkoba Tahun Anggaran 2014 (Final Report on the National Survey of Drug Abuse, Fiscal Year 2014). Jakarta: Badan Narkotika Nasional; 2015 [cited 24 Jan 2017]. Available from: http://www.bnn.go.id/read/pressrelease/12691/laporan-akhir-survei-nasional-perkembangan-penyalahguna-narkoba-tahun-anggaran-2014

[12] Nevendorff L, Praptorahardjo I. Chrystal-Meth in Indonesia. Chrystal-meth use and HIV-related risk behavior in Indonesia. Jakarta: AIDS Research Center-Atma Jaya Catholic University of Indonesia; 2016 [cited 24 Jan 2017]. Available from: http://mainline-eng.blogbird.nl/uploads/mainline-eng/Mainlines_sober_facts_on_chrystal_meth_use_in_Indonesia1.pdf

[13] From focus group discussions with representatives of key population communities, 19 January 2017, in Jakarta.

Current HIV response to the key populations

The sharply decreasing trend in heroin injecting has been followed by the transition of sexual transmission among male sex workers and waria, as the main drivers of the HIV epidemic, to unprotected anal sex amongst the vibrant developing MSM communities across Indonesia.

In the past decade, a number of factors have contributed to a muted response to this sexually driven epidemic, including limited reach and funding for civil society organisations (CSOs) supporting prevention services tailored to MSM and waria (distribution of condoms and lubricant sachets); limited MSM- and waria-friendly HIV counselling and testing and sexually transmitted infection (STI) healthcare services, resulting in few being tested and treated for either; an uncontrolled syphilis epidemic amongst MSM and waria; and most importantly, high levels of stigma and discrimination around MSM behaviour and sexual orientation, which has posed an obstacle to access to health services. However, more recently, with the support of the Global Fund and USAID, the Ministry of Health has attempted to strengthen its collaboration with CSOs to address these factors, paving the way for a more effective response.

Since 2010, in response to conservative social and political elements, a number of provincial administrations and the Ministry of Social Affairs have declared a nationwide crackdown on all sex trade hot spots (brothel zones or "lokalisasi") across the nation, with high profile closures of hot spots in Surabaya, Jakarta and Jayapura, with subsequent problems of coordination and collaboration across sectors to readjust the general health and HIV and STI prevention, diagnosis and treatment response.[14,15]

According to staff in healthcare facilities and FSW CSO representatives, the closures of "lokalisasi" appear to have led to: disruption in the surveillance system, with health services reluctant to register patients in voluntary counselling and testing (VCT) or STI services as sex workers; reluctance of sex workers to receive condoms or outreach worker attention; heightened likelihood of sex workers being subjected to extortion or violence; or reluctance of sex workers to carry condoms for fear of their being used as criminal evidence. Partly as a consequence of the closures, but also because of the increasing availability of internet and mobile phone communication, new avenues have opened for the sex industry in terms of connecting and negotiating with clients online.

Condom use programmes to date in Indonesia have not reduced the prevalence of HIV/STI amongst FSW to an acceptable level. The emphasis predominantly on an individualised voluntary approach rather than uniform industry-wide acceptance/requirement of condom use may have contributed to this lower use of condoms.[16] There also remain strong indicators of condoms not being used in transactional sex because of the low bargaining power of sex workers with clients, and few of them having the negotiating skills or power to refuse.[17]

Only a few sex workers visit the government primary health services to receive HIV screening (only 38% were aware of their HIV status in 2015[18]) or access treatment for HIV or STIs. Self-perceptions of rejection were

[14] From focus group discussions with CCM Indonesia members, 23 January 2017, in Jakarta.

[15] Godwin J. Sex Work and the Law in Asia and the Pacific: Laws, HIV and Human Rights in the Context of Sex Work [Internet]. 2012 [cited 2 Feb 2017]. Bangkok: United Nations Development Programme (UNDP). Available from: http://www.undp.org/content/dam/undp/ library/hivaids/English/HIV-2012-SexWorkAndLaw.pdf.

[16] Bhattacharjya M, Fulu E, Murthy L, Seshu MS, Cabassi J, Vallejo-Mestres M. The Right(s) Evidence: Sex Work, Violence and HIV in Asia: A Multi-Country Qualitative Study [Internet]. 2015 [cited 2 Feb 2017]. Bangkok: United Nations Population Fund, United Nations Development Programme dan Asia Pacific Network of Sex Workers. Available from: http://www.aidsdatahub.org/sites/default/files/highlight-reference/document/Rights-Evidence-Report-2015-final.pdf

[17] UNFPA & UNDP - Sex work and violence in Jakarta, Indonesia: Understanding factors for safety and protection.

[18] Ministry of Health of the Republic of Indonesia. Survei Terpadu Biologis dan Perilaku (STBP 2015) (*Integrated Biological and Behavioural Survey 2015*) [unpublished report]. Jakarta: Ministry of Health; 2015.

described by CSOs as frequent among sex workers diagnosed with HIV/STI at mobile clinics. Those already in HIV care or treatment, according to HIV staff, were commonly lost to local follow-up or stopped treatment as a result of their mobile work patterns or typically socially unsupportive relationships.[19]

During the Review, the themes of a decrease trend in drug injecting, difficulty identifying and accessing people who inject drugs, and an inflexibility in HIV prevention programming to address those changes was consistently noted.

From the Review consultations, government and CSO reports, and published research, it was apparent that there remain significant regulatory barriers to a fully functional needle syringe programme (NSP) and services capable of halting blood borne virus transmission among PWID. Needles/syringes are still reportedly used by police as evidence of illegal behaviours (even if only for the extortion of information/money), and as a requirement for exchange (old for new) at the only 232 NSP sites, or require a doctor's prescription at private pharmacies. Although the number of CSOs engaged in the NSP appears to have increased under Global Fund support, the implementers report great difficulty in reaching their targets due to the shifting trend away from heroin injecting towards methamphetamine smoking. NSP service coverage for PWID, as conveyed in the Global Fund reports and the last two IBBS reports, appears to be sub-optimal, but may reflect the above trend to methamphetamine smoking or other adequate access to needles and syringes through private pharmacy retailers.

Reported condom use among PWID remains very low, according to the IBBS, highlighting the very high risk of transmission of HIV through unprotected sex into young populations of sex workers, MSM, waria, and methamphetamine users. The acknowledgement, investigation and risk reduction of these bridging groups' activities have already been delayed too long to protect young MSM, FSW and PWID.

The number of clients enrolled in the methadone maintenance therapy (MMT) clinics across Indonesia remains low, with a decreasing number over the last five years: as of 2016, there were 92 clinics in 18 provinces and less than 2,500 active clients.[20] Sub-therapeutic methadone maintenance doses across the programme and urine drug tests confirming the ongoing use of drugs other than heroin were widely reported,[21] but systematic reports on these quality indicators were apparently absent.[22]

Most PWID have not accessed VCT, particularly in the last 12 months, and therefore do not know their current HIV status.[23] The additive self-stigmatisation of PWID and apparent health worker discrimination and stigmatisation, without the full engagement of CSOs in the HIV treatment cascade, act against the progression of PWID onto ART, despite ample evidence demonstrating excellent retention and response to treatment of PWID in Indonesia and elsewhere in Asia.[24]

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[19] From discussions with representative of key population communities, 23 January 2017, in Jakarta.

[20] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (HIV, AIDS and STI Report, 3rd Quarter 2016). Jakarta: Ministry of Health; 2016.p 160.

[21] Sarasvita R, Tonkin A, Utomo B, Ali R. Predictive Factors for Treatment Retention in Methadone Programs in Indonesia. J Subst Abuse Treat. 2012;42(3):239-46, doi: 10.1016/j.jsat.2011.07.009.

[22] From field visits in Jakarta, 18-20 January 2017.

The development of community-based drug treatment for methamphetamines users is beyond the remit of this Review; however, good evidence exists for non-residential, intensive, mixed psychosocial interventions including group, individual and peer support components.[25]

It was widely reported that CSOs have limited access to PWID beyond traditional access to aging and diminishing populations of heroin injectors, and were, in addition, lacking confidence in the development of community interventions for methamphetamine and other substance users. This may be particularly relevant for access and interventions with young MSM and others for whom peer-based "friend help friend" approaches and sexual harm reduction advice are appropriate.[26,27]

Challenges and opportunities

A significant proportion of the key populations (MSM, waria, FSW and PWID) diagnosed HIV positive during mobile or other HIV testing services (often implemented collaboratively by CSOs and primary health centres, or puskesmas), are not subsequently linked into care, support and treatment (CST) services provided by the puskesmas. Despite the steady increase of syphilis among MSM and waria, a syphilis test is often not systematically combined with HIV testing, while single dose treatment for the syndromic case management of most STIs should also be available onsite for all key populations. There are national guidelines available for this syndromic approach for STIs (including rectal), but they appear rarely used for these populations.[28]

Across the provinces from which reports were available, the issue of condom promotion and availability at "point of need" for PWID, FSW, MSM and waria remains critically problematic. Appropriate condoms were free, but very discreetly, within clinical rooms at some puskesmas, and at variable cost in private pharmacies, supermarkets, street stalls and convenience stores (from both commercial and social marketing agencies), but greater visibility or active promotion was reportedly not possible. The Review Team noted the broad absence of condom promotion in public or in electronic media (though one large billboard for a deluxe imported condom product was seen in Jakarta). Local government initiatives to promote and make condoms and lubricants more available to young key populations appear to have been met with opposition from the conservative community. Instruction from the Ministry of Health to health personnel was to work with relevant local stakeholders on STI prevention and promote condoms within healthcare services, as dual protection for preventing STI.[29]

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[23] Personal communication with the Ministry of Health, January 2017.

[24] Wisaksana R, Alisjahbana B, van Crevel R, Kesumah N, Sudjana P, Sumantri R. Challenges in Delivering HIV-Care in Indonesia: Experience from a Referral Hospital. Acta Med Indones [Internet]. 2009 [cited 22 Jan 2017];41 Suppl 1:45-51. Available from: http://www.inaactamedica.org/archives/suppl_2009/19920298.pdf.

[25] WHO. Therapeutic interventions for users of amphetamine-type stimulants (ATS). Technical Briefs on amphetamine-type stimulants (ATS) 4. Manila: WHO; 2009 [cited 27 Jan 2017]. Available from: http://www.wpro.who.int/hiv/documents/docs/Brief4forweb_7DF1.pdf?ua=1

[26] Sherman SG, Gann D, German D, Sirirojn B, Thompson N, Aramratanna A, et al. A Qualitative Study of Sexual Behaviours among Methamphetamine Users in Chiang Mai, Thailand: A Typology of Risk. Drug Alcohol Rev. 2008;27(3):263-9. doi:10.1080/09595230801956520

[27] Sherman SG, Sutcliffe C, Sirirojn B, Latkin CA, Aramratanna A, Celentano DD. Evaluation of a Peer Network Intervention Trial among Young Methamphetamine Users in Chiang Mai, Thailand. So Sci Med. 2009;68(1):69-79. doi:10.1016/j.socscimed.2008.09.061

[28] Field visits in Jakarta, 19 January 2017

[29] Field visits in Jakarta, 19 January 2017.a, 19 January 2017.

The other challenge is the appearance of an anti-LGTB movement in 2016, which seems to have impaired the implementation of some interventions (mobile HIV testing and counselling services and edutainment). Some MSM and waria groups believe the anti-LGBT movement will impede their access to health, making it crucial to monitor its impact. The government has also announced a ban on all programmes on mass media featuring LGBT talent or promoting sexual minority groups,[30] and many social media and internet sites of interest to LGBT people were blocked by the government at the end of 2016.

Key recommendations of the review of the national MSM programme in 2013[31] were included by the Ministry of Health and Yayasan Spiritia (a peer-led organisation for people affected by HIV, and a Global Fund principal recipient) in the current Global Fund programme. A number of best and promising practices in HIV service delivery (including MSM-friendly clinics)[32], have been included in the Global Fund programme being implemented by CSOs in close collaboration and with the support of the Ministry of Health.[33] Since April 2016, a total of 18 MSM-friendly clinics (out of 38 planned) have been established in eight provinces (16 embedded within public clinics and two within private clinics), with some clinics having committed to change their operating hours to better serve the key populations.[34]

Yayasan Spiritia is implementing operational research aimed at assessing the feasibility and acceptability of peer-mediated screening (HIV test for triage), using oral fluid, among MSM in five provinces.[35]

Box 5.1 MSM-friendly Clinics, a service delivery model

One of the MSM-friendly clinics, established by Yayasan Kasih Suwitno (YKS) in a private faith-based hospital in Jakarta in 2011, is currently being supported by USAID LINKAGES Indonesia, having been identified as an example of best/promising practice by UNAIDS Indonesia. Clinic monitoring data shows an increase in new visits (mainly MSM) and HIV testing, suggesting that the clinic is meeting the needs of this diverse population. Between 2014 and 2016, a total of 6,489 MSM were recorded as new clients of the clinic (1,510 in 2014, increasing to 3,028 in 2016) with a high yield of HIV testing also observed across the three years (26% to 28%). Among the MSM who accessed the clinic over that time, less than one-third were recorded as being referred by CSOs, suggesting that most of these men are not affiliated with CSOs.

A national MSM and waria network, Gaya Warna Lentera Indonesia (GWL-INA), established in 2007, is made up of 150 MSM and waria CSOs as well as individuals, and provides support to members for advocacy, resource mobilization, capacity building, coordination, and monitoring and evaluation. These organisations collaborate with national, provincial, and district health authorities to implement tailored interventions, including specific activities for young MSM and waria.[36] A more detailed description of the role of CSOs and barriers to more

[30] Ramadhani NF, Jong HN. Broadcasting Bill Aims to Purge LGBT Content. The Jakarta Post [online daily]. 19 Jan 2017 [cited 22 Jan 2017]. Available from: http://www.thejakartapost.com/ news/2017/01/19/broadcasting-bill-aims-purge-lgbt-content.html

[31] National AIDS Commission, UNAIDS, WHO, UNICEF, AusAID. Joint Assessment of National Men who have Sex with Men & Transgender People Program, Indonesia [unpublished report]. Jakarta: National AIDS Commission; 2013.

[32] UNAIDS. Documentation of Best and Promising Practices in HIV Service Delivery for MSM in Indonesia [unpublished report]. Jakarta: Joint United Nations Programme on HIV/AIDS; 2015.

[33] Program monitoring data from 2014- 2016: personal communication. Yayasan Kasih Suwitno, 2017.

[34] Program monitoring data from 2014- 2016: personal communication. Yayasan Kasih Suwitno, 2017.

[35] Focus group discussions with CSOs, 20 January 2017, in Jakarta.

[36] National AIDS Commission, UNAIDS, WHO, UNICEF, AusAID. Joint Assessment of National Men who have Sex with Men & Transgender People Program, Indonesia [unpublished report]. Jakarta: National AIDS Commission; 2013.

effective participation in the national response to HIV appears in Chapter 3 of this report. There are attempts to diversify and reach the MSM and waria populations via networking online; however, the effectiveness of interventions to reach high-risk networks in any depth across the diverse nature of the MSM population within the Indonesian community, is unknown.

In a more optimistic development, the USAID LINKAGES Project has shared plans to implement a Pre-Exposure Prophylaxis (PrEP) HIV Prevention study aimed at assessing its acceptability and feasibility for MSM and waria. Although the cost of PrEP medications and routine laboratory tests may also constitute an obstacle for many MSM and waria at high risk, there remain abiding perceptions amongst these communities that condoms are sufficient for protection.[37]

Adolescent sex workers, MSM and waria are rarely reachable through the standard HIV/STI programmes, while outreach workers and mobile VCT services appear reluctant to reach out to these groups because of issues of guardianship and ages of consent.[38]

An assertive and visible drug campaign continues against PWID by the National Narcotics Control Board (BNN) and the police, with reports that authorities have conducted large group arrests of methamphetamines users and raiding of parties (at which some people appear to have used drugs) in private homes.[39,40] This appears to be in concert with the reinforcement of a compulsory residential drug treatment policy by BNN, though the police are reportedly continuing to arrest and refer suspected offenders to prison in the absence of evidence of any criminal behaviour or drug dependence. Reports on this issue were vague but reinforced by verbal reports that the majority of those incarcerated were there for drug-related offenses.[41]

Worryingly, there remains a large disparity between the numbers of PWID who have tested positive for HIV and the small numbers of PWID reportedly in treatment. This may be due to many barriers, including fees, the lack of inclusion of CSOs in HIV clinics, poor follow-up (constrained by fear of breaching confidentiality, and role confusion), the questionable quality of the HIV treatment counselling, the diagnosis being made in prison (where HIV treatment appears substantially underutilised), or stigmatisation and discrimination against PWID by treatment services.[42]

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[37] Focus group discussion with representative of the MSM community and CSOs, 20 January 2017, in Jakarta.

[38] Discussions with representatives from West Java, communities and young key populations, 18, 20 and 25 January 2017, in Jakarta.

[39] Focus group discussion with PWUD, 20 January 2017, in Jakarta.

[40] Yosephine L. UN Calls on Indonesia to Build Comprehensive Mechanisms for Illicit Drug Control. The Jakarta Post [online daily]. 3 Jul 2016 [cited 27 Jan 2017]. Available from: http://www.thejakartapost.com/news/2016/07/03/un-calls-on-indonesia-to-build-comprehensive-mechanisms-for-illicit-drug-control.html.

[41] Field visit in Jakarta, 19 January 2017.

[42] Wisaksana R, Alisjahbana B, van Crevel R, Kesumah N, Sudjana P, Sumantri R. Challenges in Delivering HIV-Care in Indonesia: Experience from a Referral Hospital.

Conclusions

From the discussion above, the following conclusions can be reached:

- PWID are no longer the key driver of the HIV epidemic in most of Indonesia, and they remain largely outside the HIV diagnosis, care and treatment process.
- The successful achievement of the HIV/STI continuum of comprehensive services (LKB)[43] and Fast Track "90-90-90" initiatives,[44,45] will require considerable realignment of discriminatory policies towards, and sanctions against MSM, waria, FSW and PWID, along with their peer support networks and CSOs.
- Collaborative engagement with and support from these key populations will provide essential support to the government's efforts to control the epidemic across the country and hence to scale up the access to the HIV treatment and the prevention benefits of ART. Hard work is required to change the perception of MSM in particular, to being "part of" rather than "outside" the mainstream Indonesian community.
- The programme for the prevention of sexual transmission of HIV has many features that are applicable to all the key populations, but CSOs and healthcare facilities have so far proven to have limited access to these groups. Considerable collaborative development will be required to fulfil the "90-90-90" agenda.

Recommendation 5

5.1 Recognising the outcome of the recent Epidemiological Review, revise and expand the concept of HIV risk and harm reduction beyond illicit drug injection, to include all HIV high risk behaviours, including unprotected sex, selling sex, and using recreational drugs.

5.1.1 Acknowledge the risk of these behaviours and emphasize reduction of that risk as the health and humanitarian response to HIV. The Ministry of Health could consider achieving this through a review of the HIV programme training, policy documents and guidelines, and planning the revisions to ensure consistent understanding of HIV risk behaviour reduction in the implementation of condom-lubricant and needle-syringe programming for all those working with MSM, waria, FSW, and drug users, including PWID, and their sexual partners. By consolidating and packaging the epidemiological and operational information, the Ministry of Health could advocate to other Ministries, in particular the Ministries of Justice and Home Affairs, to induce amendments to existing laws and regulations that create barriers to access to HIV-related services by members of key populations.

5.2 For all the populations key to understanding and controlling the epidemic (men who have sex with men,

[43] Ministry of Health of the Republic of Indonesia. Roadmap Mengurangi Kesakitan dan Kematian Terkait HIV, dan Memaksimalkan Manfaat Perluasan Akses ARV sebagai Pencegahan HIV (*Roadmap for Reducing HIV-related Morbidity and Mortality, and Maximising the Benefits of Expanded Access to ARV as HIV Prevention*).

[44] UNAIDS. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic [Internet]. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014 [cited 1 Feb 2017]. Available from: http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

[45] UNAIDS. Fast-Track - Ending the AIDS Epidemic by 2030. 2014 [cited 1 Feb 2017]. Available from: http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf

waria, people who use drugs, and female sex workers), address the critical lack of leadership and constituency within their organisations and networks to facilitate their greater involvement in a more effective and collaborative government health sector response.

The Ministry of Health could consider doing this through:

5.2.1 Engaging them in the design, planning, implementation, and monitoring of interventions to better engage MSM, FSW, drug users including PWID, and particularly waria, within the entire HIV prevention, diagnosis treatment and care cascade.

5.2.2 Collaborating with civil society organisations to develop regulations and guidelines for the extension of operating hours of puskesmas and other HIV/STI services into the evenings, with the support of members of key populations based at those services. This would better engage (particularly young) PWID, MSM, waria, and FSW in HIV testing, treatment and harm reduction or HIV prevention activities.

5.2.3 Developing appropriate, engaging, plain-language treatment literacy materials (print, electronic and internet-based), including a transparent "patient charter" of service access and relevant costs, and an online educational programme for VCT/CST using social media tools, since many young and otherwise marginalised key populations have turned to the internet as their principal means of education and communication.

Box 5.2. Harm reduction and combination prevention service packages

The principle of harm reduction can be applied broadly to numerous health issues, with the aim of minimising the negative consequences of a certain behaviour, rather than trying to eradicate the behaviour itself. This pragmatic principle is already widely used in addressing drug use, sexual behaviour, and alcohol and tobacco consumption. For the first two, the risk of disease transmission is the main concern, and calls for a comprehensive approach through combination prevention, which was first defined by UNAIDS in 2010.

Combination prevention includes a mix of concurrent interventions in three key areas:

- **Biomedical:** Provision of male and female condoms; voluntary male medical circumcision programmes; pre- (PrEP) or post- (PPP) exposure ARV prophylaxis, or ARV prophylaxis to prevent mother-to-child transmission; early antiretroviral treatment, which also has an impact on prevention; MMT; NSP; handling of blood products in health facilities.
- **Behavioural:** HIV testing and risk reduction counselling; behaviour change communication; outreach and peer education; condom promotion.
- **Structural:** Programmes to eliminate stigma towards people living with HIV/AIDS and violence against women; education curriculum reform, with the inclusion of sexual and reproductive health; legal protection and human rights programmes; social protection programmes.

The impact of combination prevention could be hugely significant, and ultimately bring about the transformation of HIV from pandemic to endemic levels.

5.3 For men who have sex with men and waria, expand services beyond the traditional peer outreach and edutainment strategies for HIV prevention (which reach only the more visible or open MSM and waria networks).

The Ministry of Health could consider achieving this through:

5.3.1 Implementation of effective, strategic behavioural change communication, including diversified outreach to the MSM community (including affluent or married men), and the use of social media tailored to support their engagement across the HIV cascade to increase uptake of HIV testing and linkages to and retention in CST services.

5.3.2 Piloting and expanding community-based first-line HIV testing by trained members of key populations or CSOs, with early referral of those testing positive to qualified care centres for confirmatory testing, counselling and treatment.

5.4 Given the epidemiological situation regarding the increasing HIV infections among MSM and waria in Indonesia, strong consideration should be given to the introduction of post-exposure prophylaxis (PEP) and exploration of pre-exposure prophylaxis (PrEP) as an option for prevention.

The Ministry of Health could consider achieving this by:

5.4.1 Forming a working group within the national AIDS programme to develop advocacy, policy and guidelines for the introduction of PEP and PrEP in Indonesia, including working with Indonesian Food and Drug Administration (BPOM) and the involvement of key population networks and health care providers.

5.5 For people who use drugs, including those who inject, increase access to appropriate, quality NSP and MMT services, despite the current reduced heroin availability.

The Ministry of Health could consider achieving this through:

5.5.1 Exploring, as a matter of urgency, with CSO partners, the adjustment of current service targets and specifications for the procurement of needles/syringes, including low dead-space syringes and needles, to better meet the individual needs and geographic variability of PWID.

5.5.2 Investigating the relevant regulations to develop online training packages for pharmacists to support sustainable public health HIV prevention amongst PWID, through the sale of appropriate needles/syringes (without the barrier of exchange or prescription) and condoms/lubricant at minimal profit in retail pharmacies.

5.5.3 Developing a number of key "continuing education" modules for MMT staff and CSOs, to address psychosocial education; address concurrent alcohol, sedative and stimulant abuse; and improve the adequacy of dosage and peer support for current MMT clients; in order to improve MMT enrolment, retention and treatment programme outcomes.

5.6 For female sex workers, scale up coverage of prevention, diagnosis, treatment and support as part of a comprehensive response to HIV/STI.

The Ministry of Health could consider achieving this through:

5.6.1 Developing guidance to encourage local health authorities to work together with sex worker

representatives, using a public health approach, to recognize the existence and functionality of sex work "hotspots". This would improve the safety of those environments, facilitate access to condoms and appropriate health care, and reduce the STI/HIV risk to sex workers and their clients, for the benefit of themselves and the wider community.

5.6.2 Developing additional guidance for more sympathetic engagement and support of young sex workers to improve their utilisation of HIV/STI prevention, diagnosis and treatment, and reproductive health services, their mental health care and (if necessary) their access to legal support.

5.7 In areas where the epidemic is generalised (Papua), the Ministry of Health could consider extending prevention, HIV testing and treatment services beyond the primary care level in remote areas by:

5.7.1 Urgently developing local guidelines and training materials for all health care providers on harm reduction, gender and sexuality, condom promotion, HIV testing and HIV/STI treatment, with a sustained focus on FSW and high risk men as key actors.

5.7.2 Working with CSOs and faith-based organisations to improve the number and capacity of local and outreach staff, to improve remote access to information, condoms, syndromic case management of STIs, HIV community screening tests and to subsequent HIV testing and treatment.

5.7.3 Involving customary institutions and faith-based organisations in the understanding of harm reduction and the development of public health-led, effective HIV prevention messages, appropriate education materials and mass media communications, to match the character of the diverse cultures to effective HIV/STI prevention, diagnosis and treatment.

RSU PENGAYOMAN
3 (Tiga)
LAYANAN UNGGULAN
1 PEMERIKSAAN DAN PERAWATAN PASIEN TB
2 PEMERIKSAAN DAN PERAWATAN PASIEN HIV - AIDS
3 REHABILITASI MEDIK DAN SOSIAL KORBAN PENYALAGUNAAN NARKOBA
RUMAH SAKIT UMUM PENGAYOMAN CIPINANG
RSU. PENGAYOMAN CIPINANG
Kantor Wilayah DKI Jakarta
Kementrian Hukum Dan HAM RI
DEKLARASI JANJI KINERJA TAHUN 2017

6. Knowing your HIV status

Introduction

HIV testing is a pivotal component of HIV prevention, care and support. It constitutes the entry point into the cascade of services, from HIV infection to the mitigation of the impact of HIV disease. HIV testing has figured among national responses to HIV ever since the first Indonesian national plan was formulated in 1992. Since that time, HIV testing has been shaped by several decrees and regulations, mostly consistently in line with previous WHO guidance. National guidance regarding HIV testing is clearly spelled out in both the draft national AIDS programme (NAP) and the National AIDS Commission strategic plans.[1,2]

Enhancing access to HIV testing (and treatment) for key populations, pregnant women, their offspring, and TB patients is an important part of the UNAIDS "90-90-90" strategy,[3] to which Indonesia has subscribed, and moving towards the UNAIDS "Fast Track for ending the epidemic by 2030".[4] Current coverage of HIV testing and counselling in Indonesia, across all eligible populations, remains too low to achieve these targets.

The purpose of this chapter is to highlight progress achieved and barriers encountered in HIV testing policies, strategies and practices in Indonesia, based on documentation made available to the Review Team by the national AIDS programme at central and peripheral levels, other actors interviewed individually or through focus group discussions, and site observations.

Policy context and national regulations concerning HIV testing

The most recent (and currently applicable) regulation on HIV testing is Ministry of Health Regulation number 74/2014.[5] Overall, the Regulation is aligned with WHO guidelines. It specifically provides for the free, voluntary testing of key populations with pre-test and post-test counselling contingent to informed consent:

> *"Informed consent is universal, applicable to all patients irrespective of the disease because medical treatment essentially requires consent from the patient."*
>
> *"Informed consent in health care facilities is given verbally or in writing." Chapter III, page 24).*

While HIV testing is disallowed by the Regulation as a condition for domestic employment (*"HIV test cannot be a requirement in recruitment and job promotion,"* Chapter II, page 17), the Regulation does provide for mandatory HIV testing for two populations: (1) candidate overseas workers prior to their recruitment for

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1 Ministry of Health of the Republic of Indonesia. National Action Plan for HIV and AIDS in the Health Sector 2015-2019.

2 National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

3 The first of these three targets implies that, by 2020, at least 90% of people living with HIV will be aware of their HIV status. See UNAIDS. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic.

4 United Nations General Assembly. Political Declaration on HIV and AIDS: On the Fast-Trck to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. A/70/L.52 (7 Jun 2016); 2016

5 Minister of Health of the Republic of Indonesia Regulation no.74/2014 on the Guidelines for the Implementation of HIV Counselling and Testing.

employment in foreign countries that impose such tests and exclude from recruitment individuals found to be HIV-infected (*"HCT [HIV counselling and testing] for candidate overseas workers is performed at the designated health care facilities, at the behest of the destination country. Candidate overseas workers diagnosed with HIV during the medical examination as requested by the destination country will be declared unfit and must be referred to an HIV service provider for further care,"* Chapter II, page 18); and (2) army and police personnel (*"HCT for the Indonesian army and Police personnel is to be implemented using a variety of approaches including VCT, PICT, and routine offer at every medical check-up. Candidate personnel found to have a reactive HIV test result will be declared unfit for recruitment and recommended for further action at the nearest health care facility,"* Chapter II, page 16).

It should be noted that the Regulation refers to *Provider-initiated Counselling and Testing* (PICT), while Ministry of Health Regulation no. 21/2013 on HIV and AIDS, like with the most recent WHO guidelines,[6] refers to *Provider-initiated Testing and Counselling* (PITC), which allows for more flexibility in the interpretation of what counselling should entail prior to and after the HIV test. The Regulation also lists the key elements to be included in pre-test counselling. Several field observations during the Review pointed to the lack of familiarity among health care providers with the recommended content of counselling, and that this resulted in low uptake of HIV testing among certain populations, in particular TB patients and antenatal care (ANC) clinic attendees, as will be discussed below. The unclear notion of *"informed consent"* was also a barrier to uptake of PICT as no specific guidance had been made available to health care providers, who often interpreted the Regulation as imposing a requirement for signed informed consent (or dissent) by individuals who were offered a test.

Overall, the Ministry of Health and the National AIDS Commission should be congratulated for their efforts to scale up HIV testing in line with WHO-recommended policies and practices. The national legislation on HIV testing and counselling may benefit from an update responding to the evolving needs of the population (key populations, in particular) and the translation of policy and legislation into actual practice.

Table 6.1 Self-reported HIV testing frequency ("ever tested") in key populations (as % of key population samples surveyed)

Indicator (%)	IBBS Group A			IBBS Group B	
	2007	2011	2015	2009	2013
Percentage of Direct FSW that ever tested for HIV	53	57	86	54	66
Percentage of Indirect FSW that ever tested for HIV	36	36	72	31	39
Percentage of Waria that ever tested for HIV	64	72	89	45	50
Percentage of MSM that ever tested for HIV	31	39	71	25	38
Percentage of PWID that ever tested for HIV	50	63	72	40	54

[6] WHO. Consolidated guidelines on HIV testing services 2015. Geneva, World Health Organization; 2015.

Note on **Table 6.1**: Individuals included in the Integrated Behavioural and Biological Surveys (IBBS) have to meet two selection criteria: (1) Having engaged in behaviours associated with the definition of "key populations" in the 12 month-period preceding the survey; and (2) Having participated in no previous IBBS prior to the survey recorded in the year indicated at the top of each column. Thus, the ratios displayed in each cell result from sequential cross-sectional surveys of population samples that differ from one survey to the next.

The Group A geographic areas where IBBS were conducted are districts with "high" HIV prevalence, while Group B are categorized as districts with lower prevalence.

Access to, and use of HIV testing opportunities

HIV testing is primarily targeted at key populations and populations[7] considered "at risk" and "vulnerable", such as TB patients and pregnant women, and additionally, to a wider section of the population. HIV testing services have been established and expanded under the auspices of the Ministry of Health at provincial, district and puskesmas levels.

