The Integration of HIV and AIDS Response into the Health System
Landscapping from nine provinces in Indonesia
THE INTEGRATION
OF HIV AND AIDS
RESPONSE
INTO THE HEALTH SYSTEM:
Landscaping from nine provinces in Indonesia
The Integration of HIV and AIDS Response into the Health System: Landscaping from nine provinces in Indonesia

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National Library: Catalog under Issuance

The Integration of HIV and AIDS Response into the Health System: Landscaping from nine provinces in Indonesia/ Ignatius Praptoraharjo; Iko Safika; M. Suharni; Ignatius Hersumpana; Chrysant Lily K; Ita Perwira; Satiti Retno P; Swasti Sempulur; Eviana Hapsari Dewi / Yogyakarta: Center for Health Policy and Management (CHPM) Faculty of Medicine, Universitas Gadjah Mada. (Publishing affiliation with INSISTPress)

17x25cm; 92pages
First edition, September 2016
ISBN: 978-602-0857-26-8

I. The Integration of HIV and AIDS Response into the Health System: Landscaping from nine provinces in Indonesia

Written with the support of the Australian government through a grant from the Department of Foreign Affairs and Trade (DFAT) to the Center for Policy and Health Management (CHPM), Faculty of Medicine, Universitas Gadjah Mada. This publication does not represent the views of either the Government of Australia or the Government of Indonesia.

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Center for Policy and Health Management (CHPM), Faculty of Medicine, Universitas Gadjah Mada
Foreword - DFAT

The Australian government through its Australia-Indonesia Partnership for HIV (AIPH) program supports Indonesia's national goals of preventing and limiting the spread of HIV, improving the quality of life of people living with HIV, and alleviating the socio-economic impacts of the epidemic.

This study through Universitas Gadjah Mada on integrating HIV into the National Health System, looks at how the HIV program that is usually centrally driven, mostly with donors' funding and delivered parallel to the existing health system can be integrated into the system for its sustainability.

The study assessed the level of integration at the national, provincial, and district/city levels, in eight provinces (North Sumatera, DKI Jakarta, East Java, Bali, South Sulawesi, West Papua, Papua, and NTT).

The study echoes the notion that integration is the organisational framework that can strategically improve a program's effectiveness, efficiency and sustainability. However, the effort to reach the expected integration level is highly dependent on the various contexts where AIDS response and the health system operate. Political commitment from local leaders, the local economy, laws and regulations that are not always in favour of HIV/AIDS response, and the interaction among stakeholders in the health system and HIV/AIDS response determine the level of integration in study locations.

Evidence-based policy is strongly supported by the Australian Government in its partnership with the Government of Indonesia. It is hoped this study will assist the Government of Indonesia to further integrate HIV/AIDS programs into the health system and develop a sustainable strategy to support HIV/AIDS response.

James Gilling
Minister, Development Cooperation
Australian Ambassador for HIV/AIDS, Malaria and Tuberculosis
Australian Embassy Jakarta
Foreword – Indonesian Ministry of Health

With the blessing of God the Almighty, the report of the first research phase “The Integration of HIV and AIDS Response into the Health System”, is completed. The concept of integration, which depends on the context of program intervention and synchronization of interventions, both structural and functional, and various forms, and the perception of involvement of multiple stakeholders, become important components in this research.

This first research phase was conducted to answer the following questions: (1) how far have HIV and AIDS policies and programs been integrated into the national health system, and (2) what forms and composition of vertical approaches can maintain the effectiveness and sustainability of programs in the health system functions either politically, economically or socio-culturally. The research was conducted with a systematic qualitative method conducted by research teams from 8 universities in 11 districts/cities. The collection of data and information was done through interviews, in-depth interviews and Focused Group Discussions (FGD), that was continued to wording, coding, grouping, thematic evaluation and desk-review verification.

This first phase found that at the upstream level intervention programs show a lack of integration whereas the downstream level is dependent on the interest, support, and implementation of local health providers despite the formation of an AIDS Commission. Professionalism, competency, authority, and political interest influence the integration of this program into the national health system.