By 2017, 3,771 HIV testing centres were operating in the public sector and 152 in the private/non-governmental sector.[8] While the reported number of HIV tests performed in Indonesia has steadily increased from 280,000 in 2011 to 990,000 in 2016,[9] a wide gap remains between the size of populations who need be tested and the actual number of tests performed. The proportion of key populations reporting having ever been tested for HIV exceeded 70% in 2015 in high-prevalence districts (Group A) included in the Integrated Behavioural and Biological Surveys (IBBS), but the figure was comparatively lower in Group B (lower HIV prevalence districts) in 2013, the most recent year for which results were available (**Table 6.1**). HIV testing ratios may have declined in more recent years in key populations who are faced with increasing difficulties in accessing services, in particular female sex workers, who dispersed after the closure of transactional sex venues and are thus harder to reach (as described in Chapter 5).

Overall, based on the most recent data available to the Review, the availability and use of HIV testing and counselling services seem to have expanded through 2015. However, unabated stigma, discrimination and misconduct by law enforcement personnel towards key populations are likely to perpetuate or even increase the barriers to HIV prevention, care and support for those who need them most.

Alignment of HIV testing methods and technologies

The Review Team noted that there were variations across provinces, districts and both primary and referral care institutions in the methods and diagnostics used for HIV testing. For example, a referral hospital in Jakarta would require an ELISA test to confirm a test result obtained through a rapid test. This added one more obstacle to rapid enrolment in care and treatment and involved extra out-of-pocket cost. The algorithm for HIV testing

[7] Minister of Health of the Republic of Indonesia Regulation no. 74/2014 on the Guidelines for the Implementation of HIV Counselling and Testing Chapter I, page 9. Vulnerable populations are understood in this report as people who, for any social, economic, environmental, cultural, personal or other reasons may become prone to becoming exposed to a risk of acquiring HIV infection.

[8] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (HIV, AIDS and STI Report, 3rd Quarter 2016). Jakarta: Ministry of Health; 2016.

[9] Ibid.

should be streamlined across health services, public or private. Reagents and diagnostics should be procured based on the list of WHO-pre qualified biological products, and health staff should be trained on adhering to national guidelines, which should be updated based on guidance from a newly formed Technical Working Group under the auspices of the national AIDS programme. (More on this topic is to be found in Chapter 11).

HIV testing of clients already reached by services in TB and antenatal clinics

Recognizing that the expansion of HIV testing among key populations may be constrained by barriers to access, the Review Team was concerned about the persisting low rate of uptake of HIV testing in two easy-to-reach priority populations, namely in TB diagnostic and treatment services and antenatal care attendees. Among the difficulties encountered by care providers with regard to offering HIV testing to TB patients and to pregnant women was their lack of preparedness and comfort about the ways in which informed consent should be sought. To this end, draft guidance on seeking informed consent is proposed by the Review Team for TB patients and for pregnant women. (See Chapter 8 on PMTCT and Chapter 9 on TB/HIV). These drafts should be evaluated locally, adapted as may be required, and a final version endorsed by a national AIDS programme Technical Working Group before they are disseminated within health services.

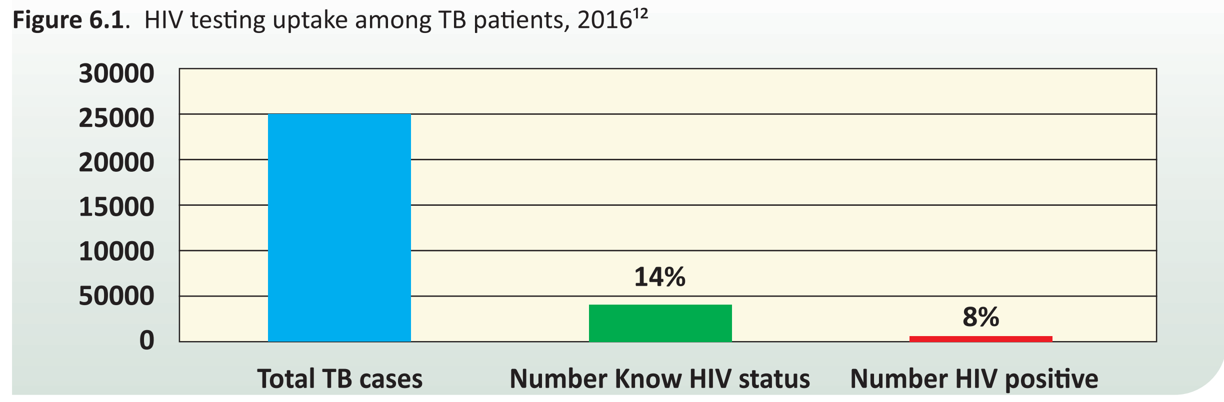
HIV testing of TB patients

Indonesia is among the top five global TB disease burden countries, while HIV prevalence remains relatively low, except in Papua. Although TB/HIV collaborative activities (TBCA) began in Indonesia in 2007, only 2.9% of TB patients in 2014 knew their HIV status, a rate which increased to a mere 14% by 2016 (**Figure 6.1**).[10]

Box 6.1. Low coverage of HIV testing for TB patients

"Of those tested [in 2014], 24% were coinfected (TB cases with HIV infection), and, of these, 43% received ART, and 49% received cotrimoxazole preventive therapy (CPT). Only 49% of the previous year's coinfected patients were successfully treated. In Papua, the proportion of TB patients registered in 2014 who had an HIV test result recorded in the TB register was 27.8% (2,496/8,967), and of those, 30% were HIV positive (749/2,496). Of those, only 31% received CPT and only 25.2% were given ART during TB treatment."[11]

Figure 6.1. HIV testing uptake among TB patients, 2016[12]



[10] Ministry of Health of the Republic of Indonesia. SITT: Integrated TB Information System; 2016.

[11] PEPFAR. Country Operational Plan (COP) 2015 Strategic Direction Summary Indonesia [Internet]. Washington: President's Emergency Plan for AIDS Relief (PEPFAR); 2015 [cited 10 Feb 2015]. Available from: https://www.pepfar.gov/documents/organization/250292.pdf.

[12] Ministry of Health of the Republic of Indonesia. SITT: Integrated TB Information System; 2016.

During the field visits the Review Team noted that the lack of availability of services and complicated procedures for offering and conducting HIV tests, including a requirement to sign informed consent forms, are hampering optimal implementation and coverage of PITC among TB patients. These constraints are compounded by stigma attached to HIV and TB on the part of communities and health staff. (See Chapter 9 for further explanation of the low rate of PITC among TB patients. Chapter 9 also proposes a simplified script that can be used by TB care providers when offering an HIV test to TB patients). This is a great missed opportunity for detection of HIV-positive individuals and their timely enrolment in ART.

HIV testing for pregnant women and of HIV-exposed infants

Among the key components of preventing mother-to child transmission of HIV are testing pregnant women for HIV (and also testing for syphilis; and early HIV testing of exposed infants (early infant diagnosis, EID), with follow-up until their final HIV status is established. Additional important prevention and case-finding can be obtained by testing the partners of pregnant women who test positive. In 2016, an estimated 10% of pregnant women were tested for HIV, and less than 5% of HIV-positive mothers initiated ART.

Regulation 74/2014 calls for the systematic offer of HIV testing to pregnant women.[13] Over the past 20 years, worldwide, there has been dramatic progress in scaling up highly effective, comprehensive prevention of mother-to-child transmission of HIV (PMTCT) programmes and reducing number of new HIV infections in children in developing countries. With the WHO recommendations on "Option B+" (lifelong ART for HIV-positive pregnant and breastfeeding women) and "treat all" PLHIV, including HIV-positive pregnant women,[14] the MTCT rate can be reduced to less than 2%.

The global UNAIDS plan urges programme scale-up and acceleration, and the global community has committed itself to the elimination of mother-to-child transmission of HIV and syphilis (and hepatitis B) as a public health problem.[15] The Western Pacific and Asia regions are developing a strategy for triple MTCT elimination, including Hepatitis B and syphilis. Scaling up PMTCT programs in large countries with a mix of concentrated and low prevalence generalized epidemics, such as Indonesia, poses particular challenges in view of the current low coverage of HIV testing among ANC attendees and babies of HIV-positive mothers. The testing rate for syphilis among pregnant women in Indonesia was at a low 3.4% in 2011 and 10% in 2016,[16] while coverage of Hepatitis B surface antigen (HBsAg) testing among pregnant women in 2015 ranged between 1.3 and 8%.[17] HIV testing coverage among pregnant women has to be increased significantly to achieve the elimination of MTCT by 2020. Pregnant women have a low perception of their risk of having been exposed to HIV and thus might not to agree to the HIV test, especially if ANC staff do not promote this as part of basic care. In addition, it was reported to the Review Team that the availability of test kits in ANC clinics was uneven and re-supply irregular, although local governments are allowed to procure test kits. To overcome the low acceptance rate of HIV testing in ANC

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[13] Minister of Health of the Republic of Indonesia Regulation no. 74/2014 on the Guidelines for the Implementation of HIV Counselling and Testing. Chapter III, page 22.

[14] WHO. Consolidated Guidelines on the Use of Antiretrovirals for Treating and Preventing HIV Infection. Recommendations for a Public Health Approach [Internet]. Second edition. Geneva: World Health Organization (WHO); 2016 [cited 7 Feb 2017]. Available from: http://apps.who.int/iris/ bitstream/10665/208825/1/9789241549684_eng.pdf?ua=1.

[15] WHO. Elimination of mother-to-child transmission (EMTCT) of HIV and syphilis: Global guidance on criteria and processes for validation (June 2014). Geneva, World Health Organization; 2014.

[16] Ministry of Health of the Republic of Indonesia. Sexually Transmitted Infections report, SIHA [unpublished data]. HIV, AIDS and STI Sub-Directorate; 2016.

[17] Ministry of Health of the Republic of Indonesia. Early detection of Hepatitis B among pregnant women. Reported from programme data. HIV, AIDS and STI Sub-Directorate; 2015.

clinics, the Review Team has proposed a simplified script for ANC clinic providers to secure informed consent (or dissent) when offering an HIV test to pregnant women (see Chapter 8). However, it should be noted that in many sites, including some of those visited by the Review Team, the routine offer of HIV testing to pregnant women, as an integrated part of essential ANC care, was well received, and uptake was high.

Community-based HIV testing, counselling and referral

Based on focus group discussions and interviews involving key populations, these populations would be keen on engaging in community-based HIV testing whereby first-line tests would be offered, along with peer counselling, to members of the community by trained, supervised and supported members of the same community. Individuals found positive or having an indeterminate HIV test result would then be referred to health care centres for confirmatory testing and counselling, and, as the case may be, provision of care, support and treatment. The Review Team was informed that such an option was being considered by the national AIDS programme, prior to its feasibility, cost and safety evaluation in a few pilot projects. The Review Team welcomed this initiative.

Recommendation 6

6.1 Increase access to and use of HIV testing with a priority focus on key populations.

By 2017, the Ministry of Health, with provincial offices and implementing partners should develop and implement a set of creative, novel testing approaches, informed by epidemiological data, to reach the first 90% target of the HIV response strategy. As the epidemic may affect both key populations and other segments of the population, HIV testing approaches should be context-dependent, depending on HIV prevalence, size of the target populations, their location, and their access to HIV testing and referral to care services.

6.1.1 Through training, retraining and supervision, HIV testing and counselling should be considerably scaled up across the health system, with priority given to provinces, districts/cities and puskesmas with high proportions of key populations as-well-as at-risk and vulnerable populations.

6.1.2 The procurement and distribution of HIV, syphilis and hepatitis B testing equipment and reagents should be coordinated at the central level jointly by the national AIDS programme and the Directorate of Family Health on the basis of quantified and justified requests from provincial and district health offices.

6.1.3 Regulations and best practices in relation to the promotion, offer and performance of HIV testing, counselling and initiation of HIV care and treatment should be updated to reflect evolving needs and the need to grow further skills and practices in all public and private health facilities.

6.1.4 The availability of HIV testing should be ensured by a cost-sharing basis between central and peripheral entities engaged in HIV. A portion of this funding should be directed to support the training and retraining of public and private health staff as well as for HIV testing and counselling quality assurance and control.

6.2 Update HIV testing algorithms and practices and align their application nationally

By mid-2018, the HIV testing algorithms should be reviewed and revised as needed by Ministry of Health. This process may consider involving public and private practitioners, laboratory specialists, representatives of the national regulatory authority and informed members of civil society

organisations, for the review update process. The updated algorithm should integrate rapid HIV tests, self-tests and community-based testing methods that could be used as a first-line screening method.

6.2.1 The specific tests used within the HIV testing algorithm should be made consistent and streamlined across all health care facilities throughout the country, as recommended by the Ministry of Health and determined by the national AIDS programme. This should be implemented by the end of 2017. To ensure quality, test kits should be chosen from the WHO prequalification list.

6.2.2 The Ministry of Health should consider updating HIV testing guidance by the end of 2018 to adopt testing as triage in community, outreach, mobile, and non-ART facilities for wider access to testing, prioritizing districts with high HIV prevalence and low testing coverage. Individuals testing positive at the first test will be referred to the ART facility for confirmation of the diagnosis using the national algorithm, and start ART. The recommendation should be fully implemented by central, provincial and district health offices, local health facilities and public and private implementing partners by no later than mid-2019.

6.2.3 By end-2018, , the Ministry of Health, provincial offices, and major hospitals should reduce the routine use of ELISA testing. The use of rapid diagnostic tests should be widely implemented as it will increase patient access, reduce patient loss through delays in the availability of results and referral, minimize barriers to testing due to test costs for patients, and reduce costs to the health services.

6.3 Expand provider-initiated HIV testing and counselling of TB patients

6.3.1 The NAP and the National Tuberculosis Programme should jointly intensify the implementation of TB/HIV activities in priority districts by establishing decentralized and simplified HIV testing services, and linkage of all HIV-positive TB patients to TB treatment and ART.

6.3.2 By mid-2017, all sites offering TB services should have the capacity to systematically offer HIV testing to TB patients and enrol in HIV care and treatment those diagnosed HIV-positive, or refer them to nearby sources of care.

6.3.3 Verbal informed consent (or dissent) to HIV testing should be secured from TB patients prior to testing, using a simplified pre-test counselling approach proposed by the Review Team after its field-testing, revision and validation.

6.4 Expand provider-initiated HIV testing and counselling of pregnant women

6.4.1 By early 2018, the NAP and the Directorate of Family Health should develop efforts jointly with peripheral health offices to rapidly scale up integrated HIV testing and counselling in antenatal clinics and to promote partner testing for women whose HIV test positive.

6.4.2 Verbal informed consent to HIV testing should be secured from ANC clinic attendees prior to testing, using a simplified pre-test counselling approach proposed by the Review Team after its field-testing, revision and validation.

6.4.3 Public and private ANC clinic staff should be trained on how to offer HIV testing to pregnant women in addition to diagnostic tests for syphilis and hepatitis B, and to take the necessary measures for HIV-positive mothers and their children to enrol in care and treatment.

6.4.4 Consider the use of new combination testing technologies, such as the WHO-recommended combination HIV-syphilis RDT.

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7. Expanding access to, and take-up of, care, support and treatment

Introduction

The last national HIV programme review was conducted in 2011. At that time, 39,128 people had started antiretroviral treatment (ART) across 276 sites in Indonesia.[1] The review recommended a number of key actions to improve care, support and treatment (CST) for people living with HIV. These included:[2]

- Collaboration with the CSO sector to improve the coverage and quality of service provision.
- Health systems strengthening and the development of a continuum-of-care approach.
- Strengthened capacity to analyse and use routine data at local level.
- Improved ART uptake and retention thorough (i) improved coordination and partnership across all stakeholders; (ii) appropriately integrated and decentralized CST services; (iii) strong referral mechanisms and linkages within and outside the health system; and (iv) the provision of comprehensive services adapted to health system level and needs.
- Optimization of antiretroviral (ARV) drug regimens, in particular the use of simplified, less toxic once-daily regimens.
- Involvement of PLHIV in all aspects of CST, including the development of policy, strategy and guidelines, planning, and service provision.

Since 2011, there has been significant progress in several of these areas. Notable improvements include the involvement of CSOs in the provision of HIV services; partial decentralization of ART services; and the introduction of the WHO-recommended once-daily fixed-dose combination of TDF+3TC+EFV as a preferred first-line regimen.[3] These and other programme improvements have allowed for a significant expansion of ART services, with 141,596 HIV-positive individuals, cumulatively, having started ART as of September 2016. This represents a high proportion of people starting ART according to current national guidelines, although the number still in care is lower, at 73,037.

1 Ministry of Health of the Republic of Indonesia. Review of the Health Sector Response to HIV and AIDS in Indonesia. Jakarta: Ministry of Health; 2011.

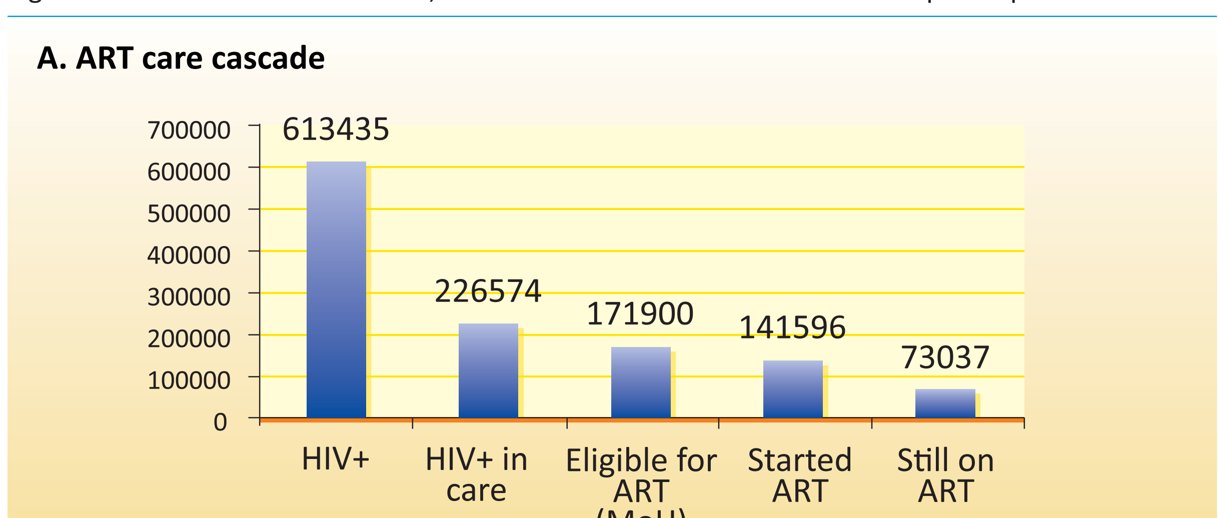
2 *Ibid.*

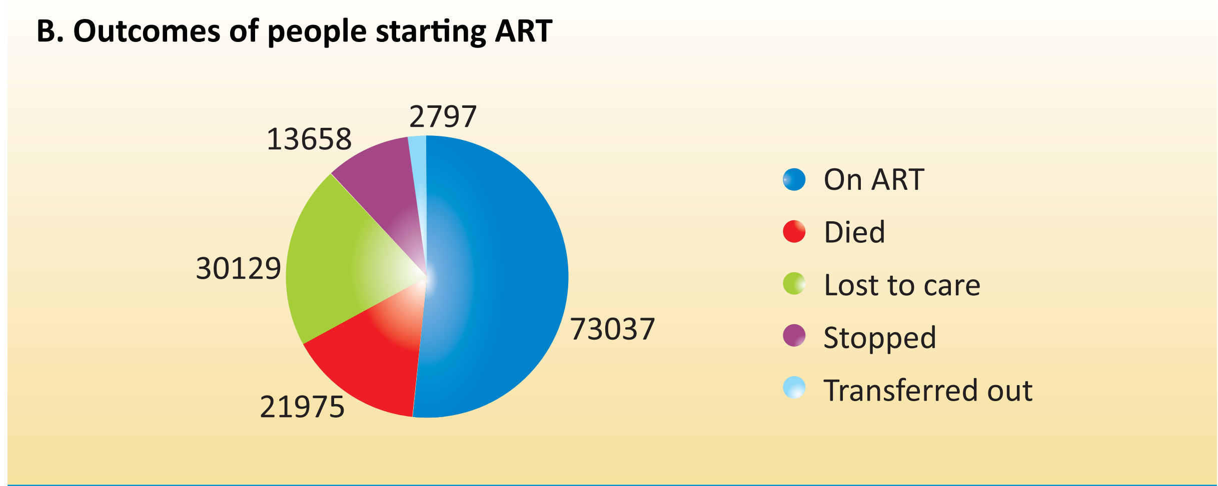
3 WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Geneva: World Health Organization (WHO): 2013.

4 Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (*HIV, AIDS and STI Report, 3rd Quarter 2016*). Jakarta: Ministry of Health; 2016.

Over the last five years, however, evidence and policy has evolved and since 2015 WHO has recommended that all people living with HIV should be started on ART irrespective of CD4 cell count.[5] Viewed from this perspective, ART coverage in Indonesia is low-only 62% of PLHIV in care, and only 11% of the total number of PLHIV in the country are on ART (**Figure 7.1A**).[6] At the time of this Review, the national guidelines specified limited ART eligibility based on clinical (WHO Stage 3 and 4) and immunological (CD4 <350 cells/mm³) criteria, with immediate initiation for certain PLHIV.[7]

Figure 7.1 The cascade of ART care, treatment outcomes and in Indonesia up to September 2016[8]





[5] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Second Edition. Geneva: World Health Organization (WHO): 2016.

[6] This proportion is in accordance with the most recent estimates of the HIV disease burden in which ART coverage in Indonesia is reported at 11.67% (confidence interval = 8.08%-15.97%). See Haidong Wang, et al. Estimates of Global, Regional, and National Incidence, Prevalence, and Mortality of HIV, 1980-2015: The Global Burden of Disease Study 2015.

[7] The 2014 national guidelines for ART recommend immediate initiation for PLHIV in the following categories: with TB and hepatitis B coinfection, pregnant and lactating mothers, in a discordant partnership, key populations (MSM, female transgender, sex workers, PWID), members of general population residing in a generalized epidemic setting, and those <5 years old.

[8] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (*HIV, AIDS and STI Report, 3rd Quarter 2016*). Jakarta: Ministry of Health; 2016.

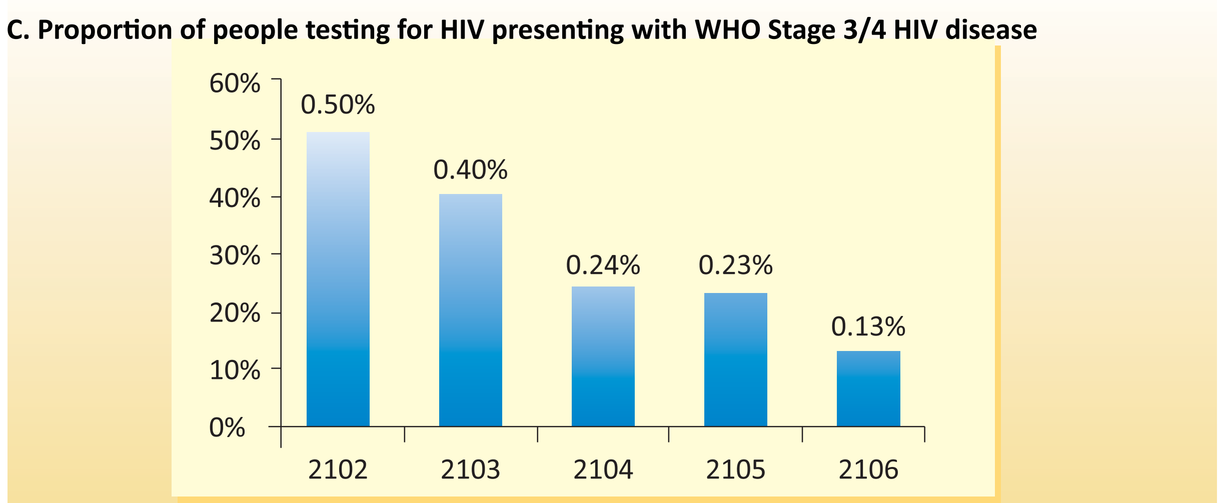


Figure 7.1A indicates that there is a major challenge in identifying people who are HIV-positive, enrolling them into care and retaining them on ART. A second important challenge relates to the number of patients on ART who achieve long-term successful outcomes. Access to viral load is still very limited in Indonesia, and there are no national data on rates of virological suppression: only a minority of sites visited during this programme Review were able to provided data on virological suppression.

Almost half all patients who started ART (68,559 individuals, 48%) are no longer on treatment **(Figure 7.1B)**. Among these, 32% have died and 46% are lost to care. The outcomes of patients lost to care are not known, but studies outside Indonesia show that a substantial proportion of these patients who are lost to follow up will also have died.[9] Therefore, the actual number of patients who have died is likely to be higher.

Overall, cumulative mortality among people starting ART has decreased, from 18.6% of people starting ART up to 2013, to 15.5% up to 2016. This can be partly explained by the fact that people are being identified earlier in their disease progression, with a reduction in the proportion of people testing HIV+ who have symptomatic (WHO Stage 3/4) HIV infection. A substantial drop in the proportion of people with symptomatic HIV disease was observed between 2013 and 2014, from 40.4% to 23.3%, which may partly reflect the change in the national guidelines allowing for an immediate start of ART for an expanded group of patients,[10] including key populations and serodiscordant couples **(Figure 7.1C)**.

However, data on HIV mortality should not only consider people starting ART, but should be viewed from a continuum of care perspective. The median CD4 count continues to be low in most CST sites[11] and it is possible that many more sick people might not have been identified as having HIV infection. The limited coverage of ART, in particular among TB-HIV coinfected patients who are at high risk of death, together with the high rates of loss to follow up, mean that mortality among PLHIV is higher than reported by the national AIDS programme.

Treatment coverage and decentralization

Treatment coverage - the number on ART as a proportion of the total number eligible for treatment according

[9] Wilkinson LS, Skordis-Worrall J, Ajose O, Ford N. Self-transfer and mortality amongst adults lost to follow-up in ART programmes in low and middle-income countries: systematic review and meta-analysis. Trop Med Int Health, 20: 365-379. 2015.

[10] Minister of Health of the Republic of Indonesia Regulation No. 87/2014 on the Guidelines for Antiretroviral Treatment.

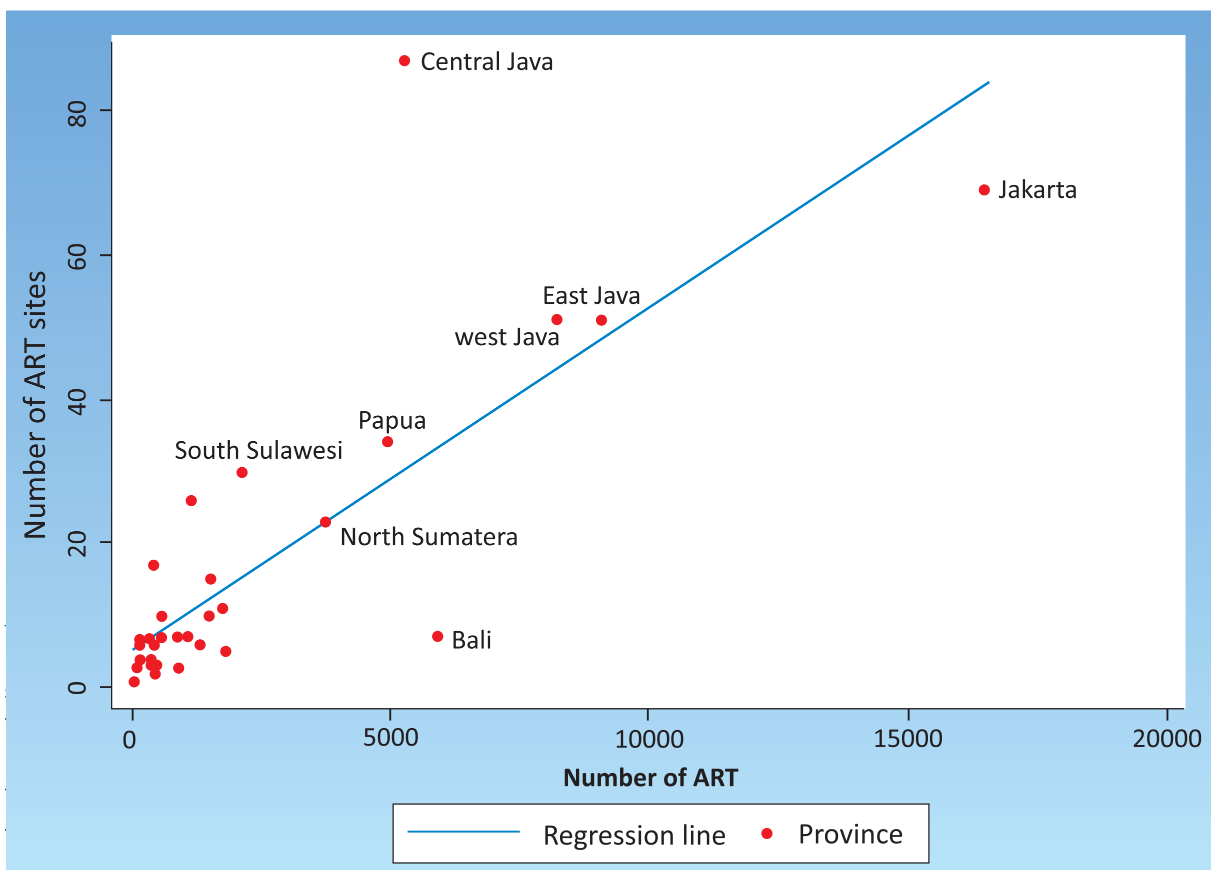
[11] Information from field visits in West Kalimantan and Jakarta on 18-20 January 2017 and discussions with representatives of health facilities from Aceh, West Java, Bali and Papua on 19 January 2017 in Jakarta. On a number of occasions it was

to national guidelines - varies by province, from less than 20% in North Maluku to 60% in West Sulawesi. There is no clear relationship between the number of HIV-positive people in care for ART, and treatment coverage. As an example, the numbers of people registered in care are similar in West Java (21,169) and Papua (25,004); however, the proportion of people on ART is almost twice as high in West Java compared to Papua (39% versus 20%).[13] This indicates highly variable performance in ART initiation across provinces, and the potential for drawing lessons from high-performing provinces.

Decentralization of antiretroviral therapy to primary health care services is promoted by the National Strategy and Action Plan 2015-2019,[14] as an important way to improve rapid access to ART. Decentralization has occurred in most provinces, and was observed to be working well during the Review: primary health care staff are comfortable initiating and delivering ART, and the majority of sites visited have capacity to manage more patients. There is a clear relationship between the number of sites initiating ART and the number of people on ART (**Figure 7.2**), giving support to the strategy of decentralization. Nevertheless, it was noted that implementation of decentralization in some sites remains slow, and is not clearly supported by a strategic plan and timeframe.

Lack of decentralization can lead to worse patient outcomes. During the Review, several sites reported that transportation costs were a leading cause of PLHIV becoming lost to follow up. In order to improve access to ART and retention in care - both of which are major concerns for the HIV programme - the process of decentralization should be accelerated with adequate capacity building.

Figure 7.2: Relationship between number of ART sites and number of people on ART[15]



Graph does not include satellites

A strategic approach to decentralization of ART services is required, guided by disease burden and unmet need for treatment. Related strategies to increase access to ART should be considered, including reducing the frequency of clinic visits and ART dispensing for stable patients (3-6 months after initiation), in line with WHO recommendations[16] The current regulations for hospital accreditation do not allow task shifting to nurses, and limited support for this option was expressed by some clinicians during focus group discussions.[17]

Treatment initiation and monitoring

The most recent treatment guidelines developed by the Ministry of Health in 2014 promoted the Strategic Use of Antiretroviral Therapy (SUFA), under which key populations and people in serodiscordant relationships would be started on ART irrespective of CD4 cell count in order to reduce HIV transmission.[18] This represented an advanced approach, and placed the Indonesian HIV programme ahead of WHO recommendations at the time. During the Review, the SUFA policy appeared to be well implemented and accepted; only a minority of patients start ART with advanced HIV disease, and in many sites the majority of patients being followed on ART were asymptomatic.