Finally, we express our gratitude to the Center for Policy and Health Management (CHPM) Faculty of Medicine, Universitas Gadjah Mada as the coordinator supported by DFAT, AusAid, and all the parties involved in the effort to describe, analyse and provide scientific recommendations so that HIV and AIDS response is fully integrated into the national health system.

Jakarta, 19 September 2015
Direktur Jenderal Pengendalian Penyakit dan Penyehatan Lingkungan

[Signature]

Director General, Health and Environmental Protection
# Table of Contents

Foreword - DFAT ................................................................. 3
Foreword – Indonesian Ministry of Health.............................. 4
Table of Contents.................................................................. 5
List of Tables ......................................................................... 5
List of Diagrams ..................................................................... 8
List of Figures ......................................................................... 8
List of Acronyms ..................................................................... 9
Executive Summary ................................................................ 12
I. Introduction ........................................................................ 14
   A. HIV and AIDS Response in Indonesia ................................. 14
   B. The Health System and HIV and AIDS Response ................ 15
   C. Research Questions and Objectives .................................. 17
      a. Research Questions .................................................... 17
      b. Research Objectives .................................................. 17
   D. Conceptual Model ........................................................... 18
   E. Research Methods ........................................................... 19
      a. Research Design and Procedure .................................. 19
      b. Study locations ......................................................... 20
      c. Participants ............................................................... 20
      d. Instruments .............................................................. 20
      e. Data Management .................................................... 21
      f. Data Analysis .......................................................... 21
      g. Structure of the Report .............................................. 23
II. Context ............................................................................ 24
   A. The Context of HIV and AIDS Policies and Programs at the National and Local Level ........ 24
      a. Political Commitment ................................................. 24
      b. Laws and Regulations ................................................. 25
      c. Economics .............................................................. 25
      d. Local Health Problems ............................................. 26
   B. HIV and AIDS Epidemiological Profile and Pattern of Risk Behaviours in Study Locations .... 27
   C. Local Response to HIV and AIDS .................................... 28
III. Key Stakeholders in HIV and AIDS Response ....................... 31

5
A. Introduction ................................................................. 31

Roles and Interactions of Stakeholders in HIV and AIDS Response ........................................ 31

It was found that the interest of the stakeholders in all provinces including local AIDS committee, District/Provincial Health Office and NGOs was high. The interest of district hospitals, community health centers (Puskesmas) and key populations was high in 10 study locations. Meanwhile, the interest of local parliament, government working units and local planning agency was low in 10 study locations. In terms of power, the District/Provincial Health Office in all study locations showed high power. The power of mayors/regents was high in 9 study locations. The power of IDPs is relatively high in all study locations with an average score of 8.5. The power of Puskesmas, NGOs, key populations, government working units and traditional/religious institutions is shown in the following figure: ........................................ 31

1. Stakeholder Positions ........................................................................................................... 33
   a. High Interests and High Power .................................................................................. 33
   b. High Interest and Low Power ................................................................................. 35
   c. High Power and Low Interest .................................................................................. 39
   d. Low Power and Low Interest ................................................................................... 41

2. Interactions between Stakeholders .................................................................................... 43

IV. Patterns of Integration .................................................................................................... 46

A. Introduction ......................................................................................................................... 46

B. Dimensions of Health System Functions ........................................................................ 46
   1) Management and Regulation .................................................................................. 46
   2) Financing ................................................................................................................... 49
   3) Human Resources ..................................................................................................... 52
   4) Strategic Information Management ......................................................................... 57
   5) Management of pharmaceutical supplies and medical equipment ....................... 59
   6) Community Participation .......................................................................................... 61
   7) Service Delivery .......................................................................................................... 63

C. Level of Integration Based on Dimension of Functions of the Health System .................. 68

D. Level of Integration Based on Types of Interventions ..................................................... 70
   1. Level of Integration of Prevention Programs ............................................................ 71
   2. Level of Integration of CST Programs ...................................................................... 71
   3. Level of Integration of Impact Mitigation Programs .................................................. 72