International policy and practice on starting ART has evolved in recent years. The results of two large randomized trials have demonstrated that starting ART irrespective of CD4 cell count is also important for reducing mortality. One of these trials showed that immediate ART was beneficial in preventing illness and death from tuberculosis even among patients with high CD4 cell counts, and that with the provision of isoniazid preventive therapy (IPT), it resulted in a 44% lower risk of severe HIV-related illness and a risk of death from any cause that was 35% lower than the risks with deferred initiation of ART and no IPT.[19] An implementation study of "Test and Treat" among key populations, a collaboration between WHO, the Kirby Institute of the University of New South Wales, Australia, and four Indonesian universities was ongoing at the time of the Review.

There is evidence from Indonesia that starting ART early for all PLHIV will result in economic as well as health benefits. An economic analysis in Indonesia supports a move to Treat All. This study found that cost reductions can potentially be realized by early treatment initiation, and recommended scaling up ART at the community level to improve early uptake and adherence, and reduce transportation costs for patients.[20]

The Review Team noted that, in general, ART is initiated quickly (within two weeks) once eligibility is established. However, most sites require baseline laboratory testing prior to starting ART, and in cases patients where there is no insurance, patients were charged for these tests (up to $25). Laboratory testing is not required by WHO as a precondition to starting ART as this may act as a barrier to initiation, in particular if patients have to pay.

[15] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (HIV, AIDS and STI Report, 3rd Quarter 2016). Jakarta: Ministry of Health; 2016.

[16] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (HIV, AIDS and STI Report, 3rd Quarter 2016). Jakarta: Ministry of Health; 2016.

[17] Reported during discussions with representatives from health facilities from Aceh, West Java, Bali and Papua on 19 January 2017 in Jakarta.

[18] Minister of Health of the Republic of Indonesia Regulation No. 87/2014 on the Guidelines for Antiretroviral Treatment. SUFA was adopted as policy for the first time in 2013. See Ministry of Health of the Republic of Indonesia (2013). Roadmap to Reduce HIV-related Morbidity and Mortality, and Maximize the Benefits of Expanded Access to ARV as HIV Prevention.

[19] TEMPRANO ANRS 12136 Study Group. A Trial of Early Antiretrovirals and Isoniazid Preventive Therapy in Africa. N Engl J Med 2015. 373: 808-22.

[20] Siregar AY, Tromp N, Komarudin D, et al. Costs of HIV/AIDS treatment in Indonesia by time of treatment and stage of disease. BMC Health Serv Res 2015. 15:440.

Initiation of ART on the same day as HIV diagnosis was discussed. While this can be good practice to reduce pre-ART loss to follow up, and is in line with WHO guidelines that promote accelerated ART initiation, concern was expressed that not all patients will be ready to start ART on the same day. Attention therefore needs to be paid to patient readiness, which will have an impact on adherence and retention.

First-line ART regimens for adults follow the WHO-recommended once-daily fixed-dose combination of TDF+3TC+EFV, and its wide use was observed in the Review. There were few instances of stock outs, with the exception of a major stock out in mid-2016, which for some facilities lasted several months and required increasing prescribing frequency to every two weeks, and in some cases substituting TDF for AZT. The availability of second-line regimens is more limited, and third line options are not yet available.

During the Review it was reported from some sites that a high number (up to 10%) of patients had stopped drugs due to side effects of Efavirenz. Since these are reversible in most cases in 3-4 weeks, this high rate of treatment discontinuation points to the need for improved education of patients by health care providers.

Of particular concern is that appropriate paediatric ART formulations do not exist, leading health providers to break up adult tablets (which can lead to misdosing) or to provide sub-optimal drugs (notably stavudine). The procurement and distribution of paediatric formulations, in particular lopinavir/ritonavir pellets for children under 3 years of age as recommended by WHO, is a priority.

Finally, the availability of viral load testing for ART monitoring remains extremely limited, and a strategic plan for expanding access is required. This is discussed further in Chapter 10 of this Review.

Coinfection management

A substantial number of TB patients are coinfected with HIV, with over 10% of TB patients testing positive. However, HIV testing coverage is low (<20%) and the true burden of TB-HIV coinfection is not known. Improving access to HIV testing for all TB patients is a priority given the high yield of this testing approach, and the urgency of providing immediate ART to all TB-HIV coinfected patients.

The HIV programme Review Team, together with the Joint External Monitoring Mission for TB, identified a number of key challenges to be addressed to improve the response to TB-HIV; these are summarized in Chapter 9.

HIV-hepatitis C virus (HCV) coinfection is associated with disease progression[21] and increased mortality[22] among people living with HIV in Indonesia. According to the limited published data, a high proportion of HIV-HCV-coinfected patients have chronic HCV infection, with over half (62%) of patients having liver disease warranting prompt treatment.[23]

The Review noted that while testing for hepatitis B virus (HBV) is generally provided, there were few examples where HCV testing was available. Access to testing and treatment for HCV needs to be expanded, as this will become an increasingly important priority for the country.

[21] Anggorowati N, Yano Y, Heriyanto DS, et al. Clinical and virological characteristics of hepatitis B or C virus co-infection with HIV in Indonesian patients. J Med Virol 2012. 84:857-65.

[22] Chen M, Wong W, Law M, et al. Hepatitis B and C Co-Infection in HIV Patients from the TREAT Asia HIV Observational Database: Analysis of Risk Factors and Survival. PLoS One 2016. 11:e0150512.

[23] Durier N, Yunihastuti E, Ruxrungtham K, et al. Chronic hepatitis C infection and liver disease in HIV-coinfected patients in Asia. J Viral Hepat. 2016. Dec 5. doi: [Epub ahead of print].

Recommendation 7

The Ministry of Health of the Republic of Indonesia has endorsed the Global 90-90-90 and Fast-Track Targets for Ending AIDS by 2030.[24,25] According to international standards, all people living with HIV should be started on ART. For Indonesia, this implies a ten-fold expansion in treatment coverage. In order to reach this goal, the HIV programme needs to make substantial improvements in identifying people who are HIV positive and linking them to treatment and care services.

To support these goals, the following priorities are recommended.

7.1 The First 90: Improve access to HIV testing and linkage to care.

By 2018, the national AIDS programme and the National TB Programme should, within their respective areas of responsibility:

7.1.1 Reinforce policy to ensure that HIV testing is available free of charge for all in need.

7.1.2 In particular, reinforce the policy of HIV testing for all TB patients: ensure that HIV testing is available at all health centres where TB services are provided.

7.1.3 Remove the requirement for signed consent for HIV testing. HIV testing should be consensual, but signed consent (either to "opt in" or to "opt out") is not required.

7.1.4 Expand community-based HIV testing using lay providers, using a 'test for triage' strategy, in which those who test positive are referred to a facility for further confirmation and diagnosis.

7.1.5 Establish regular coordination meetings between health facilities and NGOs involved in providing community-based HIV testing and linkage to care to review progress on expanding testing and linking PLHIV to health services.

7.1.6 Develop and implement a strategic plan for accelerated decentralization, focusing on geographical areas with high HIV prevalence, low ART coverage, and where access/distance to services is a barrier to expanding ART.

7.2 The Second 90: Update the HIV treatment guidelines in line with the WHO recommendation to "Treat all" irrespective of CD4 cell count

7.2.1 The Ministry of Health should expedite and finalize the updating of the HIV treatment and care guidelines in 2017, in particular to reflect the international standard of care to treat all HIV-positive individuals irrespective of CD4 cell count.[26]

7.2.2 By 2017, a clear dissemination and education plan should be developed to ensure that health providers are aware of and can access the latest guidelines.

7.2.3 The national HIV programme should consider establishing a website repository to support guideline dissemination.

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[24] UNAIDS. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014.

[25] UNAIDS. Fast - Track - Ending the AIDS Epidemic by 2030. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014 [cited 5 Feb 2017]. Available at: http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report .

[26] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Second Edition. Geneva: World Health Organization (WHO): 2016.

7.2.4 By 2018, the Ministry of Health should ensure access to appropriate ART formulations for paediatric HIV.

7.2.5 Charges for lab tests, including CD4 and viral load, for PLHIV attending a clinic outside their home province/area should be in waived the same way as for those with health insurance or residents of the same province.

7.3 The Third 90: Improve retention in care and virological suppression

7.3.1 By 2018, following appropriate training or retraining, health care workers, including counsellors, need to educate patients on the benefits and possible side effects of ART so that patients do not stop the drugs due to side effects.

7.3.2 Reinforce peer support services and links with community-based organisations to support adherence and retention.

7.3.3 By 2018, national, provincial and district health authorities should ensure that all ART services within their purview monitor patient retention and have a mechanism for tracing patients who are lost to care, which could include phone calls, SMS and outreach through CSOs and networks of positive persons.

7.3.4 National, provincial and district health authorities should adopt the WHO recommendation to reduce the frequency of clinic visits/ART dispensing for patients who are stable on ART to increase clinic capacity and improve retention.[27]

7.3.5 Improve capacity for viral load monitoring (see Chapter 10).

7.3.6 Health services at all levels should establish linkages with social protection schemes such as nutrition and financial support programmes, where available, as drugs are but one part of therapy as a whole.

7.4 Improve the quality of care for the management of coinfections

7.4.1 Improve access to testing and treatment for HCV for PLHIV.

7.5 Improve data quality and build capacity to improve programme performance

7.5.1 Improve programme quality through supportive supervision, continuing medical education, and use of data.

7.5.2 Implement cohort monitoring, starting in sentinel sites, to improve the understanding of ART outcomes over time.

7.5.3 Improve consistency in data reporting between the TB and HIV programmes at the district, provincial and national levels.

[27] Ibid.

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World Health
Organization
Joint External TB Monitoring Mission (JEM
and
Country Review on HIV Response
Indonesia

8. Preventing mother-to-child HIV transmission

Background

Over the past 20 years, there has been dramatic progress in scaling up highly effective, comprehensive prevention of mother-to-child transmission of HIV (PMTCT) programmes and reducing new paediatric infections in resource-limited settings. With the WHO recommendations for "Option B+",[1,2] for lifelong ART for HIV-positive pregnant and breastfeeding women, and "Treat all" persons living with HIV, including HIV-positive pregnant women,[3] risk of mother-to-child transmission of HIV can be reduced to under 2%, from a background risk of 20-40%, while also promoting the health of the mother and reducing sexual transmission. The "Global Plan"[4,5] catalysed country scale-up and the global community has now committed itself to the elimination of mother-to-child transmission of HIV (EMTCT) as a public health problem.[6] Several regions, including Asia, are developing the strategic framework for 'Triple elimination" of infant HIV, syphilis and hepatitis B.[7]

The key components of PMTCT programmes include:

- testing pregnant women for HIV and testing the partners of those testing positive;
- treating HIV-positive women with ART and linking mothers to chronic ART care;
- early infant testing of exposed infants, early ART for infected infants, and following all exposed infants to determine final HIV status.

Successful PMTCT programmes require integrated service delivery as part of maternal, newborn and child health (MNCH) services, both antenatal and postpartum, and strong linkages to HIV treatment.

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[1] WHO. Programmatic update: Use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Geneva: World Health Organization (WHO); 2012 [cited 13 Feb 2017]. Available from: http://www.who.int/hiv/pub/mtct/programmatic_update2012/en/

[2] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach. Geneva: World Health Organization (WHO); 2013.

[3] World Health Organization. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach. Second edition. Geneva: World Health Organization (WHO); 2016.

[4] UNAIDS. Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive [Internet]. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2011 [cited 13 Feb 2017]. Available from: http://www.unaids.org/en/resources/documents/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf.

[5] UNAIDS. On the Fast-Track to an AIDS-free Generation: The Incredible Journey of the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive [Internet]. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2016 [cited 13 Feb 2017]. Available from: http://www.unaids.org/en/resources/documents/2016/GlobalPlan2016.

[6] WHO. Global guidance on criteria and processes for validation: Elimination of mother-to-child transmission of HIV and syphilis. Geneva: World Health Organization (WHO); 2014.

[7] Nguyen VTT, Trang HQ, Anh NTL, Anh LAK, Minh TB, Vuong ND, et al. An Innovative Approach to Triple Elimination of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B in Viet Nam. Poster session presented at the 8th International AIDS Society Conference on Pathogenesis, Treatment and Prevention; 19-22 Jul 2015; Vancouver.

Indonesia has approximately 5.3 million annual births, high first ANC (antenatal care) attendance (>95%) and an estimated national HIV prevalence of 0.3% (programme data suggest ANC prevalence as high as 0.7%) in pregnant women, but with some provinces (e.g. Jakarta) close to the 1% threshold for a generalized epidemic. Papua, in east Indonesia, has a generalized epidemic, with ANC prevalence of 2.3%[8] and PMTCT coverage still low. In 2016, HIV testing in pregnant women was estimated at around 10%, with approximately 48% of those testing positive initiating ART; overall, 5-10% of the total estimated number of HIV-positive mothers in Indonesia initiated ART.[9] Scaling up PMTCT programmes in large countries with concentrated and low prevalence epidemics, such as Indonesia, poses particular challenges, but providing access to testing and treatment for all pregnant women is the building block to a successful PMTCT programme and an important part of the UNAIDS "90-90-90" strategy and moving to the "Fast Track" for ending the epidemic by 2030.[10,11]

PMTCT in Indonesia lags behind other countries in the region (Figure 8.1). A recent analysis by WHO[12] showed that among the countries with the highest number of new paediatric infections, Indonesia ranked 7th, with an estimated 4,950 new infections, or about 3% of new paediatric infections globally.

Progress since the 2011 Review

PMTCT Recommendations from the 2011 HIV Country Review

The last HIV country review in 2011[13] coincided with important advances in the policy framework for PMTCT and the beginnings of a national PMTCT programme. The 2010 data available for that review showed that, while at least one health facility provided PMTCT services in 21 of the 33 provinces,[14] overall coverage for testing (<1%), ARV prophylaxis (4%), and impact of preventing new paediatric infections, was very low. Given the low and uneven PMTCT coverage, the 2011 review made one major and two supporting recommendations:

- Develop a national PMTCT strategy, including strengthening linkages to HIV care, support and treatment services; specialised regional centres for training and support; and clinical leadership from Obstetrics and Gynaecology services.
- Develop minimum PMTCT service standards, including training of obstetricians and gynaecologists.
- Create regional PMTCT 'centres of expertise' to act as models for service delivery, training and networking.

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[8] Ministry of Health of the Republic of Indonesia. Integrated Biological and Behavioral Survey Tanah Papua 2013. Jakarta: Ministry of Health; 2013.

[9] Ministry of Health of the Republic of Indonesia, WHO and UNAIDS, various reports, including WHO. Progress report on HIV in the WHO South-East Asia Region, 2016. [Internet]. New Delhi: World Health Organization (WHO); 2016 [cited 5 Feb 2017]. Available from: http://www.searo.who.int/entity/hiv/data/pr-hiv-sear.pdf?ua=1

[10] UNAIDS. Fast-Track Commitments to End AIDS by 2030 [Internet]. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2016 [cited 5 Feb 2017]. Available from: http://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf.

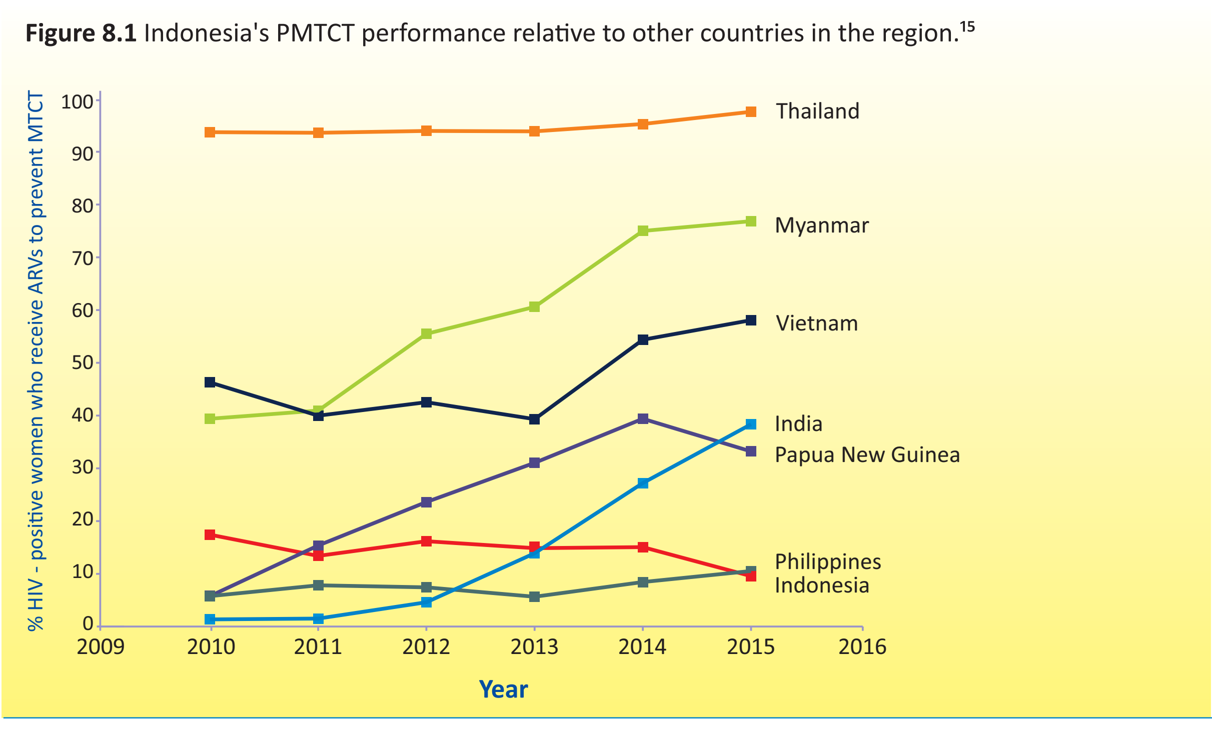
[11] UNAIDS. UNAIDS 2016-2021 Strategy: On the Fast-Track to End AIDS [Internet]. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2016 [cited 5 Feb 2017]. Available from: http://www.aidsdatahub.org/sites/default/files/publication/UNAIDS_Strategy_2016-2021.pdf.

[12] Personal communication with the HIV Department, WHO, January 2017.

[13] UNAIDS Estimates 2016.

[14] Ministry of Health of the Republic of Indonesia. Review of the Health Sector Response to HIV and AIDS in Indonesia 2011. Jakarta: Ministry of Health and World Health Organization; 2011.

Figure 8.1 Indonesia's PMTCT performance relative to other countries in the region.[15]



These recommendations were made at a time when HIV testing coverage for pregnant women in Indonesia was extremely low, and at the beginning of the adoption of "Option B+". It was recognized that new policies, implementation guidance and a strategy were needed to support the scale-up of a meaningful PMTCT programme, that it needed to have links with the developing ART programme, and be part of essential MNCH services and the continuum of care. It was also recognized that a specific focus to scale up PMTCT in the higher prevalence provinces of Jakarta and Papua was needed.

Policy and implementation guidance updates in Indonesia since 2011

There has been impressive progress in the formulation of new regulations, policies and implementation guidance for PMTCT since 2011. In 2013, the Ministry of Health issued a circular and regulation for integrating HIV testing in ANC services as part of the Continuum of Treatment and Care (LKB), initiated four PMTCT model districts, and formalized the guidance for "B+" as part of the PMTCT national guidelines.[16,17] Guidelines for implementation and a policy on rapid diagnostic testing (RDT) by trained midwives and nurses were issued in 2015.[18,19] In 2016, the updated policies were actively disseminated to all provinces, addressing ANC standards

[15] Indonesia had a total of 33 provinces in 2010; the 34th province was established in 2012.

[16] Minister of Health of the Republic of Indonesia Regulation No. 51/2013 on the Guidelines for the Prevention of Mother to Child Transmission of HIV.

[17] Ministry of Health of the Republic of Indonesia. Rencana Aksi Nasional Pencegahan Penularan HIV dari Ibu ke Anak (PPIA) Indonesia 2013-2017. (National Action Plan, Prevention of HIV Transmission from Mother to Child 2013-2017) [Internet]. Jakarta: Ministry of Health; 2013 [cited 5 Feb 2017]. Available from: http://www.kebijakanaidsindonesia.net/jdownloads/Publikasi%20Publication/rencana_aksi_nasional_pencegahan_penularan_hiv_dari_ibu_ke_anak_ppia_-_2013_2017.pdf

[18] Ministry of Health of the Republic of Indonesia. Pedoman Pelaksanaan Pencegahan Penularan HIV dan Sifilis dari Ibu ke Anak bagi Petugas Kesehatan (Guidelines for Implementing Prevention of HIV and Syphilis Transmission from Mother to Child for Health Workers). Jakarta: Ministry of Health; 2014.

[19] Minister of Health of the Republic of Indonesia Regulation No. 25/2015 on Laboratory Testing during Pregnancy, Delivery and Postpartum in Health Facilities.

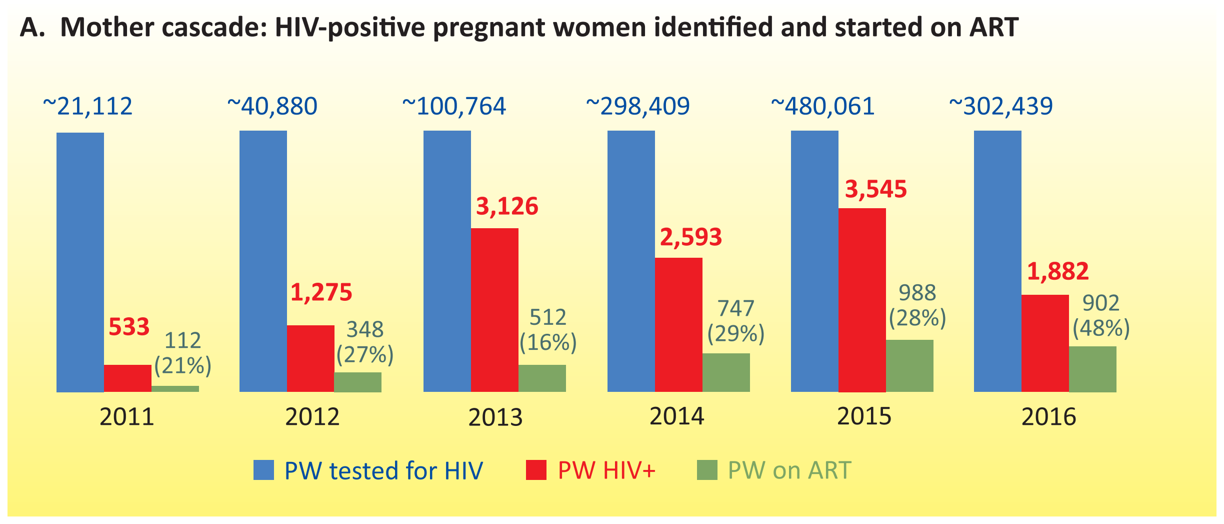
and including HIV and syphilis screening as part of LKB.[20,21]

These important documents updated and clarified the national guidelines, included HIV-positive pregnant women as a key target group for early ART initiation in Indonesia's broader Strategic Use of ARV (SUFA) strategy, and recognized that PMTCT needed to be integrated as an essential part of MNCH services.

Progress in coverage since 2011

While national coverage remains very low, since 2011 there has been significant progress in scaling up and decentralizing PMTCT services and increasing coverage of HIV testing and ART, and the framework is now in place for further scale-up.

As shown in **Figure 8.2**, HIV testing of pregnant women has increased more than 20-fold from 2011-2016, from around 21,000 to more than 500,000 (estimated full-year number); the number of HIV-positive pregnant women identified has increased from approximately 500 to almost 3,600, and the number of HIV-positive pregnant women starting ART increased from more than 100 to almost 1,000. However, with 5.3 million pregnancies annually and an estimated HIV prevalence of 0.3%, 2016 testing coverage was around 10%, and at least 10% of HIV-positive pregnant women were identified, with less than half of those initiating ART (note: different data sources report somewhat different PMTCT testing and ART coverage data). No data are available for retention on **Figure 8.2** National PMTCT programme coverage[22]

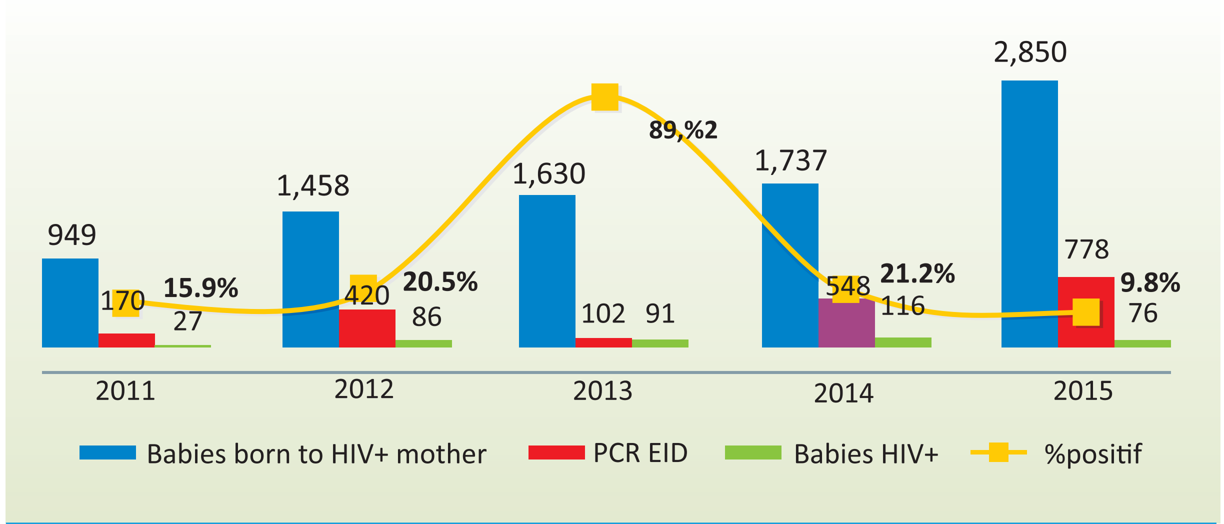


[20] Minister of Health of the Republic of Indonesia Regulation No. 97/2014 on Pre-Pregnancy, Pregnancy, Delivery and Post-partum Health Services, the Provision of Contraception Services and Sexual Health Services.

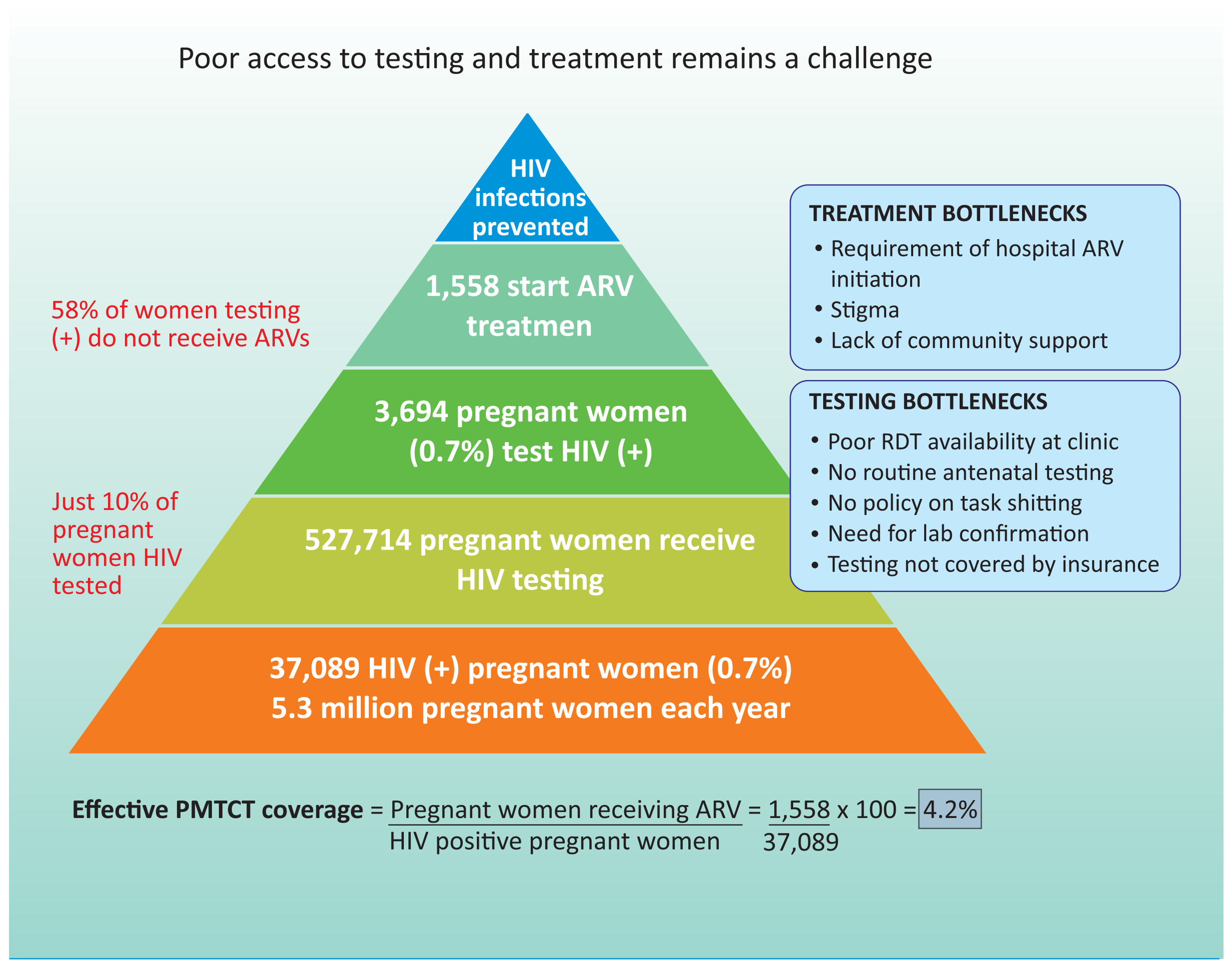
[21] Minister of Health of the Republic of Indonesia Regulation No. 43/2016 on Minimum Standards for Health Services.

[22] Sources: Figures 9.2A and 9.2B: Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (HIV, AIDS and STI Report, 3rd Quarter 2016). Jakarta: Ministry of Health; 2016, and Ministry of Health: Monthly Report on HIV and ART Treatment (unpublished data); Figure 9.2C: UNICEF, unpublished programme data analysis presented to the PMTCT TWG, January 2017.

B. PMTCT HIV-exposed infant cascade



C. 2016 programme estimates of testing and treatment coverage, and bottlenecks.



ART at delivery or at 12 months post-delivery, which would be needed to fully assess the protection against MTCT provided by maternal ART. The figures illustrate the "cascade" effect for identifying and initiating HIV-positive mothers on treatment and some of the key barriers and bottlenecks. Note that Figure 9.2C extrapolates from 2015 unpublished programme data in several sites with a 0.7% HIV prevalence in pregnant women, while the consensus population estimate is closer to 0.3%.[23]

The 2016 HIV Epidemiologic Review[24] included annexes with specific PMTCT data from selected provinces.[23 above] A summary of the data from the two highest prevalence provinces (**Table 8.1**) shows higher testing rates, higher HIV prevalence in pregnant women, and higher ART initiation among the positives, compared with the national average, but overall coverage remains low for these focus provinces and there continues to be a steep drop from testing positive to initiation on ART.

Table 8.1 Summary of 2015 PMTCT Cascade Data, Jakarta and Papua[25]

	Jakarta n (%)	Papua n (%)
Pregnant women (PW)	196,901	70,123
PW attending ANC	196,418	70,000
PW tested for HIV	66,964 (34%)	17,527 (25%)
PW testing HIV+	559 (0.8%)	236 (1.3%)
HIV+ PW starting ART	134 (24%)	135 (57%)

Source: MOH: HIV Epidemiologic Review 2016

Despite these sobering data, there are several Ministry of Health-supported model district sites (**Table 8.2**), which show high performance along the PMTCT cascade and offer some best practices and lessons learned.[26] Results from these model sites show much higher testing and ART initiation rates than the national average, and, notably, 100% ART initiation among HIV-positive pregnant women in Surabaya and Sorong (Papua). High performance was attributed to local engagement and supervision; integration of PMTCT into routine ANC (with both HIV and syphilis); support for opt-out provider-initiated testing and counselling, along with effective client counselling to increase ART uptake; decentralized ARV provision (local district procurement complementing central logistics and supply); and decentralized ART initiation.

[23] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[24] *Ibid.*

[25] *Ibid.*

[26] UNICEF Indonesia, internal reports on model district sites.

Table 8.2 PMTCT cascade in three Ministry of Health-supported model district sites, Jan-Sept 2016.[27]

	West Jakarta n (%)	Surabaya n (%)	Kota Sorong n (%)	National n (%)
Estimated PW	40,683	47,480	5,890	5,360,292
PW tested for HIV	20,447 (50%)	17,172 (36%)	3.148 (53%)	474,534 (9%)
HIV+ PW	24 (0.14%)	14 (0.08%)	24 (0.76%)	3,474 (0.73%)
HIV+ PW on ART	11 (39%)	14 (100%)	24 (100%)	678 (20%)

Source: MOH: HIV Epidemiologic Review 2016

Current issues

While important first steps have been made in developing a national PMTCT programme in Indonesia, scale-up, testing and ART coverage remain low. The Review identified a number of key issues that need to be addressed to help accelerate the programme and achieve the desired impact of decreasing paediatric HIV infections and improving the health of mothers.

From regulations to implementation guidance

Appropriate policy regulations on PMTCT are largely in place, but the implementation guidance is either not finalized or not disseminated. On field visits and in key informant discussions, the Review Team was told that the policies were often not clearly disseminated to the provincial, district or puskesmas level, or not well understood in terms of how to implement, and the expectations and responsibilities at the subnational level.

Related to this, while key technical policies have generally been updated to reflect current global guidance and evidence, there is continued uncertainty or uneven implementation of various policies, including opt-out vs. opt-in HIV testing and written versus verbal consent; male partner testing; where and how to initiate ART with HIV-positive mothers; indications for C-section; guidance on infant feeding; early infant diagnosis (EID); and follow-up of exposed infants, etc. Additional implementation guidance and technical training is needed to clarify updated policies. An example is provided below, conveying essential information to ANC attendees that may guide their decision to opt-in or opt-out of an HIV test. (**Box 8.1.**) Written informed consent or dissent is not required, and the care provider can record the decision the ANC attendees have verbally expressed. This example could be tested in Indonesia, validated, adapted as required, finalized and widely disseminated.

[27] UNICEF. PMTCT Cascade 2016 [unpublished data]. Jakarta: United Nations Children's Fund (UNICEF); 2016.

Box 8.1 Sample informed consent form for PITC among pregnant women

Sample form for verbal informed consent to HIV testing among pregnant women as part of provider-initiated testing and counselling

Verbal informed consent form - PMTCT (sample)

1. You are consulting because you are (may be, intend to become) pregnant and we want to make sure that both yourself and the newborn will be in good health.
2. While the risk is very low in Indonesia, in some cases, women who are pregnant may have been exposed to HIV, the virus causing AIDS, before or during pregnancy.
3. We would like to offer you a test that will determine whether or not you are infected with HIV. The Ministry of Health is recommending the HIV test for all pregnant women as part of essential prevention screening during antennal care, along with other tests such as syphilis and Hepatitis B. Information about this is in your mother-child health booklet.
4. If the test turns out to be negative, you will be reassured that you are not infected with this virus and, if you apply safety precautions until the baby is born, both you and the newborn will be free of the virus.
5. If the test is confirmed as positive, it means that you carry the virus, which will endanger your health and may be passed on to your baby unless you and your newborn baby receive appropriate treatment. It also could be passed to your husband/partner if he is not already infected.
6. In such a case, we will refer you to a centre that offers treatment free of cost. In the rare case of being infected with HIV, it is important to start treatment as early as possible in the pregnancy.
7. If you prefer not to take this test even though you may be infected with HIV without knowing it, HIV infection may severely affect your health, and you may transmit the virus to your baby and perhaps those with whom you have intimate sexual relations. If you decline to take the test, we will ask you to consider taking the test at your next visit and we will continue to take normal care of you during your pregnancy.
8. The result of the HIV test will be confidential. Only you, your antenatal clinic attendant and your HIV care providers will be confidentially aware of your infection status.

Do you agree to take this test?

Response dated and recorded by the care provider (check box) in patient's record:

Agreed to take the HIV test	Declined to take the HIV test

Integration of PMTCT as part of MNCH, with strong linkages to care, support and treatment (CST)

Current policies promote the integration of PMTCT services in MNCH, as part of the national AIDS programme. This recognizes that PMTCT services need to be provided in ANC, newborn and postpartum services at primary care, and that many of the essential services should be provided by midwives. Progress is being made to include HIV and PMTCT in the basic monitoring tools of the MNCH programme, including the mother and child booklets, and the ANC, delivery and newborn registries. However, PMTCT services need to continue to receive support from the national AIDS programme in order to assure HIV standards and a reliable supply of test kits

and ARVs. There are also important synergies to be gained by linking HIV testing and PMTCT with syphilis testing, and, potentially in the future, with hepatitis B testing, as part of an anticipated triple elimination approach.

Decentralized service delivery, ART initiation, linkages to CST, access to EID and viral load testing

Decentralization is essential to achieving high coverage of PMTCT services, and is part of the Ministry of Health's strategy and policies for both integration in MNCH and local access to ART at CST sites and puskesmas level. While HIV testing can be decentralized to puskesmas level (or below), there are different service delivery models for initiation and maintenance of ART: in some cases ART is provided at the ANC (or the CST site at the same puskesmas) and in some cases referrals are made to nearby CST sites, depending on local capacity and patient volume. In addition, while EID testing is currently low, and viral load testing is only just beginning (see Chapter 8 and Chapter 11 of this Review), the appropriate service models need to be developed to support EID and viral load testing (either through the regional referral lab network, or the expanding network of districts with the rapid molecular test). Viral load testing needs to be available to HIV-positive pregnant women, as with all other patients on ART.

Private sector

In many settings, particularly in urban areas, up to 60% of antenatal care is provided by the private sector. Currently, little is known about the provision of PMTCT services in the private sector and very little is reported into the national HIV and AIDS Information System (SIHA). However, information obtained during the Review, including field visits and interviews, indicated that HIV testing and access to ART for HIV-positive pregnant women is very low in the private sector.

Better knowledge of the epidemic, the cascade and the continuum of care

The introduction of cascade reporting at all levels has been a valuable addition to programme and surveillance data, since it focuses on retention of HIV-positive mothers and exposed infants along the continuum of care. The continuum of care, however, poses specific challenges for tracking of mothers and infants across facilities (ANC, postpartum and well-child care and CST), biological time points (pregnancy, postpartum), and linking mother-infant pairs for services and outcomes. Review of cascade data, particularly at district and puskesmas level, is extremely useful in engaging local programme managers and health care providers to assess the strengths and weaknesses of the local programme, and develop local solutions and problem solving.

Scale-up

With the building blocks of the PMTCT programme in place, the big challenge for Indonesia is to scale up testing for all pregnant women (estimated 5.3 million births annually) throughout the country, and to assure that HIV-positive women are initiated and retained on ART. The Ministry of Health has committed to providing 5 million rapid diagnostic tests for HIV in 2016 to support the achievement of 40% testing coverage among pregnant women in 2016 and 80% testing coverage in 2019,[28] towards achieving the 90-90-90 goals for 2020 and EMTCT.[29] Key opportunities include a strategy of prioritizing scale-up in higher prevalence and higher burden

[28] Ministry of Health of the Republic of Indonesia. National Action Plan for HIV and AIDS in the Health Sector 2015-2019.

[29] UNAIDS. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014. WHO. Global Guidance on Criteria and Processes for Validation: Elimination of Mother-to-Child Transmission of HIV and Syphilis. Geneva: World Health Organization (WHO); 2014.

provinces, while strengthening the commitment to scale up universal HIV testing for pregnant women as part of the essential package of MNCH care in all provinces and districts, and including the private sector.

Recommendation 8

The overall goal for PMTCT is to assure that all HIV-positive pregnant women have access to effective PMTCT interventions, in both public and private sectors, integrated into MNCH and Family Health, and linked to CST sites for lifelong ART. For Indonesia to move from its current low coverage/low impact to a high coverage/high impact programme, the Review makes the following recommendations:

8.1 Increase HIV testing of pregnant women

Build on the policy of testing all pregnant women for HIV with provider-initiated testing and counselling (PITC) in order to increase testing from the current national coverage of 10% to >90%, with a short-term priority on scaling up in higher prevalence and higher burden areas, while moving to universal testing.

8.1.1 Continue to expand routine opt-out testing integrated in MNCH services, with support for training and task-shifting for midwives and doctors at puskesmas and in all ANC services, following either the 3 RDT test algorithm or one screening test and referral for confirmation, depending on local service delivery models, and assure linkages to ART for HIV-positive women.

8.1.2 Give special attention to expanding HIV testing for pregnant women in the private sector, linking positives to ART and increasing reporting in SIHA. Support an analysis of opportunities and barriers to scaling up PMTCT in the private sector, with action steps and follow through. Engagement with medical and nursing schools, professional medical societies, private and faith-based hospitals, and financing/reimbursement systems (e.g. the national health insurance scheme, JKN) will be an important part of this effort.

8.1.3 Clarify and move from the older concept of "PICT" to "PITC", to further embed HIV testing as an essential part of the ANC package, with community information, education and communication (IEC) and demand creation.

8.1.4 Expand male partner testing, with a focus on testing partners of pregnant women who test positive; monitor and reduce stigma and discrimination and gender violence; and increase community sensitization and support.

8.1.5 By the end of 2017, develop a plan to scale up testing in pregnant women to strive towards >90% coverage by 2020 (or at a minimum, 70% coverage if 90% is felt to be unachievable by 2020), including intermediate targets and mapping to focus on:

- High prevalence and higher burden provinces and areas;
- Private sector hospitals and clinics;
- National scale up to all provinces and districts.

8.2 Increase ART for pregnant women who test HIV positive

Current cascade data show a sharp drop from testing HIV positive to initiation on ART for pregnant women, although recent model district projects show high initiation on ART and successful linkages.

8.2.1 By mid-2017, conduct a situational analysis to assess gaps and best practices/best service delivery models for linking HIV-positive pregnant women with ART.

8.2.2 By the end of 2017, develop an updated implementation strategy/guidelines to support the initiation on ART of >90% of HIV-positive pregnant women by 2020 (or at least 60% if 90% is felt to be unachievable by 2020):

- Include annual intermediate targets;
- In conjunction with HIV treatment and the national CST plan, include an updated strategy on decentralization of ART to puskesmas level for HIV-positive pregnant women, where realistic; generally support a "hub and spoke" linkage approach with CST sites;
- Include enhanced civil society and peer support for HIV-positive pregnant women to support their initiation and retention on ART;
- Include access to viral load testing for HIV-positive pregnant and postpartum women in the viral load scale-up plans.

8.3 Strengthen integration of PMTCT in MNCH and develop a dual/triple elimination strategy

The Review recommends that PMTCT services are fully integrated within MNCH and Family Health, as part of the national AIDS programme, and included as an essential package of MNCH services. Steps to strengthen this integration should include the following:

8.3.1 Update current regulations (from both HIV/Communicable Disease Directorate and Family Health) as needed, and provide PMTCT implementation guidance and training for integration, including management, service delivery responsibilities, updated policies and interventions, and PMTCT quality of care indicators and reporting. Training should be provided to both medical (i.e. OB/Gyn) and nursing (i.e. midwives) providers.

8.3.2 Develop a strategic plan for dual EMTCT of HIV and syphilis, within the current global and regional frameworks, and anticipate a possible triple elimination strategy (including hepatitis B), which is currently being considered. Seek additional integration synergies with other ANC testing, such as haemoglobin and malaria.

8.3.3 Review and update the joint coordination strategy and responsibilities of MNCH and HIV for supporting, implementing, monitoring and reporting on the continuum of care from PMTCT to chronic ART for HIV-positive pregnant and postpartum women and their exposed and infected infants. The systems that need to reflect the essential data include: MNCH cards and registers, MNCH PWS (*Pemantauan Wilayah Setempat*) reporting and SIHA. For HIV-positive pregnant women and exposed infants, reporting and tracking should include the use of coded unique identifiers and links between mother and infant.

8.3.4 Explore further opportunities for PMTCT integration in the Ministry of Health's "GERMAS" and "Family Health" initiatives.

8.4 Update and disseminate comprehensive PMTCT guidance and an action plan for acceleration

Ensure that the current comprehensive PMTCT guidance is well understood and followed, and update as needed to include new global recommendations relevant for Indonesia.

8.4.1 Develop a clear, updated roadmap for national and provincial scale-up, with annual targets, including a strategic approach of priority scale-up in higher prevalence settings, and expansion of coverage and reporting from the private sector.

8.4.2 Continue support for the newly formed PMTCT TWG/steering group to update, harmonize and disseminate implementation guidance, highlight best practices, monitor progress and assess guidance needs for managers and providers.

8.4.3 Ensure that areas of confusion or uneven implementation, such as infant feeding (early initiation of breastfeeding and continued breastfeeding in the presence of ART, with individual choice on formula feeding) and C-section (HIV alone is not a medical indication) are well understood. To this end, provide practical implementation guidance and job aids, and incorporate into pre-service and in-service training to medical and nursing providers.

8.4.4 Assess the relevance of the new WHO recommendation for "high risk" infants (born to HIV-positive mothers with <8 weeks of ART prior to delivery)[30] and the feasibility of enhanced infant prophylaxis (with dual ARV) for 12 weeks for "high risk" infants.

8.4.5 Support the scale-up and reporting of early infant diagnosis (EID) testing at 6 weeks and include final diagnosis of exposed infants at 18 months or the end of breastfeeding.

8.5 Strengthen M&E for PMTCT

To better monitor the PMTCT programme and impact, additional efforts are needed to analyze current SIHA data on PMTCT and the PMTCT cascades, and identify and address gaps and issues that are preventing reliable monitoring.

8.5.1 By mid-2017, review current reporting flow within puskesmas, CST sites/hospitals and districts to assure harmonization of data between MNCH and HIV and optimize reporting in SIHA on the PMTCT cascade and the continuum of HIV care for HIV-positive pregnant women.

8.5.2 Include postpartum retention and viral load suppression indicators on the maternal cascade, and infant ARV prophylaxis, EID testing, and final diagnosis indicators on the infant cascade.

8.5.3 Consider publishing PMTCT cascade data in Ministry of Health quarterly and annual reports, so that data may be used more effectively for programme planning and improvement, and encourage local review of cascade data at district and puskesmas level.

8.5.4 Plan for refresher training on how to fill primary data forms and SIHA entries correctly at facility level. Promote the use of already developed integrated reporting tools (e.g. ANC-PMTCT report form, 2014).

8.5.5 By 2018, develop a PMTCT "dashboard", with key indicators, at national, provincial and district levels, to support active review of data, programme accountability and improvement across the MNCH and CST services being provided as part of PMTCT. Also consider other innovative approaches, such as line list tracking of mother-infant pairs, with unique, linked confidential identifiers, to fill the gaps in SIHA and provide more accurate and timely local data for monitoring and programme improvement.

[30] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach. Second edition. Geneva: World Health Organization (WHO); 2016.

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COUNTRY REVIEW ON HIV RESPONSE
INDONESIA
27 January 2017

Debriefing Joint External TB Monitoring Mission(JEMM)
dan Country Review on HIV Response, 2017
Ruang Leimena, Kemenkes RI, Jakarta 26 Januari 2017

9. Managing Tuberculosis and HIV

Overview

This Review of the national response to HIV coincided with an assessment of the national TB epidemiological situation and programme in Indonesia by the Joint External Monitoring Mission for TB. An exchange of data and findings between the two Review Teams allowed an alignment of the conclusions and recommendations arising from these two concurrent activities. At the time of writing of the 2017 National Review, the report on the findings of the TB mission had not been published.

Indonesia has the second highest burden of TB in the world. Indonesia is also one of the 30 high TB/HIV burden countries and the coinfection of TB-HIV is a challenge for the control of both diseases.[1] In 2015 an estimated 1,020,000 TB cases occurred in Indonesia, with an estimated 78,000 of TB patients being HIV-positive. However, less than 5% of the estimated HIV-positive TB patients were detected or notified to the national TB and HIV programmes.[2]

The country has undertaken a substantial and rapid scale-up of HIV prevention and treatment services in recent times. In response to the growing epidemic, and the challenges faced in expanding coverage of prevention, treatment and retention, the Ministry of Health introduced the continuum of prevention and care approach. This integrated, decentralized service delivery model relies on close collaboration between district health offices, the district AIDS commissions, health facilities and community organisations. Important programmes such as access to HIV testing and outreach for key affected populations, prevention of mother-to-child transmission of HIV (PMTCT) as well as TB/HIV collaborative activities are being strengthened through this decentralized framework.[3]

Provider-initiated HIV testing and counselling (PITC) among TB patients remains at very low levels, although it is already mandated in the Minister of Health Decree no. 21/2013 on HIV and AIDS Control.[4] Most TB units still rely on the limited number of HIV units to offer HIV tests.[5] This is further compounded by the fact that TB staff are not considered by the national AIDS programme (NAP) for capacity building and hence lack the confidence to offer HIV tests. Patients need to sign informed consent forms to opt in or out of HIV testing, which can further act as a barrier to test acceptance.[6] Building the capacity of the staff providing TB services at hospitals and puskesmas, and the provision of simplified tools and processes for counselling and HIV testing, are keys to enhancing acceptance and coverage of HIV testing among TB patients. The lack of these elements in previous national AIDS programme efforts to train TB staff on HIV testing through PITC workshops at provincial and district levels likely explains the limited increase in HIV testing.

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1 WHO. Global Tuberculosis Report 2016, page 147. Geneva: World Health Organization (WHO); 2016.

2 *Ibid.*

3 Ministry of Health of the Republic of Indonesia. Report of the Joint External TB Monitoring Mission 2013. Jakarta: Ministry of Health; 2013.

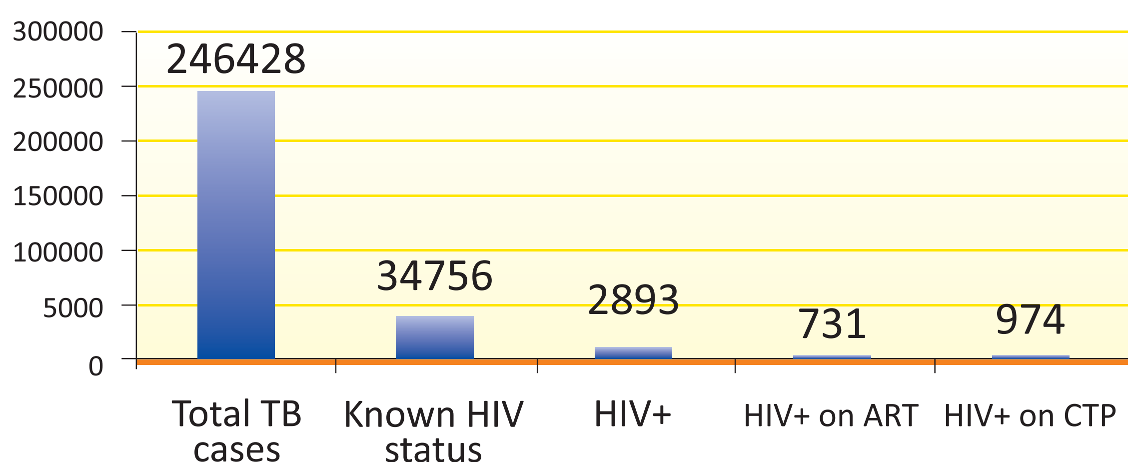
4 Minister of Health of the Republic of Indonesia Regulation No. 21/2013 on HIV and AIDS Control.

5 Information provided during field visits in West Kalimantan on 18-20 January 2017and FGDs with participants from Aceh, West Java and Bali on 18-19 January in Jakarta.

6 Reported by health care workers during field visits in Jakarta and FGDs with participants from Aceh, West Java and Bali on 18-19 January 2017; in a meeting with the pneumology, infectious disease and laboratory associations on 23 January 2017 in Jakarta; and at the Plenary Meeting of the GFATM Country Coordinating Mechanism on 20-22 December 2016 in Jakarta.

In 2015, only 14% of TB patients knew their HIV status, with 8% having positive HIV test results. Bali is the only province where more than 50% of TB patients knew their HIV status. The proportion of TB patients in Papua and Papua Barat who knew their status was less than 40%.[7] In 20 out of 34 provinces, less than 10% of TB patients knew their HIV status.[8] Analysis of district data for 2014 shows that only 25 out of 505 districts achieved more than 50% HIV testing coverage in TB patients, and a further 177 districts did not report any data on HIV testing. During the field visits the Review Team noted that the low availability of services and complicated procedures for offering and conducting HIV tests are hampering optimal implementation and coverage of PITC among TB patients. This is compounded by stigma surrounding both HIV and TB among communities, patients and staff. This is a great missed opportunity for the detection of HIV-positive individuals and timely linkage to ART.

Figure 9.1 Number of HIV+ TB patients on antiretroviral therapy, 2016[9]



The NAP data shows that only 54% of coinfected patients received cotrimoxazole preventive therapy (CPT) and 51% received ART.[10] However, a review of data reported by the National TB Programme (NTP) for the same reporting period shows that less than 25% of HIV-positive TB patients started ART and less than 35% started CPT (**Figure 10.1**).[11] This mismatch points to the lack of mechanisms for sharing and validating the data between the NAP and NTP at facility, district and national levels. As a result, the TB/HIV data reported on both the SIHA and SITT data systems remains incomplete. Gaps in the systematic recording of HIV status on TB records, and hence reporting, were also noted. Provision of Isoniazid preventive therapy (IPT) is also suboptimal, with less than 10% of eligible PLHIV identified in 2016 receiving IPT (**Figure 10.2**). Hence, although the NTP and NAP recommend linkages between TB and HIV units,[12] these do not result in the gaps in data sharing and implementation of collaborative TB/HIV activities being bridged.

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[7] Ministry of Health of the Republic of Indonesia. SIHA: Laporan Bulanan Perawatan HIV dan ART. (*SIHA: HIV Care and ART Monthly Report*). Jakarta: Ministry of Health; 2015.

[8] Ministry of Health of the Republic of Indonesia. SITT: Sistem Informasi Tuberkulosis Terpadu. (*SITT: Integrated Tuberculosis Information System*). Jakarta: Ministry of Health; 2015.

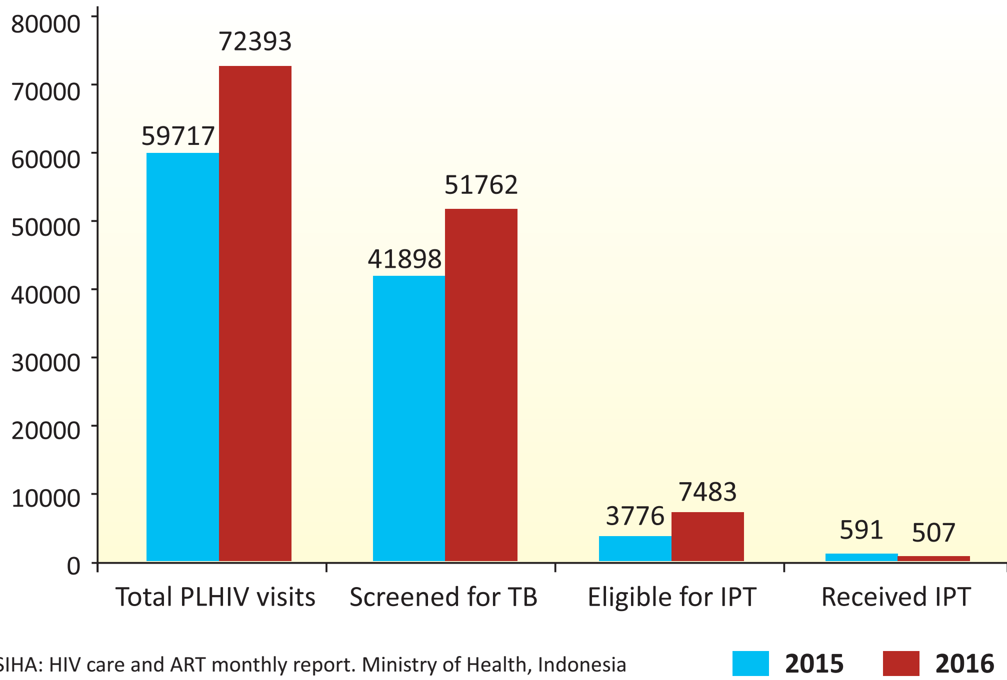
[9] Ministry of Health of the Republic of Indonesia. National TB Control Programme; 2016.

[10] Ministry of Health of the Republic of Indonesia, 2015.

[11] Ministry of Health of the Republic of Indonesia. National TB Control Programme report through SITT. Jakarta: Ministry of Health; 2016.

[12] PEPFAR. Country Operational Plan (COP) 2015 Strategic Direction Summary Indonesia [Online]. Washington: United States Department of State, The U.S. President's Emergency Plan for AIDS Relief (PEPFAR); 2015 [cited 25 Jan 2017]. Available at: https://www.pepfar.gov/documents/organization/250292.pdf.

Figure 9.2 Intensified case finding and IPT coverage[13]



Source: SIHA: HIV care and ART monthly report. Ministry of Health, Indonesia

TB patients also receive limited information, education and communication (IEC) on HIV and STI prevention, using materials supplied at the few sites where services are available. However, TB patients at the majority of TB diagnosis and treatment sites without an HIV testing facility do not have access to any HIV prevention messages or services, which again is a missed opportunity. Moreover, the NGOs and CSOs working with the NAP and NTP have had very limited engagement with TB/HIV activities, resulting in missed opportunities, for example, for HIV NGOs to promote intensified TB case finding and IPT, or for TB NGOs to promote HIV testing of TB patients and link them to ART if found positive. The inclusion of collaborative TB/HIV activities within the terms of reference of the NGOs and CSOs that are engaged by the NTP and NAP would provide an opportunity to gain efficiencies in implementation and increase the coverage of both national programmes.

Early initiation of ART and the expansion of treatment have already been introduced through the SUFA (Strategic Use of ARV) programme in Indonesia.[14] However, ensuring the linkage of HIV-positive TB patients to ART should receive special attention, both in hospitals and at the primary health care level, considering the high case fatality without treatment. This calls for a decentralization of ART services and the establishment of strong linkages between the HIV testing and ART sites. Staff providing TB services should also support the linkage of HIV-positive TB patients to ART while on TB treatment. Many operational gaps still need to be addressed by the NTP and NAP using the collaborative mechanisms established at the national, province and district level. Operational guidance for diagnosis, linkage and follow up of HIV-positive TB patients should be provided to the staff providing TB and HIV services across the country systematically in order to achieve the targets in the National Strategic Plan.[15]

[13] Ministry of Health of the Republic of Indonesia. SIHA: Laporan Bulanan Perawatan HIV dan ART. (S*IHA: HIV Care and ART Monthly Report*). Jakarta: Ministry of Health; 2016.

[14] The Strategic Use of ARV (SUFA) initiative is based on the recommendations of the WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection (June 2013) and is legally provided for by Minister of Health Regulation No. 87/2014 on Antiretroviral Treatment.

[15] Ministry of Health of the Republic of Indonesia. National Action Plan for HIV and AIDS in the Health Sector 2015-2019. Jakarta: Ministry of Health; 2015.

Observations

After visiting a number of health care facilities in the country,[16] the HIV and TB teams were able to observe the following:

Weak TB/HIV collaboration at the national, province and district level

- Due to a lack of regular meetings and issue-based discussions, key operational issues remain unresolved, including a lack of free HIV rapid tests, stock outs of Isoniazid and cotrimoxazole, incomplete recording and reporting (177 districts did not report in 2015) and the mismatch of reported ART data between the NTP and NAP.

HIV testing services

- Not all TB patients are offered tests due to anticipated stigma, or tests are offered only to those identified as having a high risk of HIV.
- Resistance to offering HIV tests was noted among specialists, such as pulmonologists, and TB staff due to a lack of confidence about offering HIV tests to TB patients.
- Clients were required to provide signed consent (both to test or to opt out), resulting in lower acceptance by patients.[17]
- The quality of counselling was suboptimal.
- Some private clinics charge the patients for HIV testing because they perform a blood test (ELISA), which is not offered by the government. However, not all clients have insurance coverage for ELISA testing.
- Although patients who test positive are referred to services that provide ARV treatment, there are no outreach workers or other coordination mechanisms between the HIV diagnostic services at TB sites and the HIV services.

Linkage to ART

- Not all puskesmas are able to initiate ARV for TB-HIV coinfected patients or follow them up after TB therapy has ended. All TB-HIV patients should receive ARV as soon as possible during TB therapy (15 days to maximum 2 months)[18] but this strategy is not well known among health workers. Delays in starting ART, even with a very low CD4 cell count, were noted.
- CPT coverage is low: cotrimoxazole procurement is delegated to districts, but monitoring of districts by the NAP to ensure that they are procuring sufficient cotrimoxazole is inadequate.

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[16] Observations were drawn from site visits in West Kalimantan from 16 to 28 January 2017 and a meeting with professional organizations at the Ministry of Health on 23 January 2017. The observations pertain to both the TB Joint External Monitoring Mission (JEMM) and the HIV review. All five TB JEMM teams visiting regions looked into TB/HIV issues and provided observations and recommendations, which are reflected here.

[17] WHO guidelines indicate that verbal consent for HIV testing is sufficient in most settings: WHO. Consolidated guidelines on HIV testing services. 5Cs: Consent, Confidentiality, Counselling, Correct Results, and Connection. Geneva: World Health Organization (WHO); 2015. The national guidelines also provide for this: see Minister of Health of the Republic of Indonesia Regulation no. 74/2014 on the Implementation Guidelines for HIV Counselling and Testing, Attachment, Chapter III.

[18] Minister of Health of the Republic of Indonesia Regulation No.87/2014 on Antiretroviral Treatment; WHO. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization (WHO); 2015.

Intensified TB case finding and TB prevention at HIV care sites

- PLHIV are not offered Xpert MTB/RIF even though it is recommended in the guidelines.[19,20,21] Xpert MTB/RIF machines are located at TB sites and are generally not available at HIV sites. A focus on diagnosing Rifampicin-resistant TB, a lack of systematic mechanisms for specimen transportation, and poor linkage between HIV units and the TB laboratories where the Xpert MTB/RIF machines are placed were also observed.[22]
- Less than 10% of eligible PLHIV started IPT. It was also noted during field visits that PLHIV who are on ART are not given IPT.
- Stock outs and unavailability of Isoniazid 300 mg were observed at the sites visited due to low use of the drug during the period when the drug was procured.
- Clinicians' reluctance to prescribe IPT was said to be due to fear of drug resistance, despite the absence of evidence to support this concern.[23]

Other key issues

- The national health insurance scheme (JKN) covers only one consultation per month for chronic conditions; this is a disincentive to providing a TB service if an HIV service has already been charged that month.
- Involvement of the private sector in joint planning and implementation of TB/HIV activities would increase capacity.
- Infection control practices-a critical component at HIV care and treatment sites considering the very high TB burden in Indonesia-are not systematically implemented.

Recommendation 9

9.1 *The national HIV and TB programmes should rapidly scale up the TB/HIV response in Indonesia, using a differential approach.*

The following recommendations have been endorsed jointly by the HIV Review Team and the TB joint External Monitoring Mission. The national AIDS programme and National TB Programme should:

9.1.1 Agree on an initial target number (20-25) of model districts where the TB/HIV response in Indonesia should be scaled up, taking into consideration criteria such as disease burden (presence of HIV key populations, large numbers of PLHIV enrolled in care), the presence of good

[19] Minister of Health of the Republic of Indonesia Regulation no. 87/2014 on Antiretroviral Treatment.

[20] USAID. Challenge TB - Indonesia Year 2. Annual Report: October 1, 2015 - September 30, 2016 [Online]. United States Agency for International Development (USAID); 2016 [cited 28 Jan 2017]. Available at: http://pdf.usaid.gov/pdf_docs/PA00MF82.pdf.

[21] WHO. Automated Real-Time Nucleic Acid Amplification Technology for Rapid and Simultaneous Detection of Tuberculosis and Rifampicin Resistance: Xpert MTB/RIF Assay for the Diagnosis of Pulmonary and Extra-Pulmonary TB in Adults and Children. Policy Update [Online]. Geneva : World Health Organization (WHO); 2013 [cited 1 Feb 2017]. Available at: http://apps.who.int/iris/bitstream/10665/112472/1/978 9241506335_eng.pdf?ua=1.

[22] Observations from the TB Joint External Monitoring Mission (JEMM) in January 2017.