E. Level of Integration Based on Study location .................................................................. 72

F. Factors that Influence Integration in the Region ................................................................. 73

G. The Relation between Integration and Effectiveness of HIV and AIDS Programs .......... 75

V. Conclusions and Recommendations .............................................................................. 78
   a. Conclusion .................................................................................................................... 78
b. Recommendations .......................................................................................................................... 80

Bibliography ....................................................................................................................................... 82

Appendix 1. Research Instrument: Primary Data Collection ................................................................. 85

Appendix 2. Sub-system, Dimensions, and Questions that Lead to Measurement of Integration ........................................................................................................................................ 89
List of Tables

Table 1. Functions and Dimensions of the Health System ................................................................. 22
Table 2. Forms of Assistance from MPI and Location .................................................................... 33
Table 3. District hospitals and HIV/AIDS Services in the Study Locations ................................ 37
Table 4. Roles of Non-Health Office SKPD in HIV and AIDS response in the Study locations ...... 42
Table 5. Nomenclature Differences between General Healthcare Workers and AIDS Workers... 54
Table 6. HIV and AIDS Services in the Study locations ................................................................. 63
Table 7. Level of Integration based on the Dimensions of Functions of the Health System........ 68
Table 8. Level of Integration of HIV and AIDS Programs based on Type of Integration .......... 70
Table 9. Level of Integration According to Study location ............................................................. 72

List of Diagrams

Figure 1. HIV Prevalence per 100.000 people in the study locations ........................................ 27
Diagram 2. Risk factors of HIV and AIDS transmission .............................................................. 28
Figure 3. Cascade of HIV and AIDS Treatment ........................................................................... 30
Figure 4. Interest and Power of Stakeholders in HIV and AIDS in the Study Locations .......... 32
Diagram 5. Proportion of HIV and AIDS Financing in Sidoarjo District ................................... 50
Diagram 6. Relation between Integration and Effectiveness ....................................................... 76
Diagram 7. Relation between Level of Integration and Number of ODHA on ARV Treatment .... 77

List of Figures

Figure 1. Conceptual Framework .................................................................................................. 18
Figure 2. Position of Stakeholders in the Region ........................................................................ 32
List of Acronyms