[23] Balcells M, et al. Isoniazid Preventive Therapy and Risk for Resistant Tuberculosis. Emerging Infectious Diseases, 12: 744-51; 2006. WHO. Guidelines for Intensified Tuberculosis Case-Finding and Isoniazid Preventive Therapy for People Living with HIV in Resource-Constrained Settings. Geneva: World Health Organization (WHO); 2011. WHO. Recommendation on 36 Months

infrastructure for the diagnosis and treatment of HIV and TB, and good performance on both the NAP and NTP indicators. These districts may be chosen from among the 141 priority districts designated by the national AIDS programme and 90 districts designated by the NTP.

9.1.2 In the selected districts, focus on technical support, human resources, training and logistics availability, and scale up implementation to achieve ambitious levels of coverage: detect 100% of the estimated HIV-positive TB cases by ensuring screening of 100% of PLHIV at every opportunity, and ensuring coverage of HIV testing among 100% of TB patients. In addition, 100% ART coverage and provision of preventive TB treatment for all eligible PLHIV should be targeted in these districts if applicable.

9.1.3 Provide diagnosis and treatment services closer to the location of patients by covering all hospitals and puskesmas with HIV testing services and increasing the number of ART and satellite sites.

9.1.4 Introduce and expand the practice of pre-HIV testing counselling in TB clinics, using a simplified approach (See the example, in Box 9.1, proposed by the HIV Review Team, to be tested, adapted as needed and disseminated to all TB diagnostic sites); and substitute verbal opt-in and opt-out statements by patients for the currently practiced signed consent or dissent to HIV testing, in accordance with existing Ministry of Health regulations and WHO Guidelines.

9.1.5 Strengthen supervision and monitoring by enhancing human resources and using technology such as e-health or m-health to track the patients.

9.1.6 Use the lessons from these selected districts to guide and support the expansion of TB/HIV activities to the remaining priority HIV districts. The efficiency and effectiveness of management of TB patients in the TB clinics; their agreement to taking an HIV test on-site after counselling and consent; the provision of HIV care on-site if indicated and feasible or through referral to an HIV care facility; the enrolment of dually infected patients in ART and adherence to TB and HIV treatments could be used to monitor progress.

9.2 The national AIDS programme and the National TB Programme should jointly intensify implementation of TB/HIV activities in all HIV priority districts (the selected districts in 9.1.1 and remaining priority districts) by establishing decentralized and simplified HIV testing services, intensified TB screening and detection using rapid tests such as Xpert MTB/RIF, and linkage of all HIV-positive TB patients to TB treatment and ART. To this end:

9.2.1 The NAP and the NTP should disseminate the use of a specific diagnostic algorithm for TB in PLHIV and ensure systematic screening of all PLHIV for TB at each visit, based on the main TB signs and symptoms (cough/fever/weight loss/night sweats of any duration; lymph node enlargement).

9.2.2 With support from the NTP, provide access to Xpert MTB/RIF as the initial test for TB diagnosis in all PLHIV.

9.2.3 The NAP should intensify training and sensitization of doctors and staff and promote the use of Isoniazid preventive therapy as per the national guidelines.

9.2.4 The NAP and NTP should jointly provide enabler support for linking 100% of HIV-positive TB patients to ART.

9.2.5 The NTP should closely track and record ART initiation and continuation early during the course of TB treatment and systematically refer patients to ART sites. This information should be cross-checked for completeness at regular intervals, preferably every quarter.

Box 9.1 Sample informed consent form for PITC among TB patients

Example of rapid counselling for the offer of an HIV test by care provider to a TB patient as part of Provider-initiated Testing and Counselling (PITC)

Verbal informed consent form - TB (sample)

1. You have been diagnosed with tuberculosis and you will be offered free treatment for this disease for your own benefit and to prevent the transmission of tuberculosis to others.
2. In some cases, TB infection is associated with infection with HIV, the virus causing AIDS. I would like to offer to you to be tested for HIV free of cost.
3. If the test turns out to be negative, you will be reassured that you are not infected with this virus.
4. If the test is positive, it will mean that you are infected with this virus and that you will be referred to an HIV care centre and offered free treatment for this infection to be taken along with your free treatment for tuberculosis.
5. If you prefer to not take this test although you are not aware if you are infected with HIV or not, we will respect your decision. But please note that HIV infection may affect severely your health and that, if you are HIV-infected, you may transmit the virus to those with whom you have intimate sexual relations. Even if you decline to take the HIV test, we will continue to take care of you by treating your tuberculosis.Verbally agreed to take the HIV testVerbally declined to take the HIV test
6. The result of this test will be confidential. Only you, your TB care provider and your HIV care provider will be aware of your infection status.

Do you agree or decline to take this test? (Check box):

Response to be recorded by the care provider in patient's record

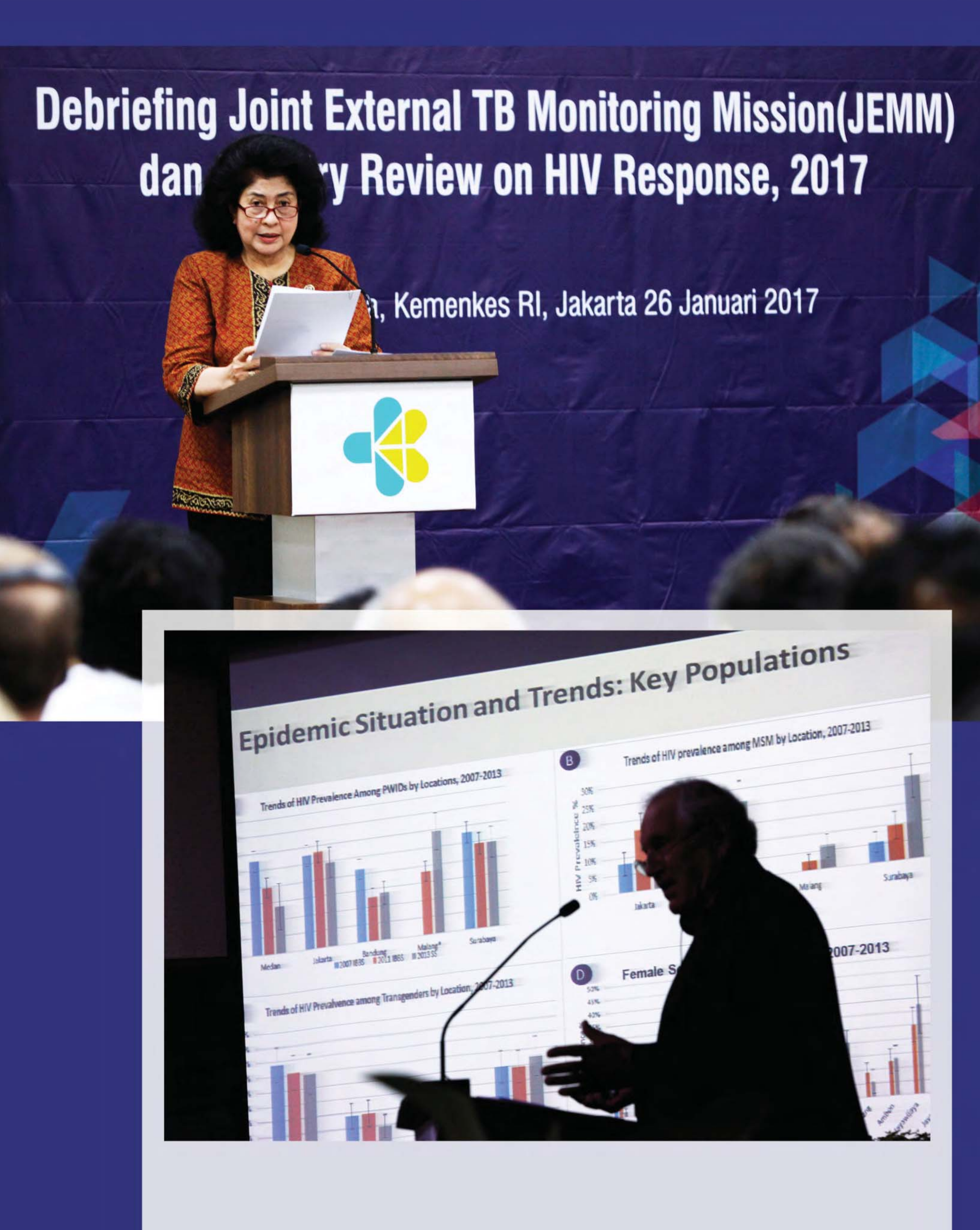
Date:

Verbally agreed to take the HIV test	Verbally declined to take the HIV test

9.3 In low TB/HIV burden districts, the national AIDS programme and National TB Programme should strengthen implementation of current activities by addressing gaps in recording, reporting and logistics; introduce a simplified approach to HIV testing/PITC; and track the linkage of HIV-positive TB patients to ART. To this end:

9.3.1 The NAP and the NTP should jointly organize and provide technical support for refresher training in health offices, TB clinics, hospitals and peripheral health facilities to disseminate best practices in HIV and TB diagnosis, monitoring and logistics.

9.3.2 Simplified tools for counselling and securing informed consent to HIV testing among TB patients (as proposed in **Box 9.1**) should be field-tested, adapted as needed and widely disseminated throughout the health system.



Debriefing Joint External TB Monitoring Mission(JEMM)
dan
ry Review on HIV Response, 2017
Kemenkes RI, Jakarta 26 Januari 2017
Epidemic Situation and Trends: Key Populations
Trends of HIV Prevalence Among PWIDs by Locations, 2007-2013
Trends of HIV prevalence among MSM by Location, 2007-2013
Medan
Jakarta
Bandung
Malang
Surabaya

10. Adapting and expanding the reach of biomedical monitoring

Introduction

The last national HIV programme review was conducted in 2011. The review recommended a number of key actions to improve laboratory systems for people living with HIV. These included:[1]

- Develop national expert teams for laboratory services. These would provide regular mentoring and technical assistance to provinces and districts.
- Provincial health authorities should ensure adequate funding for laboratory testing.
- Revise referral systems to ensure that more expensive or complex testing is referred to higher level laboratories (e.g. provincial or regional hospitals), while cheaper and less technically complex tests can
- be routinely performed at puskesmas level.
- Ensure that at all clinics and facilities offering laboratory testing for HIV, CD4, STI or OI, laboratory staff are certified and have access to refresher training when required.
- Ensure that all laboratories follow Ministry of Health guidelines, and where possible use testing procedures that have been evaluated by the Ministry of Health and participate in quality assurance schemes. Feedback reports of such schemes should be systematically provided to the participating laboratories and supportive supervision provided.
- Support further decentralization and networking of CD4 testing at selected sites using point-of-care technologies.
- Provide viral load testing at key referral laboratories.
- Ensure timely reporting of feedback on external quality assurance (EQA) reports for HIV and Cd4.
- As ART coverage expands, continue to expand the implementation of ARV resistance monitoring, in particular low cost initiatives such as the Early Warning Indicators, in ART sites.
- Train all laboratory staff in HIV testing.
- Strengthen the system of referral laboratories for CD4, viral load testing and MDR-TB diagnosis.

Since that time, there has been significant progress in several of these areas. A Laboratory Technical Working Group and HIV Drug Resistance Working Group were introduced as part of the National HIV Working Group to provide technical assistance as well as direction and decision making for laboratory issues. Funding has been sought specifically for laboratory systems through the Global Fund. All laboratory staff who perform HIV testing are trained and certified, and are working in over 3,000 facilities and hospitals, including more than 2,000

[1] Ministry of Health of the Republic of Indonesia. Review of the Health Sector Response to HIV and AIDS in Indonesia. Jakarta: Ministry of Health; 2011.

puskesmas;[2] however, at the time of writing of 2017 Review report, the programme was being reviewed, including the implementation of refresher training.

Laboratory systems are a critical piece of the UNAIDS 90-90-90 cascade.[3] The current cascade in Indonesia is discussed in Chapter 8 of this report (Expanding Access to Care, Support, and Treatment). It is clear that laboratory gaps exist in the first and last 90s: identifying infants, children, and adults who are HIV-positive, as well as monitoring patients on ART to achieve virological suppression.

Since 2011, global guidance has been updated, including that for laboratory systems. Viral load testing is strongly recommended as the preferred treatment monitoring test to measure treatment failure.[4] HIV testing guidelines have been released to provide clarity on testing algorithms, testing strategies for unique settings and priority populations, and strongly recommend task shifting of HIV rapid diagnostic testing (RDT) to lay providers.[5] The 2016 WHO consolidated ART guidelines introduce several laboratory-based recommendations, including:[6]

- Nucleic acid testing for use at or near to the point of care for early infant diagnosis.
- The addition of nucleic acid testing at birth to existing early infant diagnosis testing approaches (conditional recommendation).
- Routine testing of infants and children admitted to or attending inpatient care or malnutrition clinics (strong recommendation).
- Offering HIV testing to infants and children attending outpatient or immunization clinics (conditional recommendation).
- Maintaining the strong recommendation for viral load as the preferred treatment monitoring tool; dried blood spot specimens can be used to determine the viral load using an ART failure threshold of 1,000 copies/ml, similar to that using plasma (conditional recommendation).
- CD4 testing can be stopped in individuals who are stable on ART and virally suppressed (conditional recommendation).
- Point-of-care CD4 testing to prioritize patients for urgent linkage to care and ART initiation (conditional recommendation).
- Electronic communication (GPRS/SMS printers) to transfer test results rapidly and reduce delays (conditional recommendation).

Finally, recent guidelines have strongly recommended that HIV self-testing be offered as an additional approach to HIV testing.[7] Self-testing is recommended as a test for triage (not diagnosis) with linkage to care for those who test positive, and confirmatory testing prior to treatment initiation.

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[2] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (HIV, AIDS and STI Report, 3rd Quarter 2016). Jakarta: Ministry of Health; 2016.

[3] UNAIDS. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014.

[4] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Geneva: World Health Organization (WHO): 2013.

[5] WHO. Consolidated guidelines on HIV testing services. Geneva: World Health Organization (WHO); 2015.

[6] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Second edition. Geneva: World Health Organization (WHO); 2016.

[7] WHO. Guidelines on HIV self-testing and partner notification: supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization (WHO); 2016.

HIV testing coverage

HIV testing strategies currently cover the testing of all patients who have medical conditions indicating HIV (such as tuberculosis), testing pregnant women during ANC visits, and testing key populations and 'special' populations: partners of HIV-positive patients, hepatitis patients, prisoners, and high risk men.[8] There is limited outreach and community testing. Over 3,000 hospitals and facilities are currently performing HIV testing. Testing targets are ambitious (see **Table 10.1**).

Table 10.1 HIV testing targets[9]

Indicator	Year					
	Baseline (2013)	2015	2016	2017	2018	2019
Screening	**714,719**	**7,506,643**	**3,218,184**	**4,684,721**	**6,018,083**	**6,321,526**
Key populations	465,912	6,391,791	1,016,487	1,377,297	1,583,391	1,738,638
Special populations	248,807	1,114,852	2,201,697	3,307,424	4,434,692	4,582,888
PLHIV on ART	**50,400**	**65,609**	**87,778**	**112,051**	**138,498**	**167,120**

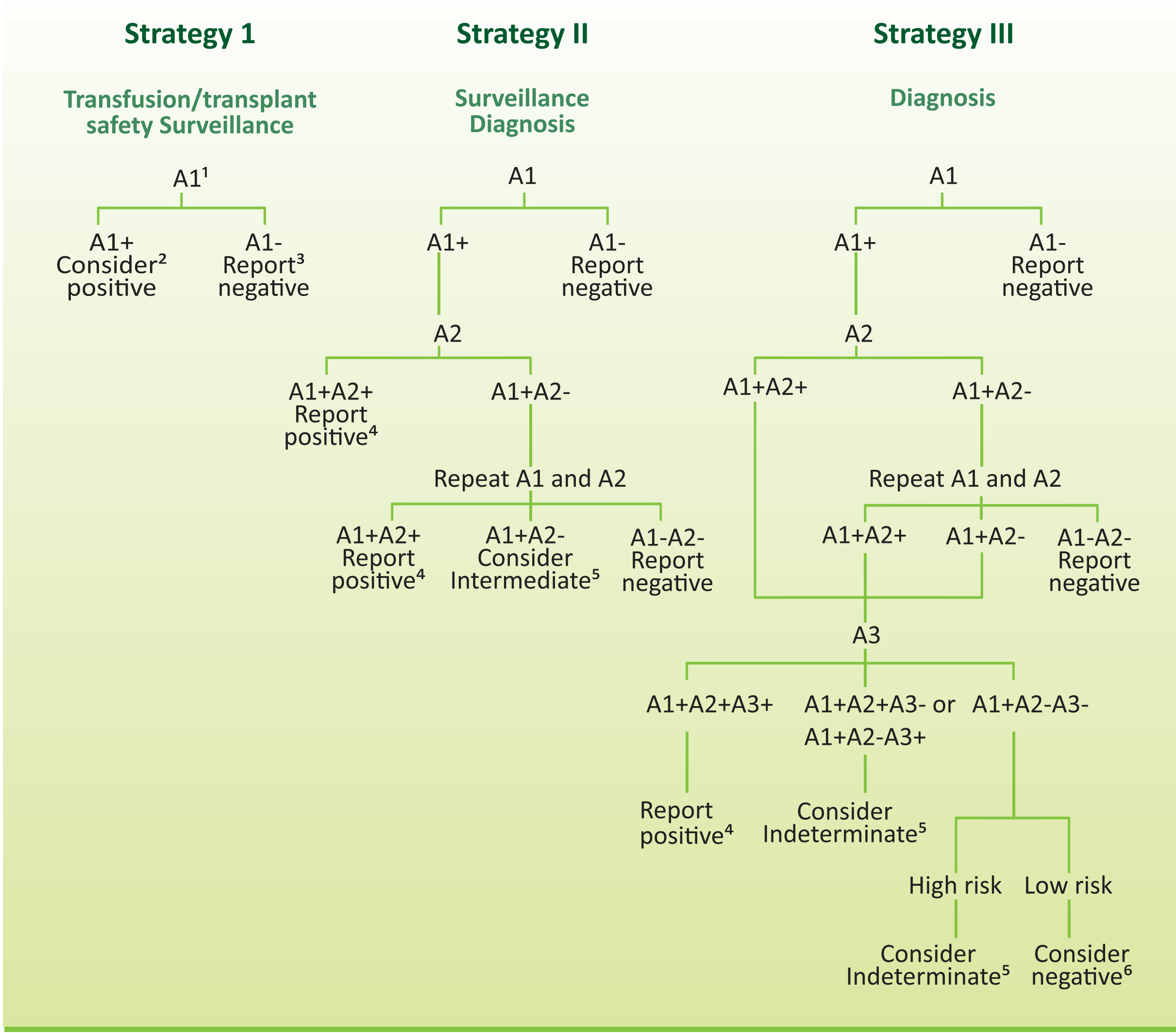
The current national HIV testing algorithm consists of three different rapid diagnostic tests used in sequence to identify HIV-positive patients (**Figure 10.1**). This algorithm is consistent for low prevalence (<5%) settings and in line with WHO guidelines. It was found, however, that the order of tests varied by laboratory and puskesmas.[10] Implementing a consistent and streamlined algorithm, using the same RDTs as the first, second, and third tests, as well as utilizing those from the WHO prequalification list, will ensure quality, minimize misdiagnosis, simplify procurement, and reduce costs. Rapid diagnostic tests should be included in the e-catalogue for procurement of laboratory/health products.

[8] Minister of Health of the Republic of Indonesia Regulation 74/2014 on the Guidelines for the Implementation of HIV Counselling and Testing.

[9] Ministry of Health of the Republic of Indonesia. National Action Plan for HIV and AIDS in the Health Sector 2015-2019. Jakarta: Ministry of Health; 2015.

[10] Information from a field visit to health facilities in Pontianak, West Kalimantan on 19 January 2017 as well as discussions with the Association of Indonesian Health Laboratories and the Ministry of Health in Jakarta, 23 January 2017.

Figure 10.1. HIV testing algorithm in Indonesia



Some laboratories continue to utilize ELISAs for HIV testing.[11] While this is supported by the necessary laboratory infrastructure in some settings, it was found to be a barrier to patient access to HIV testing. Rather than utilize RDTs at the site of entry, patients were referred to higher-level sites for testing. This can lead to patient loss to follow up as well as higher patient and health care costs.

A two-test HIV algorithm is recommended for high prevalence (>5%) settings. The recent epidemiological review identified several sub-populations (e.g. TB-HIV confected patients, key populations) and regions in Indonesia with high HIV prevalence.[12] A more simplified two-test HIV algorithm could be considered in Indonesia when testing specific populations, based on a review; however, implementing two different algorithms (two-test and three-test) based on population, region, or other differentiating factors might introduce complications on all levels, including procurement, costing, implementation, testers, patients, discrimination, etc.

[11] Information from a field visit to health facilities in Pontianak, West Kalimantan on 19 January 2017 as well as discussions with the Association of Indonesian Health Laboratories and the Ministry of Health in Jakarta, 23 January 2017.

[12] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

Early infant diagnosis coverage

Access to early infant diagnosis (EID) is currently low across Indonesia, with less than 1,000 infants tested per year of the estimated 3,000 born to HIV-positive women enrolled in PMTCT and approximately 15,000-20,000 HIV-positive pregnant women each year.[13] There are 14 molecular technology devices for performing EID testing in the country; however, only ten are presently functional.[14] The EID algorithm is in alignment with current WHO guidance;[15] however, gaps exist in ensuring access to testing. Implementation of the algorithm was observed to be poor in many hospitals and facilities visited by the Review Team.[16] Some provinces indicated that due to the lack of available EID testing, facilities were instructed not to test or prepare samples for infants, but wait until 18 months of age to perform the HIV algorithm using RDTs. This is concerning because data suggest that the peak of infant mortality for untreated HIV-positive infants is 2-3 months of age, while 50% of untreated HIV-positive infants die within the first two years of life.[17,18] Furthermore, it is worth considering utilizing all 30 facilities in the country that have molecular testing technologies for EID testing to support expansion of access. The EID and viral load volumes needed are unlikely to exceed the capacity of these devices, suggesting that additional devices may not be necessary, especially in the near term.

Previously, patient sampling required whole blood samples from infants. However, it is difficult to perform venipuncture in young children; moreover, sample storage times are very limiting for whole blood or plasma. Fortunately in 2016, dried blood spot (DBS) samples were introduced for EID, and training has begun in 12 provinces, starting with ART referral hospitals. Significant further expansion of DBS sample collection sites will be imperative to expand access to this critical test. Additionally, pre-perforated dried blood spot cards will allow for more efficient laboratory sample processing and reduce the risk of contamination.

Monitoring of patients on ART

Access to viral load testing is currently low across Indonesia, with less than 5,000 patients on ART tested in 2016 of the estimated 73,037 currently on treatment (see Chapter 8). Indonesia has 30 facilities in 24 districts with molecular technologies capable of performing viral load testing; however, only 18 machines in 15 districts are presently functional. Current machines can perform up to 40,000 tests per year, suggesting that the 30 existing machines could perform over 1 million tests per year (assuming an 8-hour day), which is more capacity than required, even if all estimated 600,000 HIV-positive patients are identified and initiated on treatment. Furthermore, the 18 functional technologies could collectively perform well over 500,000 tests per year (assuming an 8-hour day), more than the need. The viral load algorithm is in alignment with current WHO guidance; however, gaps exist in ensuring access to testing. Implementation of the algorithm was observed to

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[13] Ministry of Health of the Republic of Indonesia. PMTCT programme data from SIHA, 2016.

[14] There are an additional 16 facilities that have viral load testing equipment; these could also be used for EID.

[15] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Geneva: World Health Organization (WHO); 2013.

[16] Information from a field visit to health facilities in Pontianak, West Kalimantan on 19 January 2017 as well as practitioners and experts during a discussion with professional associations on 23 January 2017 in Jakarta.

[17] Bourne DE, Thompson M, Brody LL, Cotton M, Draper B, Laubscher R, Fareed Abdullah M, Myers JE. Emergence of a peak in early infant mortality due to HIV/AIDS in South Africa. AIDS 2009, 23:101-106.

[18] Newell ML, Coovadia H, Cortina-Borja M, Rollins N, Gaillard P, Dabis F, Ghent IAS working group. Mortality of infected and uninfected infants born to HIV-infected mothers in Africa: a pooled analysis. Lancet 2004; 364:1236-1243.

be poor in many hospitals and facilities visited. Several technologies seem to not be functioning and in need of servicing and/or maintenance. A strategic plan for expanding access is required.

As patients are initiated on treatment regardless of CD4 count, the need for CD4 testing to initiate ART will decrease. However, WHO recommends CD4 testing at baseline and for patients on ART who are not stable or virally suppressed to support opportunistic infection management.[19] The significant decentralization of CD4 testing that has taken place for ART initiation eligibility can thus be used for monitoring, as suggested. Currently there are over 300 machines in 206 districts with 263 point-of-care technologies able to provide same-day testing.

Laboratory systems

The 2017 Review found that many laboratories in the country are very advanced and well equipped, and clearly capable of providing high quality testing and strong guidance. As testing is now being expanded, decentralization of laboratory strengthening and mentorship will be invaluable to support access. The national AIDS programme has identified several priorities, including the development of a national laboratory strategic plan, development of an HIV laboratory network, strengthening of the national reference laboratory, integration of TB and HIV, establishment of a quality assurance program, and strengthening of the specimen transportation system. All of these are needed and will improve both the laboratory system and the public health system in general.

The Review Team noted that some sites charge patients for baseline laboratory testing prior to starting ART, or for viral load testing. This could be a barrier to ART initiation and monitoring. Essential lab testing for HIV, including viral load testing, should be free.

Laboratory Strategic Plan

An overall laboratory strategic plan is currently in development. This will be a critical framework for strengthening the health system. Several components should be considered for this plan, including but not limited to: patient mapping and site selection/device placement guidance; service and maintenance strategy; quality assurance plan; regulatory approval framework; training and certification guidelines; supervision and monitoring plan; clinician training and demand generation strategies; procurement, supply chain, and financing plan; additional systems components, including specimen transportation, logistics management and data integration (for example data collection, logbooks, monitoring and evaluation, laboratory information management system, use of connectivity).

Quality assurance is a critical component of laboratory testing. External quality assurance (EQA) schemes have been implemented for HIV and CD4 testing. Further funding is needed to continue these activities as well as expand EQA and other quality assurance schemes to additional testing centres and for additional testing types.

Laboratory integration of HIV and tuberculosis testing

Over 500 Cepheid GeneXpert machines have been procured and/or placed throughout Indonesia by the National TB Programme. As recommended in Chapter 9 of this report, collaboration with the National TB

[19] WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach. Second edition. Geneva: World Health Organization (WHO); 2016.

Programme on integrating HIV testing using such multiplex technologies should be prioritized, as this would allow for decentralization as well as faster testing and results reporting. For patients attending facilities with such technologies, results can be provided on the same day as testing and clinical decisions quickly made, even before leaving the health care facility. Furthermore, facilities near to those with such laboratories can refer patient samples to ensure quicker testing. The Cepheid GeneXpert system can accommodate many different tests, including early infant HIV diagnosis, HIV viral load, Hepatitis C viral load, and so on. Additional multiplex technologies are in development. Utilizing these technologies would allow for cost savings, efficiency gains, and improved patient impact through integrated systems and networks and faster testing.

Regulatory approval

A clear and structured regulatory approval process has been implemented. That framework includes a common dossier for submission and review, e-registration, and evaluation at one of the following national reference laboratories:

- Cipto Mangunkusumo Hospital (RSCM) for serology (RDT and enzyme-linked immunosorbent assay/EIA), and pre-market and post-market reagent evaluation.
- Dharmais Hospital for EQA for CD4, viral load and EID.
- Virology Lab Microbiology University of Indonesia for HIV drug resistance (DR).

Additionally, several requirements must be met prior to achieving regulatory approval, including:

- Manufacturer licence: ISO 13485 (Quality Management System).
- Distribution license (IPAK): Good Distribution Practice, Good Manufacturing Practice.
- Registration license: ASEAN Common Dossier Submission Template (CDST).

Technical evaluations have provided significant data on HIV rapid diagnostic tests, in particular, to support algorithm generation. For other test types, in particular EID, viral load, and point-of-care testing, full national technical evaluations should be reconsidered, particularly when international regulatory approval (such as WHO prequalification) and/or significant published evidence already exists. This would reduce the time to national regulatory approval and allow for faster implementation of critical tests.

There is some consideration of regulatory harmonization efforts across the region and globally, including the Global Harmonization Task Force (GHTF) and International Medical Device Regulators Forum (IMDRF).

Genotyping (drug resistance testing)

The 2011 review recommended that the reference laboratory at the Microbiology Department of the University of Indonesia be supported to achieve national referral qualification by the WHO for HIV drug resistance genotyping.[20] This process remains ongoing and should be continued. Additionally, continuing and finalizing the current drug resistance surveillance survey will be informative in understanding current national drug resistance profiles.

[20] Ministry of Health of the Republic of Indonesia. Review of the Health Sector Response to HIV and AIDS in Indonesia. Jakarta: Ministry of Health; 2011.

Recommendation 10

The Ministry of Health has endorsed the global 90-90-90 and FastTrack targets for eliminating HIV by 2030.[21] In order to reach these targets, the HIV programme needs to make substantial improvements in identifying people who are HIV-positive, linking them to treatment and care services, and monitoring them appropriately. Below are several recommendations that build on those in Section 11.1 above:

10.1 Expand early infant diagnosis testing

10.1.1 By early 2018, the Ministry of Health should train and implement decentralized dried blood spot sample collection at all facilities with PMTCT services. The use of more efficient results reporting mechanisms, such as mHealth interventions (ie. GPRS/SMS printers) should be considered as a way to reduce turnaround time.

10.1.2 By the end of 2017, the Ministry of Health should implement better pricing through the Roche Global Access Pricing deal, of which Indonesia as an included country should be able to access the $9.40 proprietary reagent pricing. Rapidly update Roche viral load technologies to automated devices to access this reduced price. Once established, negotiations with other suppliers should be conducted.

10.1.3 By 2019, the Ministry of Health, through provincial health offices, should implement a clinician training and patient education programme aimed at increasing the demand for and use of EID testing.

10.1.4 By the end of 2018, the Ministry of Health should provide guidance for laboratories to integrate EID testing with existing nucleic acid technologies, taking into particular consideration the availability of multiplex technologies. Point-of-care technologies should be considered for rapid regulatory approval (considering international regulatory approvals, including WHO prequalification, without full national evaluations).

10.2 Improve capacity for HIV viral load testing to monitor patients on ART

10.2.1 By the end of 2017, the Ministry of Health should develop a clear strategic plan for viral load implementation and expansion, including patient mapping and site selection/device placement; service and maintenance; quality assurance; training and certification; supervision and monitoring; clinician training and demand generation; procurement, supply chain, and financing; technology integration; sample transportation and logistics management; and data integration.

10.2.2 By the end of 2017, the Ministry of Health should implement better pricing through the Roche Global Access Pricing deal (see Recommendation 10.1.2 above).

10.2.3 The Ministry of Health should consider alternative purchasing options, for implementation by 2019, such as reagent rentals bundling and negotiating for an all-in per test price (including capital, test price, service and maintenance), which allow for quicker technology change when needed and ensure faster supplier servicing of broken technologies. Procurement should be centralized to ensure all aspects of testing are covered.

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[21] UNAIDS. 90-90-90: An Ambitious Treatment Target to Help End the AIDS Epidemic. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2014; UNAIDS. Fast-Track - Ending the AIDS Epidemic by 2030. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS). 2014 [cited 5 Feb 2017]. Available from: http://www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report.

10.2.4 By 2019, funding mechanisms should be considered by the Ministry of Health to ensure that viral load testing is free of charge for all HIV-positive patients. The Ministry of Health should allocate resources to ensure that patients are not expensed.

10.2.5 By 2019, the Ministry of Health should provide guidance to provincial health offices and implementing partners on establishing a sample transportation network, rather than patient referral systems. The utilization of decentralized dried blood spot sample collection at all ART sites should be considered.

10.2.6 By 2019, the Ministry of Health, through provincial health offices, should increase demand for viral load testing through clinician training and patient education.

10.2.7 By the end of 2018, the Ministry of Health should provide guidance for laboratories to integrate viral load testing with existing nucleic acid technologies, taking into particular consideration the availability of multiplex technologies. Point of care (POC) technologies should be considered for rapid regulatory approval (considering international regulatory approvals, including WHO prequalification, without full national evaluations).

10.3 Ensure patient access to high quality HIV and HIV-related testing

10.3.1 Implementation of the laboratory strategic plan and all components, including improved sample transportation networks and quality assurance systems, by 2020, should be prioritised by all levels of the HIV and laboratory programmes.

10.3.2 Laboratory testing (including CD4 testing, chemistry, haemoglobin, etc.) should not be a pre-condition to ART initiation. This should be adjusted in the next guideline revision by the Ministry of Health, by the end of 2017.

10.3.3 By 2018, the Ministry of Health should provide guidance to all laboratories and health care facilities that patients should be provided with HIV and HIV-related tests free of charge, in order to ensure high quality treatment and care.

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11. Enhancing procurement and supply systems

Introduction

The national AIDS programme (NAP) has ambitious plans in the next three years to scale up numbers of people tested, antiretroviral treatment (ART) patients, and treatment facilities. According to the Ministry of Health 2015-2019 National Action Plan,[1] the 2019 targets are as follows:

- **3.3 million people tested**, representing a 260% increase from the 1,263,871 people tested in 2015.
- **167,120 patients on ART**, which would require a scaling up of 250% from the current number of patients on treatment.
- **10,759 health facilities providing counselling and testing**. As of September 2016, there are 3024 such facilities, requiring an increase of over 350%.
- **3949 health facilities providing ART**. During the writing of this Review there were 592 such facilities, implying that the number of facilities will have to grow nearly sevenfold in the next three years.

With such exponential growth planned, resilient procurement and supply chain management (PSM) becomes even more critical to ensure an uninterrupted supply of HIV commodities, including antiretroviral drugs (ARVs), lab reagents, methadone, OI/STI drugs, condoms, lubricants, and syringes.

Another important consideration affecting procurement and supply chain management is the decentralization of ARV distribution responsibilities from the central level to the provincial and district levels. At the time of this Review, 25 of the 34 provinces are already managing distribution to the districts and health facilities, with 5 of those 25 provinces further decentralized to the district level. The future direction is to extend decentralization to all provinces and have more provinces decentralize to the district level.[2]

Progress since the 2011 Review

The 2011 review did not have an in-depth look at procurement and supply chain management, and the only recommendation was simply to "Continue strengthening of the HIV commodities procurement and supply chain to ensure uninterrupted services."[3]

For the 2017 Review, a comprehensive review of the whole supply chain was undertaken, covering forecasting, procurement, distribution, storage, inventory management, and last mile delivery, with a particular focus on ARV. In addition to the respondents noted in the Methodology section, reviewers also consulted the national AIDS programme and other stakeholders such as ARV and reagents manufacturers, distributors and other relevant departments in the Ministry of Health.

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[1] Ministry of Health of the Republic of Indonesia. Rencana Aksi Nasional Pengendalian HIV dan AIDS Bidang Kesehatan 2015-2019 (*National Action Plan for the Control of HIV and AIDS in the Health Sector 2015-2019*).

[2] Dinihari TN. Progress 2011-2016. during the TB and HIV Progress Report session for the External Review of the HIV Response 2017, 16 January 2017 in Jakarta.

[3] Ministry of Health of the Republic of Indonesia. 2011. Review of the Health Sector Response to HIV and AIDS in Indonesia 2011. Jakarta: Ministry of Health and World Health Organization.

Although a number of key issues persist (see section 12.3 below), since 2011 good progress has been made in the procurement and supply chain management of ARV overall, namely:

- Built-up experience within the NAP team, complemented by Global Fund-hired staff support.
- Decentralization of ARV management to the province and district levels.
- Expanded use of online monthly reporting of patient regimens and ARV dispensed via the HIV and AIDS Information System (SIHA) from all facilities.
- Introduction of online tendering and direct purchase of ARVs registered in the government's e-Catalogue.
- Increase in the Government of Indonesia (GOI) budget to cover 98% of ARV procurement, compared to 88% in 2011.

More details can be found in Table **12.1.** It is important to note that for other HIV commodities, the progress has not been as consistent as for ARVs.

Gaps in the national response

The main gaps identified in the Review are as follows:

ARV supply sustainability

The budget needed for ARVs is growing at a much faster rate than the increase in number of patients on ART, thus creating long-term budgetary concerns for the government. For example, the procurement cost tripled from 2015 to 2016 while the number of patients on ART increased by less than 50%.[4] The 2017 budget required is around USD $90 million for the targeted 138,000 patients on ART,[5] which is effectively $650/patient per year with nearly 97% on 1st line.[6]

Table 11.1 ARV procurement and supply chain management progress since 2011

	PROGRESS ACHIEVED SINCE 2011
1. Forecasting	• 2012: Excel-based forecasting tool developed and used for determinating annual ARV procurement quantity. • 2016: forecasting tool enhanced and upgraded (still excel-based); now called ARV Forecasting and Supply Planning (ARFAST).
2. Procurement	• ARV procured with GF funding using Pooled Procurement Mechanism. • ARV procured with government budget using E-catalogue and E-tendering, helping the procurement process to be more transparent and competitive
3. Distribution	• Decentralization of ARV management from 4 Provinces in 2011 to 33 provinces and 65 districts by December 2016.

[4] In 2016, 18 months were procured whereas in 2015 only 13 months of stock was procured due to budgetary constraints. Source: AIDS Sub-Directorate, Ministry of Health of the Republic of Indonesia.

[5] Dinihari TN. Progress 2011-2016. Presentation in: Progress Report (TB and HIV); 16 Jan 2017; Jakarta.

[6] Ministry of Health of the Republic of Indonesia. Laporan Situasi Perkembangan HIV-AIDS & PIMS di Indonesia Juli-September 2016. (*HIV, AIDS and STI Report, 3rd Quarter 2016*). Jakarta: Ministry of Health; 2016.

	PROGRESS ACHIEVED SINCE 2011
4. Storage	• Storage transitioning from Kimia Farma Warehouse at the Provincial level towards PHO and DHO warehouses.
5. Inventory Management	• Facilities reporting stock-outs have dropped from 3.8% in 2011 to 1.52% in 2016. • 592 facilities have access to SIHA and most are reporting monthly.
6. Las Mile Delivery	• GF funded program for CSOs to support health facilities with stock monitoring.

Stakeholder coordination across fragmented supply chains of HIV commodities

There are three procurement processes for ARV alone: government tender, e-catalogue and Global Fund, each with differing logistics mechanisms. Separately, supply chain mechanisms for reagents, OI/STI drugs, methadone and prevention commodities are all different. Such disparate supply chains require better coordination among the multiple actors involved within the system, including the NAP, the Directorate General of Pharmaceutical and Medical Devices (Binfar), the National AIDS Commission, suppliers, provincial health offices, district health offices, health facilities and CSOs, in order to prevent stock outs and product expiration. Frequently, the various actors act in silos.

Long ARV procurement cycle

From forecasting to delivery at health facilities requires around 15-18 months with the government tender process. The Global Fund procurement process is slightly shorter at 8-10 months. Procurement is done once a year for both processes, but the Global Fund is more flexible, with staggered deliveries and the ability to change the product mix as long as it is within the same budget.

Stock outs and expired products

- ARV: Despite the reported decline in the percentage of facilities reporting ARV stock outs, stock outs still persist in the various locations visited for reasons such as untimely reports and inability to procure fixed dose combinations (FDCs). Paediatric ARV stock outs were reported as a frequent occurrence and an option to address that is crushing adult tablets, a procedure commonly adopted. However, considering that the crushing procedure requires specific tests of safety and efficacy, we suggest a purchase of the medicines in the correct dosage for children.[7,8]
- Condoms: Condoms were consistently reported out of stock across a number of districts visited or interviewed. Some of the reasons cited were transportation costs from province to district and late deliveries during holiday seasons.

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[7] WHO. Promoting Safety of Medicines for Children [Internet]. Geneva: World Health Organization (WHO); 2007 [cited 11 Feb 2017]. Available from: http://www.who.int/medicines/ publications/essentialmedicines/Promotion_safe_med_childrens.pdf.

[8] European Medicines Agency. Guideline on pharmaceutical development of medicines for paediatric use. London: European Medicines Agency; 2013.

- Reagents: There is no coordinated effort on the purchasing and reporting of reagents across the decentralized structure, so overstock occurs. Given the short shelf life of CD4 and viral load reagents and the low number of tests performed in certain facilities, product expiry is an issue.

Tools and systems

SIHA is currently widely used by all health facilities that provide ARV. From the visits and interviews, it was clear that SIHA is well received, and data collected through SIHA is critical to the programme. Users like that it automatically forecasts the three months' ARV stock to be requested. However, SIHA needs to be enhanced in order to support the NAP's growth plans in the coming years. Key deficiencies include:

- No inventory management system module and no early warning system. Users need to record stock in/out somewhere else in parallel with recording patient regimen (both are usually paper-based). Data is only inputted monthly into SIHA, increasing the chance of stock outs between reporting cycles. The NAP has used social media as an informal way to identify stock outs at the field level.
- Lack of ability to pull reports for regimens outside of standard 1st line. This requires a full-time employee at central level to spend 2-3 weeks each month to compile the data manually.
- SIHA does not encompass other HIV commodities. A reagents module is immediately needed, as the NAP does not have visibility or control of reagents being used at province/district/health facilities. There is no system for inventory control although the central government provides reagents, as do provinces, districts and hospitals. If HIV tests are to be provided at each TB site, better planning of rapid tests is crucial, and smaller packs of rapid tests will be required as many TB sites do not generate enough volume to use all 100 rapid tests/pack (standard purchase) within a month of opening the box.
- SIHA often crashes, which frustrates and lengthens the process of data entry for many facilities.

The current ARV Forecasting and Supply Planning tool (ARVFAST) has been developed with central level needs in mind. Now that the NAP is planning to decentralize forecasting to a number of provinces in order to share responsibility and increase accuracy, ARVFAST will need to be modified accordingly.

Storage conditions

Primary challenges for storage occur at provincial/district/health facilities level due to a lack of temperature-controlled areas for ARVs as well as condoms. This issue may be exacerbated as storage is transitioned from the Kimia Farma warehouses to provincial and district warehouses.

Human resource capacity

At the central level the supply chain and logistics team consists of two civil servants, only one of whom is fully dedicated to procurement and supply chain management issues, approximately five staff hired by the Global Fund and another one hired with support from the Clinton Health Access Initiative (CHAI). The scope of work for the staff varies according to funding origin and commodities, with ARV being the most comprehensive. Existing staff capacity is sufficient for the current workload at operational level, but as the NAP scales up its programming to reach its 2019 targets, more strategic and analytical work will be needed to monitor and manage ARVs and other HIV commodities. Different skill sets are needed in addition to the existing team's capacities.

At provincial/district/health facility level, the key issue is high turnover, and in some cases a lack of knowledge of supply chain basics. Consistency and continuity are often compromised due to a lack of succession planning. This leads to inaccuracies, late or no reporting. For example, as the number of ARV facilities increased, the nationwide percentage of facilities reporting dropped from 87% in 2012 to 79% in 2015.

Recommendation 11

Based on gaps identified in the previous section, we identify the following responses that can be taken as part of Indonesia's HIV/AIDS actions in the next three to five years.

11.1 Build a cost-effective and resilient supply chain, starting with procurement

11.1.1 To safeguard programme sustainability, the Ministry of Health and its partners should conduct, by 2018, a risk assessment of the entire current supply chain system, in particular a costing analysis for all HIV commodities, to understand the key drivers for higher cost differentials compared to international pricing. The analysis should include unpacking the whole procurement process for each channel and commodity. It will require a multi-stakeholder approach to identify bottlenecks in the system across in-country company, drug and patent registrations; stakeholder coordination; transparency and accountability systems; distribution and warehousing costs; and the e-catalogue process. ARV should be prioritized as it is the key driver of the HIV budget. As at the writing of this report, USAID, UNDP and the World Bank are looking to undertake this task. To ensure quality procurement of medicines and reagents used across the health system, state and non-state actors should adopt products that are on the list of WHO pre-qualified products.

11.1.2 Starting with the 2018 procurement cycle, the National Public Procurement Agency (LKPP) should allow access to the procurement system (LSPE) for all actors involved, including the NAP, in order to be able to track the current status and party responsible within the entire procurement process. This will not only ensure proper logistic planning for the NAP, but will also ensure full transparency and accountability with the potential to accelerate the procurement process.

11.1.3 The Ministry of Health and its partners should facilitate and accelerate the process to have the existing ARVs and reagents registered in the e-catalogue by 2018. This will help reduce the long procurement cycles by way of direct purchasing.

11.1.4 By the end of 2017, the Ministry of Health and its partners should conduct a thorough analysis of paediatric ARV demand and supply chain issues and identify solutions to provide the right type of drugs, dosage strength, and quantity to every facility that treats children. Due to the small volumes needed by the country, it is recommended that the Global Fund procure them initially. By the 2018 procurement process, the Ministry of Health should ensure the ability to procure all paediatric ARVs required by the country and per the national guidelines.

11.1.5 **Quick win**: For the upcoming procurement cycle in 2018, the Ministry of Health and its procurement partners should purchase lower count packages of rapid tests for low volume TB/ART sites to avoid expiries.

11.2 Increase accuracy and efficiency by strengthening PSM tools and systems

The Ministry of Health, with the help of its partners, should strengthen the existing PSM tools and systems in the following ways:

11.2.1 Develop an inventory management module within SIHA by the end of 2017 to allow day-to-day stock recording and control of ARVs. It should be mandatory for users to record daily dispensation into the system. The module should be available on an offline basis and via mobile phone. An Early Warning System (EWS) should be a part of this module so that it automatically alerts the user when stock is low. This can be a simple colour-based system of red, yellow, green, similar to the RRonline system the Global Fund team uses for prevention commodities. As a complement to the EWS, particular social media hashtags can be used to crowdsource information from communities. For example, civil society organisations (CSOs) or patients can post #outofchocolatesyrup on Facebook, Twitter, etc. whenever Efavirenz stock is low. The HIV, AIDS and STI Sub-Directorate and provincial and district health offices can then pull all these hashtags to see the frequency and location of the reporting.

11.2.2 Explore an off-the-shelf solution or develop an inventory management system for reagents, starting with rapid and viral load tests, to be implemented by 2018. The system should have similar functions as those of ARV in SIHA, allowing for stock control, orders, and inventory management. The system should be accessible by the NAP, provincial and district health offices, and health facilities, and responsibility for maintaining accuracy should be shared. Using the system, the NAP as well as provincial and district health offices should be able to create follow-up reports and ascertain the actual number of tests performed and test results, confirming whether guidelines are being followed. The system would also help doctors to evaluate and monitor ARV treatment effectiveness. Ideally, this solution should be integrated into, or live on, the SIHA platform.

11.2.3 Modify ARVFAST to allow some provinces and districts to forecast their procurement needs by 2018. Based on these pilot provinces and districts, roll out an improved ARVFAST in 2019 to most provinces and districts.

11.2.4 **Quick win**: Add reporting capability within SIHA for all regimens, not only standard 1st line, in order to increase efficiency and accuracy by the end of 2017.

11.2.5 **Quick Win**: Increase server bandwidth for SIHA immediately, particularly during high traffic times, to avoid system crashes and time outs.

11.3 Improve the distribution process

11.3.1 By 2018, ensure that roles and responsibilities are clear and distribution costs to districts or health facility levels are calculated and included in the planning and budgeting of all HIV commodities.

11.3.2 By the end of 2017, the Ministry of Health, together with the National AIDS Commission, should analyze and resolve the gaps in the distribution of prevention commodities, i.e. condoms, needles, syringes and lubricants, particularly at district and outlet levels.

11.3.3 Set standard operating procedures (SOPs) for ARV stock lending by the end of 2017. While lending stock between health facilities is a creative solution to prevent stock outs, there is currently no clear guidance on what the procedures should be. With the increase of ART sites

and wider coverage areas, the flexibility of ARV stock movement—following clear guidelines—between health facilities can reduce stock outs in difficult to reach areas.

11.4 Streamline storage

11.4.1 Quick Win: At the district level, store prevention commodities together with other drugs in pharmacies, which have controlled temperature, by the end of 2017. Currently they are stored separately and most of the warehouses storing prevention commodities do not have a temperature-controlled area.

11.5 Invest in PSM human capital

11.5.1 By mid-2017, the NAP should complete a skills analysis for the PSM team to prepare for the exponential scale-up towards the NAP's 2019 targets. Missing skills in the team should be filled by the beginning of 2018; secondment may be necessary at the start.

11.5.2 By 2018, establish succession planning and transition documentation to be systematically put in place at ART sites, starting with facilities with the largest number of patients on ART. Training and refresher trainings on inventory management, SIHA reporting (including the new modules mentioned above), and regimen guidelines should be provided on an as-needed basis.

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12. Managing and using programme data

An analysis of the epidemiological status and trends of the HIV epidemic in Indonesia was undertaken in December 2016 by a team of national and international experts.[1] This study yielded valuable information and noted some of the strengths and weaknesses of epidemiological data and its management in Indonesia. However, the study does not discuss the strategic information system - a topic beyond the scope of the analysis assigned to the team of experts. This chapter highlights how and when strategic information is collected, aggregated, analysed, and used. The discussion covers the strengths and weaknesses of the current strategic information system and recommends actions that could be taken to strengthen it.

Routine data (HIV and AIDS case reporting)

All provinces in Indonesia have reported HIV and AIDS cases based on clinical signs and laboratory confirmation as per WHO standards. Any individual who has a positive HIV test and whose HIV infection is at WHO clinical stage 1 or 2 is reported as an HIV case, while anyone at WHO clinical stage 3 or 4 is reported as an AIDS case. HIV case notifications come from government and NGO voluntary counselling and testing (VCT) centres and health services such as prevention of mother-to-child transmission of HIV (PMTCT), tuberculosis (TB), and others. The number and proportion of people living with HIV/AIDS by age, sex and province have been reported since the 1990s. National level HIV data have also been disseminated through the websites of the Spiritia Foundation[2] (up to March 2016) and the AIDS Indonesia Community (only through 2009).[3] HIV data at district and provincial level are less accessible than the national data, and are usually presented to a limited number of HIV stakeholders at coordination meetings in the provinces or districts.

Since 2013, all provinces in Indonesia have begun to record new HIV diagnoses in the web-based application, SIHA (*Sistim Informasi HIV/AIDS dan IMS, or the HIV/AIDS and STI Information System*) (**Figure 12.1**). SIHA was developed by the national AIDS programme (NAP) and the Ministry of Health's Data and Information Centre (Pusdatin), with the NAP providing the programme data and Pusdatin being responsible for analysis and dissemination of the results.[4] The development and implementation of SIHA is a vast improvement of the HIV information system in Indonesia and will provide important and comprehensive data for the HIV programme if it is properly maintained.

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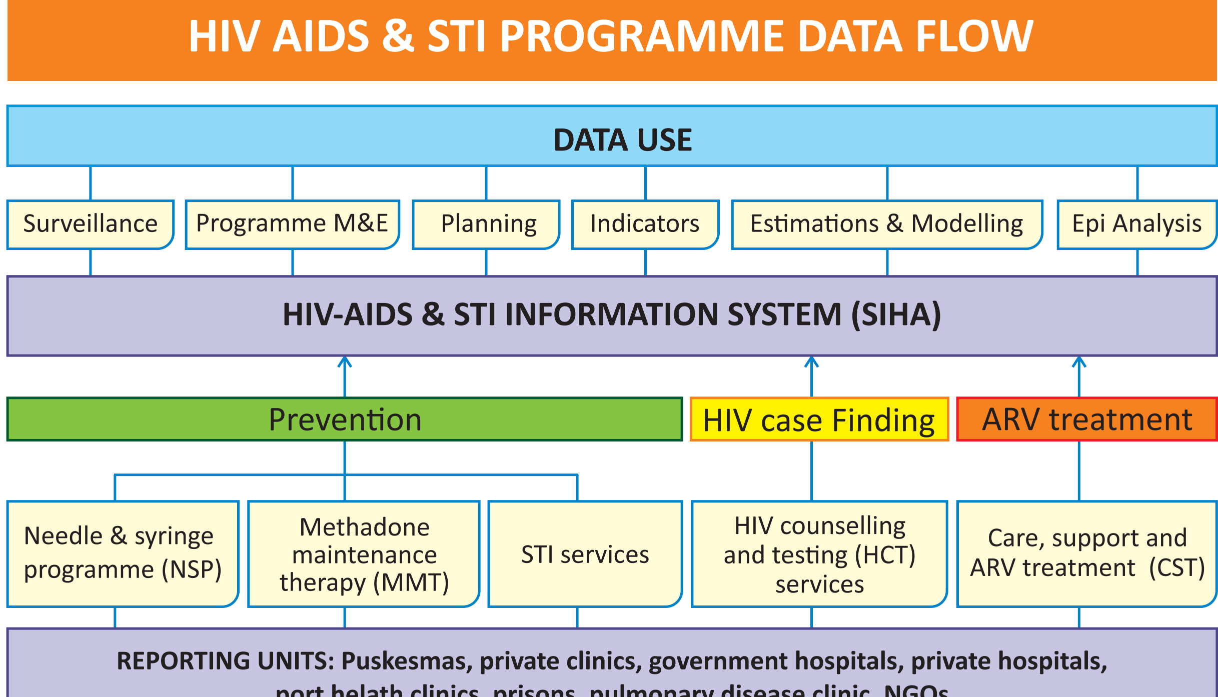
[1] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[2] Yayasan Spiritia. Laporan Kemenkes (*Ministry of Health Reports*) [Online]. Jakarta: Yayasan Spiritia; 2016 [cited 20 Jan 2017]. Available from: http://www.spiritia.or.id/stats/statistik.php.

[3] Komunitas AIDS Indonesia. Data Kasus: Daftar Data Kasus (*Case Data: List of Case Data*) [Online]. Jakarta: Komunitas AIDS Indonesia; 2009 [cited 21 Jan 2017]. Available from: http://www.aids-ina.org/modules.php?name=Data_Cases.

[4] Pusdatin. Jakarta: Pusat Data dan Informasi Kementerian Kesehatan Republik Indonesia; 2014 [cited 21 Jan 2017]. Available from: http://www.pusdatin.kemkes.go.id/folder/view/01/structure-publikasi-pusdatin-info-datin.html.

Figure 12.1. Programme data flow in SIHA



Data are being collected and recorded at health facilities and reported to the district and then the provincial health office, which then reports to the Ministry of Health. Site visits in Maluku and Jakarta provinces and focus group discussions (FGDs) with stakeholders from Aceh, Jakarta and Bali revealed findings on how data are being collected, analyzed and interpreted, and disseminated to others at different levels, which are presented below.

Recording and reporting

- **Lack of infrastructure.** Several recording and reporting staff in health facilities in Maluku and Jakarta[5] reported having to use their own personal laptops and internet access due to the lack of data entry facilities. Some provincial staff reported that reports are not always received online due to poor internet access at the sites. One public health facility on a remote island reported having to provide paper-based reports due to the lack of internet access, and consequent late reporting when bad weather prevented a sea crossing.

- **Overburdening.** It is very common for recording and reporting staff to hold two or three positions at the same time; as a result, data input is not done on a daily basis in all health facilities. Some sites reported large quantities of data to be recorded and too many registers, such as VCT, pre-ART, ART, TB, and PMTCT, that need to be filled in.[6] When there are different funding sources, each donor also requires specific data and uses different forms or systems; the National AIDS Commission also requires data but uses a system that is different from SIHA. The frequent improvement and updating of SIHA[7] since its launch has also given rise to issues at the practice level, particularly in health facilities.

[5] Site visits to primary health clinics (PHCs) in Ambon, Maluku; Langgur, Maluku; and Jakarta on 19-20 January 2017.

[6] Focus group discussions with health facility staff in Jakarta, 18 - 20 January 2017 and site visits in West Kalimantan, 18 - 20 January 2017.

[7] Reported by staff at a government facility in West Kalimantan and an NGO in Bali: the National AIDS Commission system records the profile of key populations and outreach and testing coverage.

- **Capacity of staff.** Some areas report rapid rotation of recording and reporting staff in hospitals and public health centres.[8] In Maluku, most had been working for <1-3 years. Although on-the-job training on SIHA is provided, some staff prefer to report VCT data on paper or by text message,[9] and as a result districts and provinces have only aggregate, rather than individual, data available in SIHA. A lack of capacity for data analysis was also reported.[10]

- **Data quality.** Incomplete and inconsistent data is an issue all the way up the reporting chain. Recording and reporting staff report receiving incomplete VCT/CST forms from the staff providing the services.[11] Districts report receiving incomplete and inconsistent data from health facilities. Province staff cited late reporting, inconsistencies such as unbalanced numbers of patients under age and sex categories, and misplaced categories, where, for example, pregnant mothers and TB patients are not assessed for their risk factors, and are therefore all included in the category "others" on the VCT form. This also accounts for the number of patients in the "others" category being higher than those under the risk factor categories such as heterosexual, MSM, PWID or transgender. Province staff reported that in many health services staff have to be reminded to send their reports at the end of the month. Data inconsistencies and the absence of any assessment of data quality were also reported in Jakarta.[12]

- **NGO participation in reporting.** This was not assessed in depth, but information from Maluku indicated that NGOs routinely report outreach numbers to the provincial and district health office.[13] This may not be the case in other provinces.

Thus, due to the issues above, notification reports are subject to under-diagnosis, underreporting, sub-notification, notification delay and other biases.

Data analysis and interpretation

Data is analyzed at all levels, starting from the health facilities to district and provincial health offices, and the Ministry of Health. While Pusdatin takes care of data analysis at the national level, at the provincial level the Komdat[14] (*Komunikasi Data*/Data Communication) should be responsible for analyzing data from the districts. In addition to HIV data, the Komdat also analyzes other health-related data such as health status, health resources, and determinants of health. The Komdat is not yet functioning optimally, one reason cited being the delay in data reporting from district health offices. [15]

Staff capacity for data analysis varies:

- **Health facilities/clinics.** A lot of data is being collected, but in general there seems to be little capacity to determine how it should be analysed, digested and used to improve clinic performance.[16] In some cases, the selection of variables for presentation is incorrect, for example, no distinction between total number

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[8] Site visits in Ambon and Langgur, Maluku, 18 - 20 January 2017.

[9] Site visit in Ambon, Maluku, 18 January 2017.

[10] Site visit in Jakarta, 19 January 2017.

[11] Site visit in Ambon, Maluku, 18 January 2017.

[12] Site visit in Jakarta, 19 January 2017.

[13] Site visit in Ambon, Maluku, 18 January 2017.

[14] Komdat. Aplikasi Komunikasi Data (*Data Communication Application*) [Online]. Jakarta: Ministry of Health Data Communication; 2013 [cited 25 Jan 2017]. Available from: http://www.komdat.kemkes.go.id/lama/index.php.

[15] Statement by the Ministry of Health in a meeting on 22 January 2017.

[16] Site visits in Maluku, 18-20 January 2017, and Jakarta, 18-19 January 2017.

of visits and number of new visits and the correlation with the number of HIV-positive cases; not distinguishing the number of positive tests from each service (VCT, PMTCT and TB), etc. There are exceptions, however, and strong capabilities for data analysis and interpretation were reported at some facilities in Jakarta, particularly large NGOs.[17]

- **District health office.** The analysis and interpretation of simple descriptive statistics is better than found in the clinics, with staff able to analyze and combine key variables. However, an understanding of the purpose of such analysis, or how to interpret it, is not always present.[18] It is important to note that staff capacity in a district is influenced by factors such as frequent rotation and overburdening. Moreover, strategic positions at district health offices are not always handled by health staff, which may also indirectly impact the management of programme data.[19]
- **Provincial health office**. Much higher capacity was observed at this level. AIDS programme staff were able to conduct more complex analysis and interpretation, and apply the results to assess the epidemic situation in the area concerned.[20]

Data dissemination

As mentioned above, national SIHA data are routinely disseminated through the Pusdatin website, but in most provinces and districts it is not yet provided on the Komdat Pusdatin website. The Review findings are as follows.

- **Health facilities (clinics)**. Data are presented at routine coordination meetings, but this was not assessed in depth. Some areas reported little feedback from the district and province health offices.[21] Some NGO clinics in Jakarta performed better on data dissemination, such as Yayasan Spiritia, which provides a lot of data on its website, but this is not necessarily the case elsewhere: for example, dissemination of data by Maluku-based NGO Yayasan Pelangi Maluku is very limited.
- **District health office.** At the sites visited, routine data were disseminated through coordination meetings every three to six months, which are attended by the district AIDS Commission, public health centres and hospitals and other stakeholders, although in some areas, stakeholders such as the district education, transmigration and tourism offices and district councils report being less informed.[22] Data are also not widely disseminated to other stakeholders such as religious leaders. Meetings tend to focus on numbers, trends and operational obstacles. Some district health offices also expressed a wish for more feedback from the provincial health office to guide improvements at the health facility level.
- **Ministry of Health.** The Ministry of Health disseminates HIV information through routine coordination meetings with provinces and through the web-based information system, SIHA.[23] SIHA provides basic information on, among others, the number of HIV cases by age, sex and province; yearly trends, and mortality trends. SIHA does not allow for deduplication of data or for follow-up of individual cases, and because they are not linked to the ART database, data related to CST are not yet disseminated through this website. As the Pusdatin website is also not specifically for HIV information, the possibility of providing more information may be limited; this will need further assessment. The Pusdatin data on the

[17] Site visits in Jakarta, 20 January 2017.
[18] Site visits in Maluku, 18-20 January 2017, Jakarta, 19 January 2017.
[19] Site visits in Langgur, Maluku Tenggara, 19-20 January 2017.
[20] Site visit in Ambon, Maluku, 18 January 2017.
[21] Focus group discussions with stakeholders in Jakarta, 19 January 2017.
[22] Site visits in Langgur, Maluku Tenggara, 20 January 2017, and West Kalimantan, 18-20 January 2017.
[23] Interview with Ministry of Health staff, Jakarta, 23 January 2017.

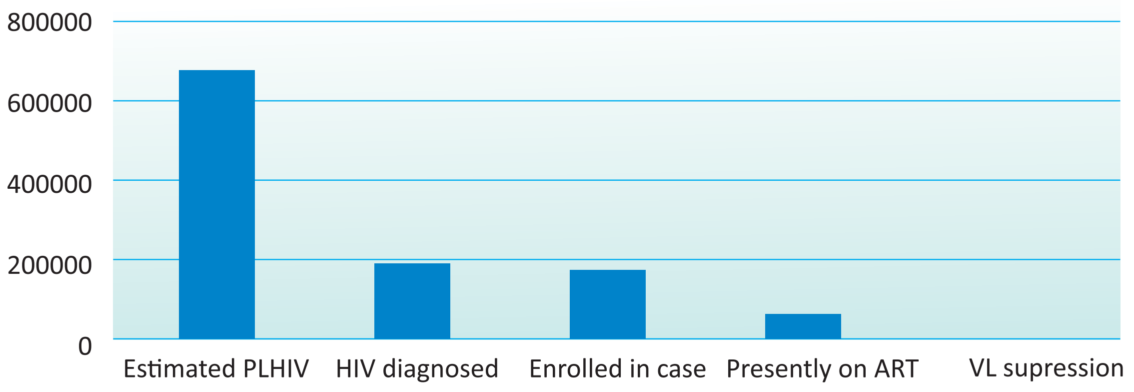
HIV profile in Indonesia were updated on 1 December 2016,[24] and had been accessed only four times (including by the reviewer) as of January 2017. This may imply that the website is not yet well known or well publicised. In addition, at the time of accessing, the website only showed data up until June 2016, which is possibly related to the flow of data from the health facilities to the Ministry of Health. Some NGOs also disseminate data which can be accessed through their websites, however, the Review did not assess whether their routine coverage for outreach, testing, and ART is also reported to the district/province/MOH.

Use of data

The Review looked at how routine data, and data from specific surveys and surveillance, are used.

- **Health facilities.** Data are being analyzed and used in a limited way for logistics planning purposes (e.g. HIV test reagents, ARVs), but not for improving clinic performance.
- **District and provincial health offices**. Analysis and interpretation of routine data is variable. Some districts and provinces are reluctant to use the limited routine data available to assess the characteristics of their HIV epidemics when no other surveys are available. In Maluku and Jakarta, routine HIV data are not being used for advocating (e.g. for funding) to the government or other sources of support (religious leaders, private sector, etc.),[25] as they are in Bali.
- **NGO data.** Many NGOs in larger cities are implementing HIV testing. However, it is not clear whether all these NGOs also report to the Ministry of Health, or whether the Ministry of Health uses such data for planning.
- Data are also used for estimations and projections, and for planning purposes.
- **Cascade analysis.** Routine data are beginning to be used to build a picture of the HIV testing and care cascade at national and (in some cases) subnational levels (**Figure 12.2** and **Figure 12.3**), although data on viral load suppression are not yet available in most provinces. [26]

Figure 12.2. HIV testing and care cascade, Indonesia 2015 (cumulative figures up to 2015)[27]



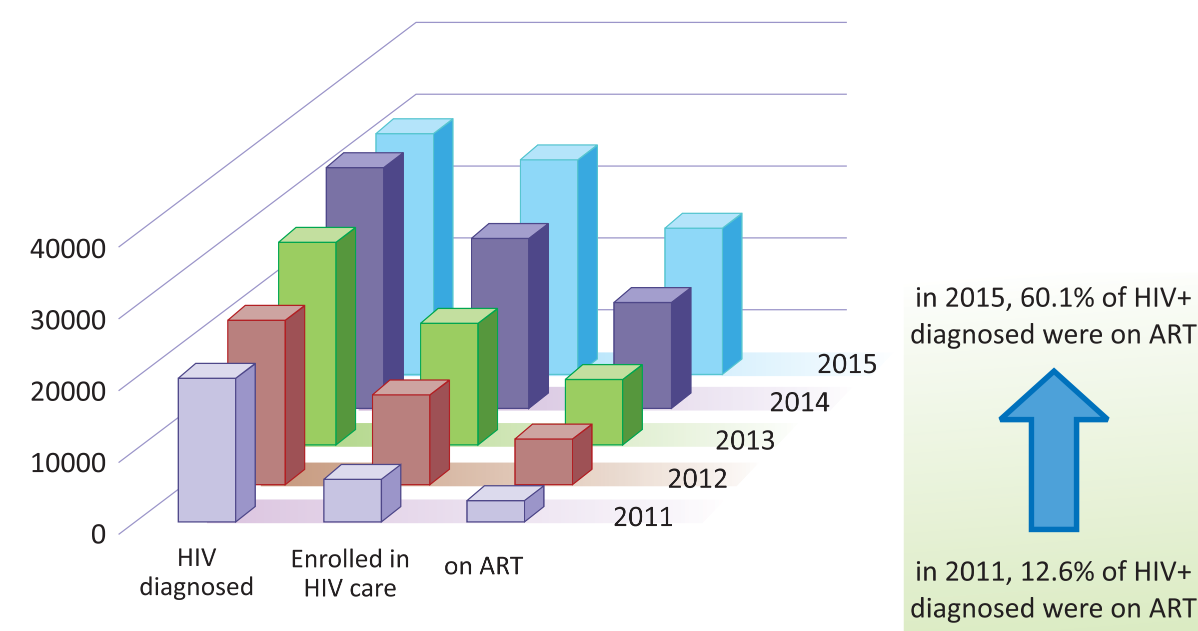
[24] Pusdatin. Situasi Penyakit HIV AIDS di Indonesia [Online]. Jakarta: Pusat Data dan Informasi Kementerian Kesehatan Republik Indonesia; 2016 [cited 25 Jan 2017]. Available from: http://www.pusdatin.kemkes.go.id/resources/download/pusdatin/infodatin/Infodatin-Situasi-Penyakit-HIV-AIDS-di-Indonesia.pdf.

[25] Site visits in Langgur, Maluku Tenggara, 19 January 2017, and Jakarta, 17 January 2017.

[26] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[27] Ibid.

Figure 13.3. Care cascade of people HIV diagnosed per year, comparative analysis 2011-2015[28]



Monitoring and supervision

Monitoring and supervision by provincial and district health office staff to ensure the coverage and quality of data being collected by health facilities was routine in at least one province.[29] This supervision may include on-the-job training on inputting and analyzing data, which is followed up via e-mail, text messaging and phone contact. However, it is difficult to determine whether these processes adequately address the data quality issues mentioned above.

Other Findings

Indonesia already has a comprehensive HIV surveillance system and has adhered to the principles of Second Generation Surveillance since the early 2000s. With this system, reporting of HIV, AIDS and sexually transmitted infection (STI) cases, estimated key populations, sentinel surveillance, and Integrated Biological and Behavior Surveys (IBBS) are generated on a regular basis. One important data source is the centralized inventory of HIV data sourced from routine data collection reported by health providers in health facilities. In addition, surveillance and surveys activities are conducted periodically, generally every year for sentinel surveillance and every 3-4 years for IBBS, in provinces and cities/districts with high HIV disease burden. This periodic process requires personnel with specialized skills and strong supervision, and therefore can produce more accurate data, but at a high cost.

- **STI recording and reporting system**. STI services preceded HIV services, and every public health centre and hospital has to report STI cases to the district and provincial health office. However, the numerous types of STI mean that adequate training is needed not only to ensure a correct diagnosis but also for

[28] *Ibid.*

[29] Site visits in Maluku, 18-20 January 2017.

accurate recording and reporting.[30] In Maluku, very limited information could be found about STIs, despite some good STI services.[31] STI data are not widely used,[32] for reasons that are unclear: it may be due to issues with the accuracy of diagnosis, or recording and reporting, or a lack of awareness about its relatedness with HIV. The Ministry of Health noted that an external evaluation had suggested simplifying the form to assess only four STIs (syphilis, urethral discharge, vaginal discharge and ulcer) to make a sensitive assessment of the risk of HIV, but this has not yet been addressed.

- **HIV-related mortality** data are only available from reported AIDS cases and from ART facilities. However, valid information is currently unavailable, due in part to high rates of loss to follow up and incomplete or absent recording and under-reporting. Moreover, in certain districts, there is no analysis of the demographic or risk factors of those who die, which could provide insights into the HIV situation. In addition, this is considered a weak component of surveillance because AIDS cases represent long-term infections.[33]

- **HIV Sentinel Surveillance (HSS)**. HSS is conducted in selected districts among key populations using convenience sampling, respondent-driven sampling (RDS) or time-location sampling (TLS) with a sample size of 250, and among pregnant women with a sample size of 400. Not all the districts conduct HSS among all key populations due to variations in the key populations targeted.[34]

  HSS is usually done every year in the same key populations in the same districts. However, the epidemic will not grow very fast in the same population. Although criteria are applied when selecting HSS districts, there are no criteria to determine whether it can be conducted in other districts if necessary, or how flexible the HSS is in responding to the dynamics of the epidemic (e.g. if the epidemic among a key population is stable over time in one district but in another district, there is a suspicion that the epidemic has changed, and HSS is needed for confirmation; or if HSS and IBBS are conducted at the same time and in the same target population).

  Although HSS is funded by the central government, there are no regulations to ensure that funding is sustained, and in 2016, the government did not allocate any funding for HSS (central funding has been allocated for 2017). Although HSS is a national responsibility, the Ministry of Health has encouraged province and district health offices to advocate for funding to the local government, but the response has been variable.[35]

  HSS is conducted by local health officials under the guidance of the NAP using updated, standardized guidelines, which are disseminated through training. The last HSS was conducted in 22 districts. Even though it is done under supervision, a number of implementation issues have led to questions about the accuracy of the data. HSS data are available at the district and provincial level, and disseminated to a limited number of stakeholders, but are not openly published.

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[30] Interview with Ministry of Health staff, Jakarta, 23 January 2017.

[31] Site visit in Langgur, Maluku, 20 January 2017.

[32] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[33] *Ibid*.

[34] *Ibid*.

[35] Interview with Ministry of Health staff, Jakarta, 23 January 2017.

- **Integrated Biological and Behavioural Survey (IBBS)**. This is done every two to three years, but at alternate groups of sites ('Group A' districts in one cycle and 'Group B' districts in the next). Thus the key populations in any one district are surveyed every three to four years.[36] The NAP has stated that IBBS is the most reliable of all the HIV surveys available in Indonesia.[37]

- **Blood donation.** In Indonesia, blood donation should be voluntary and not paid.[38] Donor recruitment programmes are directed towards achieving 100% voluntary non-remunerated blood donors (VNRD); current achievement is 81.3%.[39] According to national policy on blood donations, all blood donors should be tested for HIV, HBV and HCV. Blood donation data are not considered optimal for HIV planning as it may underestimate HIV prevalence.[40] However, these data should be available in all provinces in Indonesia and were relatively easily obtained by heath offices.

Recommendation 12

In addition to the recommendations below, this Review also endorses the specific recommendations on routine data, sentinel surveillance, IBBS, population sizes, HIV estimates and STI surveillance presented in the HIV Epidemiologic Review.[43]

12.1 Resolve issues related to data inventory infrastructure, human resource capacity, overburdening and data quality, within the next five years.

12.1.1 The Ministry of Health should encourage province and district health offices to propose other financial sources, such as the private sector as part of their mandatory corporate social responsibility.[44,45]

12.1.2 Provincial and district health offices should propose their financial and human resource needs to local government and the private sector, through established mechanisms (such as corporate social responsibility, or CSR).[46]

12.1.3 The Ministry of Health should provide training on minimum standards for data analysis so that it can be compared among districts and provinces. Training should be provided to the provincial level, and then cascaded down to district staff and health facilities.

12.1.4 The Ministry of Health, including at provincial and district levels, should consider engaging the Field Epidemiology Training Program (FETP) Indonesia, universities and NGOs to provide

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[36] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[37] Stated by the national AIDS programme on several occasions: during the development of the Population Size Estimates in 2016, during the Epidemiology Review in December 2016, and during the Country Review in January 2017.

[38] Regulation of the Government of Indonesia No. 7/2011 on Blood Services, Article VI, section 28 subsection 2. (P*eraturan Pemerintah Republik Indonesia Nomor 7 Tahun 2011 Tentang Pelayanan Darah, Bab VI pasal 28 ayat 2*)

[39] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[40] Endang Sediyaningsih-Mamhit et al. The use of blood donor data for HIV surveillance purposes. AIDS 2004, 18(13):1849-51.

[41] Site visits in Jakarta, 17 January 2017and West Kalimantan, 18-20 January 2017, and by stakeholders in a focus group discussion in Jakarta, 19 January 2017.

[42] Ministry of Health. Size Estimates of Key Populations at risk for HIV 2016. Jakarta: Ministry of Health; 2017.

assistance on data analysis and interpretation capacity building at the district level.

12.1.5 The Ministry of Health should consider developing a simple checklist of indicators of data quality (such as completeness, timelines, consistency, etc.) that can be used by province and district staff when monitoring health facilities.

12.1.6 The Ministry of Health, including at provincial and district levels, should maximise the opportunities provided by coordination meetings with health facility staff to emphasize the importance of data accuracy using the above checklist.

12.1.7 The Ministry of Health should identify training needs for staff in prioritised provinces and districts, and propose a training plan to the Ministry of Health's Agency for the Development and Empowerment of Human Resources, BPPSDM (Badan Pemberdayaan dan Pengembangan Sumber Daya Manusia).

12.1.8 The Ministry of Health should use the results of this Review to advocate to development partners (WHO, UNAIDS) to use existing data rather than adding indicators, and to encourage the development of a data reporting system that is simple, integrated and comprehensive.

12.2 Improve availability of, and capacity to use, data to assess the epidemic status at provincial and district levels, and for advocacy, within the next five years.

12.2.1 The Ministry of Health should consider recommending to the Ministry of Home Affairs that the rotation and placement of personnel in strategic positions should be in line with their expertise.

12.2.2 The Ministry of Health should encourage provincial health offices to assess the level of the epidemic in their province and collect the necessary data at province and district level. The Ministry of Health should provide consultation or assessment and screening tools as necessary to enable them to do, and encourage the involvement of academics in the process.

12.2.3 Provincial and district health offices should encourage local NGOs, private hospitals and private clinics to report their coverage of HIV testing, with results, to provide a better understanding of the epidemic situation in the area.

12.2.4 The Ministry of Health should identify the need for moderate statistic and epidemiologic training for strategic staff in prioritized provinces and districts, and propose a training plan to the BPPSDM.

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[43] Ministry of Health of the Republic of Indonesia. HIV Epidemiologic Review Republic of Indonesia 2016. Jakarta: Ministry of Health; 2017.

[44] Law of the Republic of Indonesia no. 40/2007 on Limited Liability Companies, Articles 1, 66, and 74.

[45] Minister of State-Owned Enterprises Regulation no. PeR-05/mbu/2007 on State-Owned Enterprise Partnership Programs with Small Enterprises and Community Development. (*Peraturan Menteri BUMN no. PeR-05/mbu/2007, tentang Program Kemitraan Badan Usaha Milik Negara dengan Usaha Kecil dan Bina Lingkungan*).

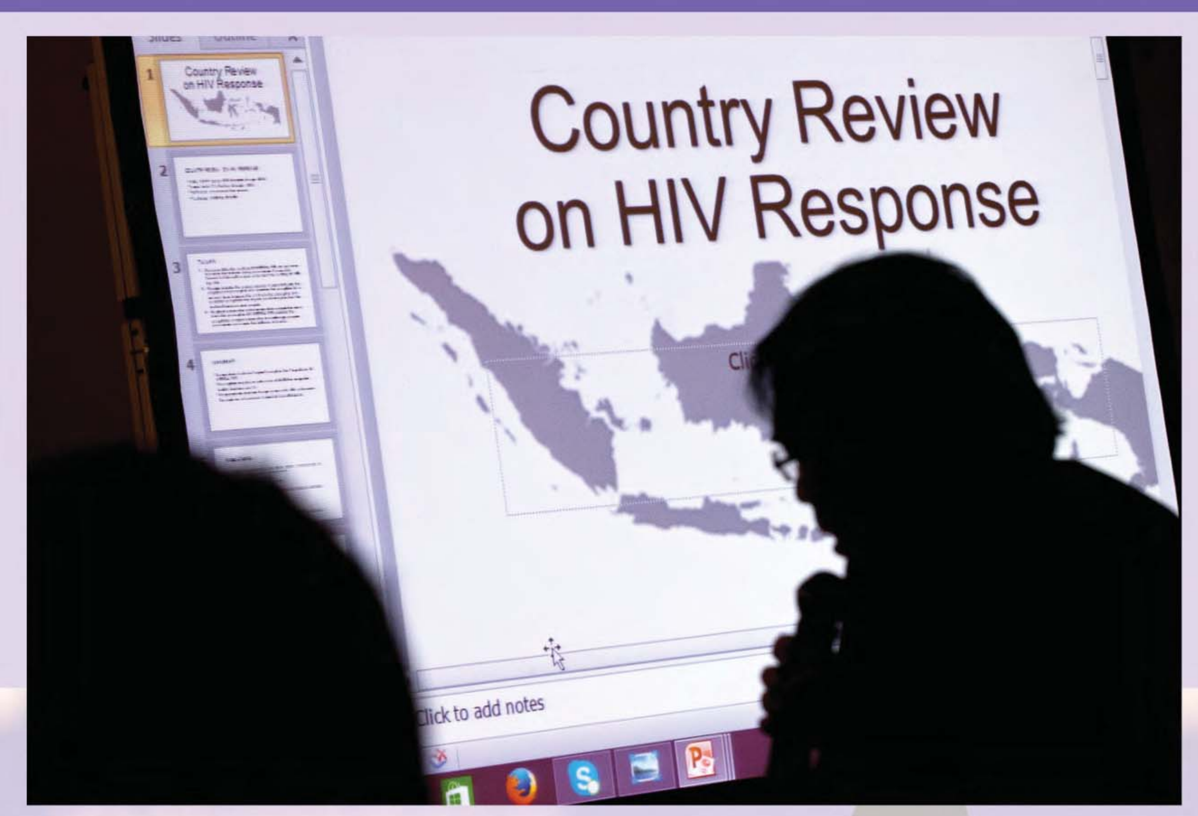
[46] For an example of how this has been done in a sanitation programme, see Sanitation Development Technical Team. Buku Panduan Tanggung Jawab Sosial Perusahaan. Sebuah Potensi Alternatif Pembiayaan Sanitasi (*Sanitation Development Technical Team, 2010. Corporate Social Responsibity Manual. Potential Alternative Funding Sources for Sanitation Development*); 2010 [cited 10 Feb 2017]. Available from: http://www.ampl.or.id/digilib/read/45-buku-panduan-tanggung-jawab-sosial-perusahaan-corporate-social-responsibility-csr-sebuah-potensi-alternatif-sumber-pendanaan-sanitasi/2896

12.2.5 The Ministry of Health should encourage provincial health offices to strengthen their communication, using available data, with relevant stakeholders, particularly the local AIDS commission, community figures and religious leaders, to strengthen social support for the response. Provincial health offices should do the same with district health offices.

12.2.6 The Ministry of Health should encourage provincial and health offices to do operational research and programme evaluations to be used specifically in the local context.

12.2.7 The Ministry of Health should try to harmonize data reporting from SIHA with other programmes such as maternal, newborn and child health (MNCH) (PMTCT), TB and STI to reduce complexity and make maximum use of the data.

12.2.8 The Ministry of Health should consider shifting the reporting system to a cascade and cohort reporting system.


Country Review
on HIV Response
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13. Sustaining HIV/AIDS financing

The purpose of this section is to explore sustainable financing mechanisms for the national response to HIV/AIDS in Indonesia. The information presented and analysed draws from a review of existing documents, interviews with policy makers and health managers, and focus group discussions.

Progress achieved in financing the HIV programmes

In terms of the financing of HIV programmes, the following achievements have been noted since 2011, when the previous review of the national response was conducted.[1]

- Domestic public direct expenditures in support of the national response to HIV have rapidly and steadily increased. **Table 13.1** shows the sources of expenditures and public expenditure on HIV, which doubled between 2011 and 2014 (the last year for which sufficient data were available for this Review). Between 2009 and 2014, domestic public funding on HIV/AIDS increased by 12% annually.[2]
- Financial commitment for HIV programmes from the central government has been increasing, in line with the concurrent decline of international funding. Between 2011 and 2014, the proportion of the international contribution to total expenditures for HIV decreased by 15% (**Table 13.1**).
- The national social health insurance scheme (*Jaminan Kesehatan Nasional*, or JKN) has made a remarkable impact on progress in recent years, which have witnessed a significant expansion of population coverage and funding mobilization. In 2013, funding from JKN accounted for 13% of total health expenditures and 40% of total government health expenditures, covering 60% of the total population (156.8 million). The JKN has become a source of funding for HIV programmes by supporting the prevention and treatment of HIV opportunistic infections, while other HIV/AIDS services were jointly funded between JKN and the government budget, including antiretroviral drug (ARV) provision financed by the Ministry of Health.
- Domestic public funding for HIV programmes has become stable. The National Strategic Plan 2014 target to reach 70% of total spending from domestic public sources[3] was nearly achieved as public funding for sustaining the response to HIV steadily increased. In 2016, 67.7% of HIV/AIDS programme expenditures came from the regular government budget (APBN) and 32.3% from the Global Fund.[4]

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[1] See Ministry of Health of the Republic of Indonesia. Review of the Health Sector Response to HIV and AIDS in Indonesia 2011.

[2] Tandon A, Prambudi ES, Harimurti P, Emiko M, Subandoro AW, Marzoeki P, et al. Indonesia -Health Financing System Assessment: Spend More, Right, and Better [Internet]. Jakarta: The World Bank; 28 Oct 2016 [cited 29 Jan 2017]. Available from: http://documents.worldbank.org/curated/en/453091479269158106/Indonesia-Health-financing-system-assessment-spend-more-right-and-better

[3] Coordinating Minister of the Republic of Indonesia for People's Welfare Regulation No. 8/2010 on the National HIV and AIDS Strategy and Action Plan 2010-2014.

[4] From interviews with representatives from the National Development Planning Agency (Bappenas), 23 January 2017, in Jakarta.

Table 13.1. Expenditure on the HIV and AIDS programme by source of funds 2011-2014 (in million USD)

Source	2011[5]		2012[6]		2013[7]		2014[8]	
	Total	%	Total	%	Total	%	Total	%
Public funding	**30.6**	**41.7**	**37.7**	**42.9**	**51.5**	**52.20**	**60.5**	**56.6**
Central government	22.2		28.2		42.9		43.1	
Local government	7.5		8.7		7.8		11.3	
BPJS[9]	0.8		0.8		0.8		6.1	
International funding	**42.8**	**58.3**	**50.2**	**57.1**	**47.1**	**47.75**	**46.1**	**43.3**
Bilateral	12.6		22.4		15.9		16.6	
Multilateral	30.2		27.7		31.1		29.3	
• Other international	-		-		0.05		0.2	
Private	**-**		**-**		**0.06**	**0.05**	**0.3**	**0.02**
TOTAL	**73.4**	**100**	**87.9**	**100**	**98.6**	**100**	**106.8**	**100**

- Funding for HIV has been extended through more channels than in previous years. District health offices and primary health centres (puskesmas) are aware that when Global Fund support ends as a result of the rapid economic growth in Indonesia, the government will have to mobilize alternate resources and improve the efficiency and effectiveness of the use of funds, including from their own sources such as the regional budget (APBD), capitation and Village Funds (Dana Desa). Village Funds are being mobilized in some districts to support certain HIV/AIDS-related activities such as "Warga Peduli AIDS" (Local Citizens Caring About AIDS), or to support nutrition for PLHIV, or prevention of mother-to-child transmission of HIV (PMTCT) programmes, or even for the transportation of patients.
- The Ministry of Health allows puskesmas to use 40% of their capitation revenue from JKN to support HIV/AIDS work, and even to buy drugs if a stock out occurs. JKN covers inpatient services for the hospital care of PLHIV with complications (opportunistic infections or a deterioration in their health).[10]

[5] Nadjib B, Megraini A, Ishardini L, Rosalina L. Final Report: National AIDS Spending Assessment 2011-2012 [Internet]. Jakarta: Joint United Nations Programme on HIV/AIDS (UNAIDS), National AIDS Commission (ID), Ministry of Health (ID); 2013 [cited 22 Jan 2017]. Available from: http://www.aidsdatahub.org/indonesia-national-aids-spending-assessment-2011-2012-nadjib-m-megraini-ishardini-l-and-rosalina-l

[6] *Ibid.*

[7] Nadjib M, Megraini A, Ishardini L, Rosalina L. Final Report: National AIDS Spending Assessment 2013-2014. DKI Jakarta: Joint United Nations Programme on HIV/AIDS (UNAIDS), National AIDS Commission (ID), Ministry of Health (ID); 2015.

[8] *Ibid*.

[9] BPJS (Social Insurance Administration Organization) claim data for opportunistic infections: see Harimurti P, Masaki E, Langenbrunner J, Guerard Y, Nadjib M, Sucahya P, et al. Integration of HIV into National Social Health Insurance. Jakarta: The World Bank and the Center for Health Research, University of Indonesia; 2015.

[10] From interviews with representatives from the National Development Planning Agency (Bappenas), 23 January 2017, in Jakarta.

Issues in financial sustainability for HIV programmes

Several challenges have to be overcome in order to sustain the achievements that have been made towards sustainable financing of the national response to HIV. These challenges include the need to find new mechanisms to meet the rising demand for HIV funding. The following issues are raised for consideration and early action.

Potential financial spaces for health and HIV programmes

Indonesia is at a relatively low level of share of GDP for health compared with many countries in this region, and other countries enjoying similar economic growth. In 2014, the per capita total health expenditure for health was USD 126, accounting for 3.6% of GDP. This was lower than in lower-middle income countries (averaging 4.2%) and East Asia and Pacific countries (averaging 4.9%).[11]

In 2015, the share of government expenditures on health accounted for a mere 1.7% of GDP,[12] which is much lower than the average of 3.2% in other middle- and low-income countries. Subnational government health expenditure accounted for 50% of the total government health expenditures (38% from district governments and 12% from provincial governments), which may suggest potential for greater local government contributions.

To achieve a fair health financing system, out-of-pocket payments (OOP) need to be low enough (20-30%) to protect people on low incomes.[13] OOP is still high (>40%) in Indonesia.[14] This high financial burden on people could be a result of low public spending on health in general, an increase in health care utilization, limited coverage of JKN, and insufficient availability of services to the JKN-insured. PLHIV and members of key populations often have limited financial resources and need better financial protection in order to access medical care.

There are wide variations in fiscal capacity and willingness to support HIV activities across regions and districts. Subnational contributions are expected to be higher in regions with high fiscal capacity. Among these, Jakarta, for example, has shown its commitment to financing a significant proportion of HIV-related expenditures. Under a decentralized system, a transfer payment system at central and provincial levels needs to be strengthened to support poor regions and districts for carrying out HIV activities. There have been some efforts to share funding for HIV between central and subnational levels, such as a 45% share from central sources and a 55% sub-national share for the provision of diagnostic reagents. However, in districts with low fiscal capacity, budget limitations pose a considerable challenge. In addition, even in non-poor regions, political will at the local level, attitudes of local decision makers towards HIV and key populations, or, in some areas, the relatively low spread of HIV, strongly influence the magnitude of local resources allocated to the HIV response.

Use of social health insurance for financing HIV programmes

People without national ID cards are not eligible for JKN coverage. Stigma and discrimination remain

[11] Tandon A, Prambudi ES, Harimurti P, Emiko M, Subandoro AW, Marzoeki P, et al. Indonesia - Health Financing System Assessment: Spend More, Right, and Better.

[12] Ibid.

[13] WHO. Health Systems Financing: the Path to Universal Coverage. The World Health Report 2010. Geneva: World Health Organization (WHO); 2010.

[14] Tandon A, Prambudi ES, Harimurti P, Emiko M, Subandoro AW, Marzoeki P, et al. Indonesia - Health Financing System Assessment: Spend More, Right, and Better.

considerable challenges in many regions, motivating PLHIV and other key populations to seek treatment outside the puskesmas in their own domicile in order to protect their privacy. They may be unable or unwilling to show their ID or Family Card (Kartu Keluarga) in the puskesmas where they are domiciled, as required to enrol in the JKN programme and get a BPJS (Social Insurance Administration Agency) card,[15] and are not covered by the insurance scheme if they seek care and treatment in another puskesmas.

Similarly, the coverage of JKN in a province excludes PLHIV and other key populations from outside the province (e.g., migrants and mobile populations, such as female sex workers), thus they are unable to benefit from JKN coverage in provinces where they temporarily reside. Consideration needs to be given to making the scheme portable for every insured person.

Care providers in some regions have begun to use direct payments from JKN to cover the costs of HIV diagnostic, care and treatment services, while other providers have no experience in using these funds. Clear guidelines and regulations are needed to enable health providers to use the JKN capitation and Indonesia Case Based Groups (INA-CBG) payments more effectively.

Funding needs for expanding HIV service coverage

The coverage of HIV services, and their use, needs to be expanded. In 2012, 17% of PLHIV, 60% of “direct” female sex workers and their clients, 14-16% of women eligible for PMTCT, and 15% of children needing care and treatment[16] had enrolled in ARV treatment.

The current and predictable increases in HIV funding do not match the more rapidly increasing need for HIV care and treatment. Total government expenditures on HIV in 2015 were estimated to have been about USD 104 million. In order to end HIV and AIDS in Indonesia by 2030, it is projected that, depending upon the scenario, between USD 3.4 billion and USD 5.8 billion will be required. This translates into an average annual resource need of between USD 229 million and USD 386 million.[17] At the subnational level, between 2010/2011 and 2012/2013, expenditures on HIV in one province in Kalimantan increased by 26%. Over the same time period, condom distribution increased fivefold, HIV testing sites increased threefold, and the number of pregnant women who were tested for HIV increased fivefold.[18] Clearly, more funding results in greater demand for and use of services, and expanding coverage of HIV testing, prevention, care and treatment.

Constraints prevail also on the supply side. The capacity of health providers does not match the increasing needs for HIV care,[19] especially in remote and rural areas. For example, budgets for training and for outreach services are critically insufficient.[20] The shortage of doctors and nurses for delivering HIV services also results from the inadequate budgets for HIV programs.[21]

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[15] Focus group discussions with staff from puskesmas in Bali, West Java, Aceh and Papua, 18-20 January 2017, in Jakarta.

[16] National AIDS Commission. National HIV and AIDS Strategy and Action Plan 2015-2019. Draft per 20 April 2015.

[17] National AIDS Commission. The Case for Increased and More Strategic Investment in HIV in Indonesia. Jakarta: National AIDS Commission; 2015.

[18] Tandon A, Prambudi ES, Harimurti P, Emiko M, Subandoro AW, Marzoeki P, et al. Indonesia - Health Financing System Assessment: Spend More, Right, and Better.

[19] Interviews with the staff from the district health office and puskesmas in North Jakarta, 18-19 January 2017.

[20] Field visit to West Kalimantan, 18-20 January 2017, and discussions with stakeholders from Bali, 18 January 2 017, in Jakarta.

[21] Field visit to West Kalimantan, 18-20 January 2017.

Proposed responses

Responses have been proposed for sustaining the financing of HIV programmes by both government authorities and health providers.

- As mentioned above, efforts have been made to share funding for certain components of the HIV response (e.g. the provision of diagnostic reagents) between central and subnational levels on a 45%/55% basis. However, this cost sharing is unaffordable for districts with low fiscal capacity.
- According to Presidential Decree no. 12/2013 on Health Insurance and Minister of Health Regulation no. 71/2013 on Health Services under National Health Insurance, the inclusion of new health technologies (such as drugs, medical devices, procedures, diagnostics, programme interventions, etc.) in the benefit package has to be approved by the Ministry of Health's Health Technology Assessment Committee (HTAC). A proposal on the integration of HIV into universal health coverage, including the introduction of new technologies, has yet to be developed and approved by the Ministry of Health.
- Certain components of HIV service provision such as prevention, treatment adherence, and outreach services are implemented by CSOs and NGOs, funded mostly by the Global Fund. Once Global Fund support to Indonesia comes to an end, following Indonesia's "graduation" to the category of upper middle-income countries, the potential alternate sources that may have to be tapped to sustain and further expand the national response to HIV include central and local governments. This could be on the basis of formal service agreements setting out the division of tasks between governments and service providers.[22]
- A reduction of the costs borne by patients could be achieved through adjustment of the JKN benefit package. In addition, the Ministry of Health/BPJS-Health could provide top-up funding to cover HIV testing costs, while health care providers should be compelled to comply with the INA-CBG payment standards and not charge patients for additional service costs.[23]
- According to National Medium-Term Development Plan 2015-2019, public-private partnerships (PPP) are among the financing mechanisms that can be used for mobilizing health development funding (including for HIV services).[24] In 2017, the National Development Planning Agency (Bappenas) will work with related ministries and the World Bank to develop implementation plans for public private partnerships.
- According to the Decentralization Law,[25] the central government procures and distributes programme drugs such as ARV, while provincial governments manage the operation of health facilities and services. Minimum Service Standards are being used to ensure commitment from local government to priority health sectors, including HIV.
- Puskesmas have recently initiated the use of capitation funds to support HIV/AIDS programme activities (drawn from the 40% of JKN[26] capitation fund payments). At the hospital level, JKN funds have been used

[22] Interview with senior staff at Bappenas, 23 January 2017, in Jakarta.

[23] Tandon A, Prambudi ES, Harimurti P, Emiko M, Subandoro AW, Marzoeki P, et al. Indonesia – Health Financing System Assessment: Spend More, Right, and Better.

[24] Discussions with HIV/AIDS programme stakeholders in West Kalimantan, in Pontianak, 18 January 2017, and Singkawang, 20 January 2017.

[25] Law of the Republic of Indonesia No. 23/2014 on Local Government.

[26] Focus group discussions with puskesmas staff from Bali, West Java, Aceh and Papua, 18-20 January 2017, in Jakarta.

- for treatment of opportunistic infections (OI), while ARVs and reagents were supplied by the central level. In some provinces, patients have to pay an administration cost (a so-called “retribution fee”) to get treatment in a puskesmas. In some puskesmas with regional public service facility (BLUD) status, patients have to pay for ARVs if they are not covered by JKN (puskesmas with BLUD status sometimes buy drugs

Recommendation 13

Based on the analysis above, the Review makes three recommendations for sustaining financing for HIV. For this purpose, three time horizons are set for initiating and implementing the recommendations: short-term (1 year), medium-term (3 years), and long-term (5 years).

13.1 Extend sources of finance for responding to the HIV epidemic

13.1.1 The central government should make HIV a health priority, and continue to increase the Ministry of Health's budget for HIV and AIDS programmes. This could be achieved in the short term.

13.1.2 The Ministry of Health should use Special Allocation Funds (DAK non-Fisik) to support HIV outreach programmes. Puskesmas can use these funds to support HIV counselling and testing, mobile clinics, and condom distribution. Puskesmas need guidelines on the programme components that can be supported by these funds. This could be achieved in the short term.

13.1.3 Bappenas and the Ministry of Health should mobilize funding from the private sector under the PPP policy. Companies throughout the country should be approached to become potential partners of the government in the response to HIV and AIDS in Indonesia. The private sector has the ability mobilize resources, a portion of which could be used for HIV programmes. This could be achieved in the medium term.

13.2 Make subnational governments more accountable in HIV financing

13.2.1 The central government and subnational governments should strengthen local capacity to develop comprehensive plans, including the budgets needed to support the AIDS programme. Integrated planning and budgeting covering all sources of funds at the district level (even puskesmas) is critical to ensure financial adequacy as part of transition process before graduation from Global Fund support. This could be achieved in medium term.

13.2.2 The central government, the Ministry of Home Affairs and the Ministry of Health should strengthen local government commitment to allocating APBD funds for HIV by endorsing the Minimum Service Standards (MSS). However, the service components under MSS are limited, and this might not be sufficient to cover the operational costs that are the local government's responsibility. One challenge is the cost of transport for patients to access care: this could potentially be supported by APBD funds. This could be achieved in the medium term.

13.3 Integrate social health insurance with HIV financing

13.3.1 BPJS and the Ministry of Health should extend JKN coverage to those at HIV risk who do not have ID cards. BPJS can work together with health departments and health providers to extend its coverage to the key populations who are currently not eligible to join the scheme, and to make JKN portable for PLHIV migrants. This could be achieved in the long term.

13.3.2 The Ministry of Health should review the setting of the fees paid health providers, using a stronger evidence base. For example, actual expenditures or costs of cases such as opportunistic infections could be taken into consideration to reflect the financial value of the HIV services provided. This could be achieved in the short term.

HIV-1/2

14. Conclusions

This Review resulted in a series of recommendations for which responsibilities and time frame for their implementation were proposed. This conclusion highlights some prominent issues that need be addressed at the highest level of Government. These are categorized according to the Terms of Reference of the Review:

Relevance and adequacy of the strategic plan of the National Action Plan focusing on the health sector response to HIV/AIDS

Two strategic documents served as background references of particular importance to this Review: one developed by the National AIDS Commission, the other by the Directorate of Communicable Diseases. Substantively, these documents are to a large extent consistent with one another although, at the time of the Review, neither had been formally validated by the Ministry of Health and/or other concerned Ministries. It was reported to the Review Team that the National AIDS Commission would have completed its term of appointment by the end of 2017 and will eventually be replaced by working groups established by the Ministry of Health. There is, therefore, a pressing need for the Ministry of Health to revise its Strategic Action Plan before the end of that year. It is hoped that the recommendations and suggested action points presented in this Review report will help in this re-planning process, with the understanding that it should be inclusive of governmental and non-governmental entities engaged in the national response to HIV. In this regard, civil society has an important role to play in re-planning and programming as well as in the implementation of the new Strategic Plan.

Creation or revision of enabling policies and programmes for HIV prevention, care and treatment and removal of barriers to programme implementation

Structural factors have a major impact on the efficiency, effectiveness and impact of the national response to HIV. In particular, the Review Team was concerned about the discordance of health-related policies, laws and regulations enacted at the central, provincial and regional levels. The updating and consolidation of the large and ever-expanding number of these documents, several of which lack an evidence base, is a step forward of paramount importance. A systematic analysis of policies, laws and regulations relevant directly or indirectly to the health sector's response to HIV should be undertaken as soon as possible to inform the updating of policies, laws and regulations centrally, with an obligation devolved to peripheral authorities to align their own policy and legal frameworks with national standards. The production of a new, comprehensive policy document in accordance with the Indonesian Constitution, domestic laws and international human rights principles, norms and standards calls for a close collaboration between the Ministry of Health and other concerned Ministries, in particular the Ministry of Home Affairs, the Ministry of Justice and Human Rights, the Ministry of Finance and other Ministries that have a bearing on people's equal and equitable access to HIV-related services. Steps

should be taken through an inter-ministerial process spearheaded by the Ministry of Health to revoke legal barriers to progress in the response to HIV, induce policy and legal modifications, formulate new evidence-based laws where needed, and monitor their implementation.

Programmatic and technical aspects of HIV/AIDS prevention, care and treatment, and the way forward for programme planning, implementation and collaboration among partners.

The Review examined the programmatic and technical aspects of the national response to HIV. While noting significant progress in some programme areas, it underscored gaps that limit the likelihood of Indonesia achieving the HIV-related targets it has adopted on the 2020 and 2030 horizons. This report contains recommendations and proposed action points relevant to strategic directions of the present and future health sector's response to HIV. The above-mentioned policy and legal analysis and the revision and consolidation of a National Strategic Action Plan sensitive to provincial and regional specific needs and capacities should guide a similar replanning and reprogramming processes on provincial, district and puskesmas levels. Scaled-up efforts across an inclusive health system should be directed equitably to key populations, at-risk populations and vulnerable populations. Major strategic adjustment will concern the move from selective enrolment of PLHIV in antiretroviral therapy to a "Treat All" strategy for the benefit of HIV-positive people and public health at large. Concurrent efforts should aim at improving the coverage, harmonization and quality of HIV-related services integrated with Primary Health Care, and their sustained financing and transparent accountability from all parties, at all levels of the geopolitical structure of the Republic of Indonesia. The alignment of central and peripheral action plans should engage all health offices in striving with enhanced determination to bring the HIV epidemics under control.

Indonesia is one of the few countries to have experienced an increase in maternal mortality in recent years after enjoying the lowest rate recorded in 2007 (228 per 100,000 live births), as documented by the most recent survey conducted in 2014.[5] There were an estimated 630,000 people living with HIV and AIDS (PLHIV) in 2015, while just 9% were on antiretroviral therapy (ART), a low figure for the Southeast Asia region, where the average coverage is 39%.[6],[7],[8] With regard to tuberculosis (TB), the most common opportunistic infection among people living with HIV, the high levels of TB and HIV coinfection and the increase in multi-drug resistant TB in Indonesia are causes for concern. There were an estimated 78,000 new cases of TB/HIV in 2015.[9]

HIV prevalence among adults (15-49 years old) reached 0.3% in 2015.10 The data indicate that the proportion of cases among men who have sex with men (MSM) has increased almost fivefold since 2011, to 10%. Nevertheless, new cases continued to be predominantly associated with heterosexual transmission (76%) up to the 3rd quarter of 2016.[11]

Annex 1: Summary of Recommendations of the Review of the National Health Sector Response to HIV in Indonesia

Almost all the recommendations below are directed at the Ministry of Health of the Republic of Indonesia as the lead institution in the health sector. Time frames, responsibilities and practical action points for the implementation of these recommendations can be seen in the main body of this report.

Chapter 1: Government system for HIV programmes and delivery: Improving the implementation of decentralization in health

1.1. In compliance with Law of the Republic of Indonesia No. 23/2014 on Local Government, develop and publish norms, standards, procedures, and criteria related to HIV and AIDS.

1.2. Strengthen collaboration with the Ministry of Home Affairs to overcome local barriers to the responses to HIV, such as human resources for health.

1.3. Be vigilant about any legislation related to HIV and AIDS issued by other ministries and agencies to ensure that such laws and regulations are informed by, and aligned with, existing national legislation and regulations, as well as with the norms, standards, procedures, and criteria document once it is formally approved by the government.

Chapter 2: Legal and policy environment: Enablers and constraints in the HIV programme

2.1. Reform national and sub-national policies and practices that hinder the effective implementation of the HIV response.

2.2. Accelerate efforts to eliminate the stigma and discrimination experienced by PLHIV, key populations and women, and ensure accountability for the implementation of a rights-based response to HIV.

2.3. Ensure that PLHIV, key populations, young people and women are able to access affordable HIV services, including HIV prevention, testing, treatment and care.

Chapter 3: The role of civil society organisations in the response to HIV: Leadership, governance and management

3.1. Ensure greater and more meaningful participation of civil society organisations at all levels (national, provincial, district and sub-district) of the health programme, and in other spheres as required, to establish and maintain an environment that facilitates and legitimises CSO participation.

3.2. Strengthen and sustain capacity for the meaningful participation of CSOs and the community in the response to HIV.

3.3. Take steps to eliminate the stigma and discrimination experienced by people living with HIV and key populations, and apply a rights-based response to HIV in conformity with the objectives of the national AIDS programme.

Chapter 4: Differentiation: The HIV epidemic in Tanah Papua contrasts with the HIV epidemics in other regions of Indonesia

4.1. Collaborate with CSOs on developing a systematic prevention programme targeting both the general population and female sex workers.

4.2. Decentralize and expand quality care at the primary health clinic (puskesmas) and rural private clinic levels.

4.3. Invest special autonomy resources strategically.

4.4. Use data to inform and support programme planning and advocacy.

4.5. In-house training (IHT) and on–the-job training (OJT) should be preferred to traditional one-time, didactic training approaches.

4.6. Leverage Law 23/2014 on Local Government, which mandates districts to ensure that minimum service standards for health are met as outlined by the Ministry of Health

4.7. Enhance the active engagement of CSOs, including religious organisations.

4.8. Ensure more effective coordination of partnerships at the national level to reduce disparity among districts in Tanah Papua.

4.9. Prioritize the scale-up of PMTCT, including voluntary partner testing of positive people and for all pregnant women, with linkages to care and treatment.

4.10. Review and update the Papua strategic plan.

Chapter 5: Understanding and responding to the epidemic in key populations

5.1. Revise and expand the concept of HIV risk and harm reduction beyond illicit drug injection, to include all HIV-related high risk behaviours, including unprotected sex, selling sex, and using recreational drugs.

5.2. Address the critical lack of leadership and constituency within organisations and networks of key populations (men who have sex with men, transgender people, people who use drugs, and female sex workers) to facilitate their greater involvement in a more effective and collaborative government health sector response.

5.3. Expand services beyond the traditional peer outreach and edutainment strategies for HIV prevention (which reach only the more visible or open MSM and waria networks).

5.4. Consider the introduction of post-exposure prophylaxis (PEP) and exploration of pre-exposure prophylaxis (PrEP) as an option for prevention among MSM and waria in Indonesia.

5.5. Increase access to appropriate, quality needle/syringe and methadone maintenance therapy (MMT) services for people who use drugs, including those who inject.

5.6. Scale up coverage of prevention, diagnosis, treatment and support for female sex workers as part of a comprehensive response to HIV/STI.

5.7. In areas where the epidemic is generalised (Papua), extend prevention, HIV testing and treatment services beyond the primary care level in remote areas.

Chapter 6: Knowing your HIV status

6.1. Increase access to, and use of, HIV testing, with a priority focus on key populations.

6.2. Update HIV testing algorithms and practices and align their application nationally.

6.3. Expand provider-initiated HIV testing and counselling of TB patients.

6.4. Expand provider-initiated HIV testing and counselling of pregnant women.

Chapter 7: Expanding access to, and take-up of, care, support and treatment

7.1. Improve access to HIV testing and linkage to care.

7.2. Update the HIV treatment guidelines in line with the WHO recommendation to "Treat all" irrespective of CD4 cell count.

7.3. Improve retention in care and virological suppression.

7.4. Improve the quality of care for the management of coinfections.

7.5. Improve data quality and build capacity to improve programme performance.

Chapter 8: Preventing mother-to-child HIV transmission

8.1. Increase HIV testing of pregnant women.

8.2. Increase ART for pregnant women who test HIV positive.

8.3. Strengthen integration of PMTCT in maternal, newborn and child health (MNCH) services, and develop a dual/triple elimination strategy.

8.4. Update and disseminate comprehensive PMTCT guidance and an action plan for acceleration.

8.5. Strengthen M&E for PMTCT.

Chapter 9: Managing tuberculosis and HIV

9.1. Rapidly scale up the TB/HIV response in Indonesia, by both the national HIV programme and national TB programme, using a differential approach.

9.2. Intensify implementation of TB/HIV activities in all HIV priority districts by establishing decentralized and simplified HIV testing services, intensified TB screening and detection using rapid tests, and linkage of all HIV-positive TB patients to TB treatment and ART.

9.3. Strengthen implementation of current activities by addressing gaps in recording, reporting and logistics; introduce a simplified approach to HIV testing/PITC; and track the linkage of HIV-positive TB patients to ART.

Chapter 10: Adapting and expanding the reach of biomedical monitoring

10.1. Expand early infant diagnosis testing.

10.2. Improve capacity for HIV viral load testing to monitor patients on ART.

10.3. Ensure patient access to high quality HIV and HIV-related testing.

Chapter 11: Enhancing procurement and supply systems

11.1. Build a cost-effective and resilient supply chain, starting with procurement.

11.2. Increase accuracy and efficiency by strengthening tools and systems for procurement and supply chain management.

11.3. Improve the distribution process.

11.4. Streamline storage.

11.5. Invest in human capital for procurement and supply chain management.

Chapter 12: Managing and using programme data

12.1. Resolve issues related to data inventory infrastructure, human resource capacity, overburdening and data quality.

12.2. Improve availability of, and capacity to use, data to assess the epidemic status at provincial and district levels, and for advocacy.

Chapter 13: Sustaining HIV/AIDS financing

13.1. Extend sources of finance for responding to the HIV epidemic.

13.2. Make subnational governments more accountable in HIV financing.

13.3. Integrate social health insurance with HIV financing.

Annex 2: Review Team Members

* Sub-team focal point.

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The following personnel from the Ministry of Health and the WHO Country Office facilitated the Review:

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Kemmy Ampera Purnamawati
Slamet Riyadi
Irvan Zacky

Annex 3. Review Agenda

<table>
<tr><th>DATE/TIME</th><th colspan="2">ACTIVITIES</th></tr>
<tr><td colspan="3">Sunday, 15 January 2017</td></tr>
<tr><td>11.00 - 13.00</td><td colspan="2">• Welcome from the Ministry of Health (Dr Endang Budi Hastuti, Sub - Directorate of HIV/AIDS and STI,)
• Briefing on the review with Daniel Tarantola (Team Leader) and Fabio De Mesquita (WHO)</td></tr>
<tr><td>14.00 - 15.00</td><td colspan="2">• Briefing on agenda and review instrument</td></tr>
<tr><td colspan="3">Monday, 16 January 2017</td></tr>
<tr><td>08.30 - 09.00</td><td colspan="2">Welcome and Introduction</td></tr>
<tr><td>09.00 - 10.00</td><td colspan="2">• Welcome and opening remarks by the Director General of Disease Prevention and Control, Ministry of Health, and the WHO Representative to Indonesia
• Introduction of Review Team</td></tr>
<tr><td>10.30 - 12.00</td><td colspan="2">Progress report on TB and HIV
o National TB and HIV strategic plans - Director of CDC (Dr. Wiendra Waworuntu)
o NTP situation, progress report and grant performance - Dr. Asik Surya
o NAP situation, review components - Dr. Endang Budi Hastuti
o Discussion</td></tr>
<tr><td>13.30 - 15.00</td><td colspan="2">Presentation of the 2016 HIV Epidemiological Review</td></tr>
<tr><td rowspan="7">15.30 - 17.00</td><td colspan="2">Review of recommendations, current situation and challenges for the national HIV programme</td></tr>
<tr><td colspan="2">- HSS</td></tr>
<tr><td colspan="2">- Leadership</td></tr>
<tr><td colspan="2">- Prevention</td></tr>
<tr><td colspan="2">- CST, TB/HIV</td></tr>
<tr><td colspan="2">- PSM</td></tr>
<tr><td colspan="2">- HIV Lab</td></tr>
<tr><td>18.00 - 21.00</td><td colspan="2">Welcome dinner</td></tr>
<tr><td colspan="3">Tuesday, 17 January 2017</td></tr>
<tr><td>08.30 - 10.00</td><td>Refinement of review tools</td><td rowspan="2">09.00 - 11.00 Meeting with Provincial Health Office, DKI Jakarta (joint session with JEMM TB @Provincial Health Office)</td></tr>
<tr><td>10.30 - 12.30</td><td>Refinement of review tools (continued)</td></tr>
<tr><td rowspan="2">13.30 - 15.00</td><td colspan="2">Field visit preparation:</td></tr>
<tr><td colspan="2">- Discussion of programme and tools for field visits - Team Leader
- Roles of external and national reviewers</td></tr>
<tr><td>15.30 - 16.30</td><td colspan="2">Security briefing – UNDSSS</td></tr>
<tr><td>16.30 - ....</td><td colspan="2">- Maluku team departing
- Arrival of participants for FGD at Ritz Carlton Jakarta</td></tr>
</table>

13.

Wednesday, 18 January 2017		
08.30 - 17.00	Field visit s:	Focus Group Discussions - 5 Groups/Rooms:
	- Maluku	1. Aceh
	- DKI Jakarta	2. West Java
	- West Kalimantan	3. Bali
		4. Papua
		5. West Papua
Thursday, 19 January 2017		
08.30 - 17.00	Field visit s:	Focus Group Discussions - 6 Groups/Rooms:
	- Maluku	1. Health Offices
	- DKI Jakarta	2. Hospitals
	- West Kalimantan	3. Puskesmas
		4. AIDS Commissions
		5. Community
		6. Youth
Friday, 20 January 2017		
08.30 - 17.00	Field visit s: - Maluku - DKI Jakarta - West Kalimantan	08.30 - 12.00 Individual or group work 12.00 - 13.00 Lunch 13.00 - 14.00 Presentation on Draft FGD reports 14.00 - 16.00 FGD Spiritia
Saturday, 21 January 2017		
08.30 - 17.00	Return to Jakarta.	
	- Individual or group work - Preparation of team findings/key findings and recommendations.	
Sunday, 22 January 2017		
08.30 - 17.00	- Individual or group work - Preparation of team findings/key findings and recommendations.	
Monday, 23 January 2017		
08.00 - 11.00	Debriefing on field visits and focus group discussions	**08.00 - 09.00 Policy Meeting with BAPPENAS @BAPPENAS Office**
	- Discussion	
11.30 - 12.00	Visits to stakeholders	
12.00 - 17.00	Policy meetings with representatives - 4 Groups:	

00

<table>
<tr><td rowspan="4"></td><td colspan="2">Group1:
National Development Planning Agency (BAPPENAS) and Ministries (Ministry of Home Affairs, Ministry of Finance, Ministry of Law and Human Rights, Ministry of Social Welfare, Ministry of Education, Ministry of Village Development); Coordinating Ministry for People's Welfare, Armed Forces, Ministry of Defence, National Police, BKKBN, Ministry of Manpower & Transmigration, Ministry of Religious Affairs, Ministry of Tourism, National AIDS Commission</td></tr>
<tr><td colspan="2">Group 2:
Professional associations: Indonesian Medical Association, Pharmacists Association, Laboratory Association, Pulmonologists Society, Internists Society, Pediatric Society; IBI, POGI, PPHI, Angsa Merah, PDPAI.</td></tr>
<tr><td colspan="2">Group 3:
MoH Inter-Sectoral meetings: Health Facilities, Quality and Accreditation Directorate, Food & Drug Administration (Badan POM) & DG of Pharmaceutical and Health Equipment (Binfaralkes), NAP and Health Human Resource Board, MoH (BPPSDM); Health Insurance and Health Financing (P2JK) and Social Insurance Administration Agency (BPJS); Family Health (Ditkesga) (4); Health Facilities (Ditfasyankes) (4); Data & Information Centre (Pusdatin), Health Promotion (Promkes), Birokomlik,</td></tr>
<tr><td colspan="2">Group 4 : CCM, Development partners, community networks:
13.00 - 15.00 with CCM Indonesia
16.00 - 17.00 with Communities</td></tr>
<tr><td>17.00 - 18.30</td><td colspan="2">Side meeting: TB - HIV collaboration meeting</td></tr>
<tr><td colspan="3">Tuesday, 24 January 2017</td></tr>
<tr><td>08.30 - onwards</td><td colspan="2">Report writing and preparation of debriefing on provisional key recommendations</td></tr>
<tr><td colspan="3">Wednesday, 25 January 2017</td></tr>
<tr><td>08.00 - 10.00</td><td colspan="2">Report writing and debriefing on provisional key recommendations</td></tr>
<tr><td>10.00 - onwards</td><td>Preparation of key recommendations - discussion with MoH expert staff</td><td>Finalisation of recommendations on thematic areas @ Ritz Carlton</td></tr>
<tr><td>13.00 - 15.00</td><td colspan="2">Finalisation of draft key recommendations for the Minister of Health</td></tr>
<tr><td colspan="3">Thursday, 26 January 2017</td></tr>
<tr><td colspan="3">HIGH LEVEL MISSION, Country Review team to join with JEMM Team</td></tr>
<tr><td>09.30 - 11.00</td><td colspan="2">Presentation of key recommendations to Minister of Health and Partnership Forum</td></tr>
<tr><td>11.10 - 11.40</td><td colspan="2">Press Conference at Ministry of Health</td></tr>
<tr><td>13.00 - onwards</td><td colspan="2">Completion of report writing on thematic components</td></tr>
<tr><td colspan="3">Friday, 27 January 2017</td></tr>
<tr><td>09.00 - 12.00</td><td colspan="2">Dissemination of recommendations to stakeholders</td></tr>
<tr><td>13.00 - onwards</td><td colspan="2">Completion of report writing on thematic components</td></tr>
<tr><td colspan="3">Saturday, 28 January 2017</td></tr>
<tr><td></td><td colspan="2">Departure of non - Jakarta - based Review Team members.</td></tr>
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Annex 4. Update on the 2011 Review recommendations

The 2011 Review of the Health Sector Response covered seven strategic areas: 1) Programme management/Health Systems Strengthening; 2) Prevention; 3) Care, support, treatment and TB/HIV; 4) Leadership, governance and management; 5) Procurement, supply, management and ARV logistics; 6) Strategic information; and 7) Laboratory.

The table below summarizes the status of the 2011 recommendations as followed up by the 2017 Review.

Key Recommendations of the 2011 Review

2011 Recommendation	Status update 2017
Governance, policy and structures	
1. The National AIDS Commission and the Ministry of Health should develop a joint plan for the transfer of coordinating and programme implementation responsibilities of the HIV health sector response to the Ministry of Health.	Governance, policy and structuresGovernment Regulation No.18/2016 on Regional Level Public Officials affirms the role of the Health Office as the sole executor of government affairs in the health sector, with functional oversight over other stakeholders, including AIDS commissions. By the end of 2017, the National AIDS Commission will be replaced by a technical advisory group at the Ministry of Health, according to information provided to the Review Team.
2. Provincial and district health authorities should strengthen collaboration with CSO sector to improve coverage and quality of service provision.	The community sector is one of the three core elements of the LKB approach (alongside the health sector and district AIDS Commissions), and as such is expected to play a key role in delivering and monitoring HIV-related services both in the community and in health facilities. CSO participation in service delivery has increased in several provinces. However, the absence of mechanisms requiring provincial and district health offices to engage with CSOs and community-based services has resulted in few opportunities for CSOs to be meaningfully involved in planning, implementing and monitoring programmes.
3. The national AIDS programme must be accorded higher priority and receive more resources to undertake its rightful role in leading the health sector response to HIV/AIDS.	A large number of laws and regulations have been enacted at central and local level, establishing a framework that serves as an important policy and legal foundation for the HIV response and reflecting the heightened recognition that tackling the epidemic is a priority. Some of these regulations represent important advances in creating a more enabling environment for evidence- and rights-based responses to HIV, but many local regulations have been enacted that impede an effective HIV response. Public funding for the HIV response has increased steadily and in 2016, 67.7% of HIV/AIDS programme expenditures came from the regular government budget (APBN). However, resources allocations for the response at subnational level are highly variable.

2011 Recommendation	Status update 2017
4. The Government of Indonesia should increase budgets and spending on HIV/AIDS. International funding mechanisms/donors should be encouraged to provide complementary support to the Indonesian response.	Domestic public spending on the HIV response has increased steadily, and accounted for 67.7% of HIV and AIDS programme expenditures by 2016. As of 2017, the government was funding 98% of ARV procurement in Indonesia. The national health insurance system (JKN) has become a source of funding for HIV programs in supporting the prevention and treatment of HIV opportunistic infections. Ministry of Health Regulation no. 21/2013 requires local governments to allocate a budget for HIV and AIDS. However, there is wide variation in fiscal capacity and willingness to support HIV activities across regions and districts.
5. More must be done to ensure the meaningful participation of groups representing the interests of male and female PLHIV, PWID, men who have sex with men (MSM) and waria in developing policies, programmes and in implementation.	Several avenues exist for cooperation on HIV between government and civil society organisations (CSOs), including networks of PLHIV and key populations, e.g. through CSO membership of the National AIDS Commission and the Country Coordinating Mechanism, and one PLHIV CSO is a Global Fund principal recipient. There are also many examples of good practice with regard to civil society working with the Ministry of Health, other partners and with each other, at national, provincial, district and sub-district level, to lead a strong and effective response to HIV. However, the potential to partner and co-design effective responses to HIV is not yet supported by strong institutional links between the Ministry of Health and CSOs, including networks of key populations.
6. Health systems strengthening and the development of a continuum-of-care approach are required and should be pursued.	The Ministry of Health began to roll out the continuum of prevention and care approach (LKB) in selected priority districts from 2012. LKB is an integrated, decentralized service delivery model aimed at accelerating and expanding access to ART (through the SUFA strategy); strengthening coverage of HIV testing, outreach and prevention interventions for key affected populations; and improving access to PMTCT, Elimination of Congenital Syphilis, TB/HIV collaborative activities and other HIV-related services. LKB is now being implemented in 231 districts and has contributed to the significant increase in HIV testing and ART coverage since 2011. Despite these efforts, prevention programme coverage of all key affected populations remains below 50%, only 11% of the estimated PLHIV are on ART and there are substantial leakages at all stages of the HIV cascade, indicating an urgent need for further strengthening of linkages and service quality in the continuum of care.

2011 Recommendation	Status update 2017
Strategic Information	
7. Strengthen capacity to analyse and use routine data at local level.	The web-based SIHA has made routine data more easily manageable and usable. M&E training for HIV program managers at provincial and district level includes a module on using data. However, capacity to analyse and interpret data at the district level remains variable.
8. Reduce the number of HIV Sentinel Sero-Surveillance sites to core sites (including the IBBS sites), to maximise financial and technical support for data collection, data analysis and reporting in those areas.	The last round of HSS was conducted in 22 sites. Province and district health offices have been encouraged to seek funding for HSS from local governments, but the response has been variable.
9. Conduct the planned biennial review of key affected populations (KAP) size estimates. A distinction should be made between indirect size estimates for national use, and direct estimates that are appropriate for local level planning.	Population size estimates (PSE) are now being conducted up to the level, and data sources for the estimates have been increased and strengthened. However, guidance on using PSE at province and district level is lacking.
10. The national working group in charge of modelling and policy analysis (sub-POKJA Surveillance) should be more active, with responsibility and resources for vetting different estimate models, facilitating consensus on national and regional estimates and interpreting results. This working group should ensure models are updated as new data becomes available.	The HIV working group includes a sub-working group for the development of surveillance, research and M&E, and an expert sub-panel for the development of surveillance and M&E.

2011 Recommendation	Status update 2017
HIV Prevention	
11. Update the current Indonesian STI Control Strategy. This should include: - The urgent scale-up of comprehensive, networked services of different levels. - Revised and disseminated STI management guidelines. - HIV and syphilis testing with linkages to mother and child health services. - Effective condom provision and promotion. - STI prevention targeting priority KAPs such as female sex workers, their clients, men who have sex with men and transgender persons.	HIV PreventionTo date, condom use programmes amongst FSW have not been effective in reducing HIV/STI prevalence to acceptable levels. Moreover, condom promotion and availability at 'point of need' for PWID, FSW, MSM and transgender people remains problematic. Despite the steady increase of syphilis among MSM and waria, a syphilis test is often not systematically combined with HIV testing. Availability of MSM- and transgender-friendly STI services is limited, while nationwide closures of sex trade hot spots have disrupted the provision of STI services to female sex workers. Updated policies on PMTCT provide for syphilis screening for pregnant women as part of routine antenatal care.
12. Develop a National PMTCT strategy that includes strengthening linkages to MCH services, HIV care, support and treatment services; specialised regional centres for training and support; and clinical leadership from Obstetrics and Gynaecology services.	New regulations, policies and guidance have updated and clarified the national guidelines, and provided for early ART initiation for HIV-positive pregnant women and the integration of PMTCT as an essential element of MNCH services. Four PMTCT model districts have been established. Significant progress has been made in scaling up and decentralizing PMTCT services and increasing coverage of HIV testing and ART. However, bottlenecks in testing and ART coverage persist, and challenges remain in disseminating and implementing updated guidance at local levels.
13. Scale up the harm reduction response in collaboration with the community, including opioid substitution therapy (OST) and NSP, to limit continuing HIV and viral hepatitis transmission amongst PWID.	There remain significant regulatory barriers to a fully functional needle syringe programme (NSP). While the number of CSOs engaged in the NSP programme appears to have increased, NSP coverage appears to be sub-optimal, and enrolment in OST has decreased in the last 5 years. This may reflect the trend away from heroin injecting to methamphetamine smoking.

2011 Recommendation	Status update 2017
Care, Support and Treatment	
14. Implement an effective continuum of care for PLHIV at district level. This requires: - Functioning coordination and partnership mechanisms with all stakeholders including hospital and public health services, PLHIV, civil society and community-based care organisations. - Appropriately integrated and decentralized CST services according to local context at province and district level. - Strong referral mechanisms and linkages within and outside the health system.Provision of comprehensive package of services adapted to health system level, and needs of PLHIV.	The continuum of care (LKB) approach has been implemented since 2012 in selected priority locations and is now in 231 districts. This integrated, decentralized service delivery model relies on close collaboration between district health offices, the district AIDS commissions, health facilities and community organisations. Important programmes such as access to HIV testing and outreach for key affected populations, prevention of mother-to-child transmission of HIV (PMTCT) as well as TB/HIV collaborative activities are being strengthened through this decentralized framework. The approach has seen a dramatic increase in the number of HIV facilities: as of 2017, national and local governments operate 2681 HIV counselling and testing sites, 655 ART sites, 1574 centres for STI services, 238 PMTCT centres and 233 TB/HIV services. A number of best and promising practices in HIV service delivery (including MSM-friendly clinics), are being implemented by CSOs in close collaboration with the Ministry of Health. ART has been decentralized to primary health care services in most provinces, contributing to a significant increase in the number of people accessing treatment. Substantial challenges remain, however, including: A significant proportion of the key populations diagnosed HIV positive are not subsequently linked into CST services; Key populations continue to report discriminatory and/or stigmatising attitudes in health services; Low availability of services and complicated procedures for offering and conducting HIV tests are hampering optimal implementation and coverage of HIV testing among TB patients and pregnant women; The pace of ART decentralization in some sites remains slow, and is not clearly supported by a strategic plan and timeframe; ART coverage varies by province.

2011 Recommendation	Status update 2017
15. Optimize ARV drug regimens - i.e. the use of simplified, less toxic drug regimens, with high barriers to drug resistance, that require minimal clinical monitoring while maintaining therapeutic efficacy. Roll-out of "one pill once daily" potent ARV regimen may significantly improve adherence to ART, retention in HIV care, and minimize side effects.	The WHO-recommended once-daily fixed-dose combination of TDF+3TC+EFV is now the preferred first-line regimen. The availability of second-line regimens is limited, and third line options are not yet available. Appropriate paediatric ART formulations are also unavailable. Access to viral load testing is still very limited and there are no national data on rates of virological suppression.
16. Continue strengthening of the HIV commodities Procurement and Supply Chain to ensure uninterrupted services.	The government now funds 98% of ARV procurement. Management of ARV distribution has been decentralised to 33 provinces and 65 districts, and improvements have been made in last mile delivery. The majority of facilities have access to SHIA and are reporting ARVs dispensed on a monthly basis. However, despite a decline in ARV stock outs, they persist in several sites and paediatric ARV stock outs are frequent. Other persistent issues include condom stock outs and overstocking, leading to expiry, of reagents.
17. Improve the overall quality of HIV care and treatment provision through supportive supervision of CST services and enhanced capacity building programme, including roll-out of clinical mentoring, continuing education.	A growing number of primary health care staff are now comfortable initiating and delivering ART, reflecting the improvements in capacity. However, there remains a need for the development or finalisation of guidance on updated policies, followed by systematic dissemination and education for health care workers.
18. PLHIV should be effectively and actively involved in all aspects of CST, including the development of policy, strategy and guidelines, planning, and provision of services. Capacity should be strengthened accordingly.	Networks of PLHIV, including and positive women's groups, are now well established at the national level and in several provinces and have a voice in national planning and monitoring forums, and one PLHIV organisation is now a Global Fund principal recipient. However, there is a need for robust mechanisms to facilitate their meaningful participation in designing, planning and monitoring policies and programmes, particularly at the subnational level.

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