AIDS  Acquired Immunodeficiency Syndrome
ARV  Antiretroviral Drugs
ART  Antiretroviral Therapy
APBN/D  Anggaran Pendapatan dan Belanja Nasional/Daerah (National Revenue and Expenditure Budget/Local Revenue and Expenditure Budget)
AusAid  Australian Agency for International Development
Bappeda  Badan Perencanaan Pembangunan Daerah (Local Development Planning Agency)
Bappeko  Badan Perencanaan Pembangunan Kota (City Development Planning Agency)
BKD  Badan Kepegawaian Daerah (Local Employment Agency)
CHAI  Clinton Health Access Initiative
CSR  Corporate Social Responsibility
DFAT  Department of Foreign Affairs and Trade, Government of Australia
Dinkes  Dinas Kesehatan (Local Health Office)
Disdikpora  Dinas Pendidikan dan Olah Raga (Local Education and Sports Office)
Disnakatrans  Dinas Tenaga Kerja dan Transportasi (Local Manpower and Transportation Office)
Dinsos  Dinas Sosial (Local Social Office)
Dinsoesnaker  Dinas Sosial dan Tenaga Kerja (Local Social and Manpower Office)
DKI  Daerah Khusus Ibukota (Special Capital Region)
DKT/FGD  Diskusi Kelompok Terarah/Focus Group Discussion
DPRD  Dewan Perwakilan Rakyat Daerah (Local House of Representatives)
Fasyankes  Fasilitas Pelayanan Kesehatan (Health Service Facility)
FK  Fakultas Kedokteran (Faculty of Medicine)
GF  Global Fund
HCPI  HIV Cooperation Program for Indonesia
HIV  Human Immunodeficiency Virus
STI  Infeksi Menular Seksual (Sexually Transmitted Infections)
OI  Infeksi Oportunistik (Opportunistic Infections)
IOMS  Inventory Order Management System
JKN  Jaminan Kesehatan Nasional (National Health Insurance)
Jamkesmas  Jaminan Kesehatan Masyarakat (Community Health Insurance)
Jamkesda  Jaminan Kesehatan Daerah (Local Health Insurance)
KDS  Kelompok Dukungan Sebaya (Peer Support Group)
Kemenkes  Kementerian Kesehatan (Ministry of Health)
KIA  Kesehatan Ibu dan Anak (Maternal and Child Health)
KIE  Komunikasi, Informasi, dan Edukasi (Communication, Information and Education)
Kominfo  Komunikasi dan Informatika (Communication and Informatics)
KPAN/P/K  Komisi Penanggulangan AIDS Nasional/Provinsi/Kota/Kabupaten (National/Provincial/City/Local AIDS commission)
KTS/VCT  Konseling dan Tes Sukarela/Voluntary Counselling and Testing
LASS  Layanan Jarum dan Alat Suntik Steril (Sterilized Syringe Service)
LKB  Layanan Komprehensif Berkesinambungan (Comprehensive and Continuity of HIV/AIDS and STIs Service)
LP2EM  Lembaga Pengkajian Dan Pemberdayaan Ekonomi Masyarakat (Institute for Studies and Economic Empowerment Society)
LSL  Lelaki Seks dengan Lelaki (Men who have Sex with Men)
LSM  Lembaga Swadaya Masyarakat (Non-Governmental Organization-NGO)
M&E  Monitoring & Evaluation
MOU Memorandum of Understanding
MPI Mitra Pembangunan Internasional (International Development Partner)
Mursenbang Musyawaran Perencanaan Pembangunan (Development Planning Assembly)
NAPZA Narkoba, Psikotropika dan Zat Adiktif (Narcotics, Psychotropic, and Addictive Substances)
ODHA Orang Dengan HIV dan AIDS (People Living with HIV and AIDS)
OMS Organisasi Masyarakat Sipil (Civil Society Organization)
OBS Organisasi Berbasis Sosial (Social Organization)
OBM Organisasi Berbasis Masyarakat (Community Based Organization)
Ormas Organisasi Kemasyarakatan (Community Organization)
Otsus Otonomi Khusus (Special Autonomy)
PAD Pendapatan Asli Daerah (Local Own-source Revenue)
PDP/CST Perawatan, Dukungan dan Perawatan/Care, Support and Treatment
Penda Pemerintah Daerah (Local Government)
Penasun Pengguna Napza Suntik (People who Inject Drugs)
Pergub Peraturan Gubernur (Governor’s Regulation)
Perda Peraturan Daerah (Local Regulation)
Permendagri Peraturan Kementrian Dalam Negeri (Ministry of Home Affair’s Regulation)
Perwal Peraturan Walikota (Mayor’s Regulation)
PITC Provider-Initiated Testing and Counselling
PKM Pusat Kesehatan Masyarakat (Community Health Centre)
PKMK Pusat Kebijakan dan Manajemen Kesehatan (Center for Policy and Health Management)
PKR Pusat Kesehatan Reproduksi (Reproductive Health Centre)
PMTS Pencegahan HIV Melalui Transmisi Seksual (Preventing HIV through Sexual Transmission)
Pokdisus Kelompok Studi Khusus (Special Study Group)
Pokja Kelompok Kerja (Working Group)
Polrestabes Kepolisian Resor Kota Besar (City Police)
Posyandus Pos Pelayanan Khusus (Special Treatment Point)
PPH/ARC Pusat Penelitian HIV dan AIDS/AIDS Research Centre
PPIA Pencegahan Penularan dari Ibu ke Anak (Preventing Mother to Child Transmission)
PTRM Program Terapi Rumatan Metadon (Methadone Maintenance Treatment Program)
Puskesmas Pusat Kesehatan Masyarakat (Public Health Centre)
Renstra Rencana Strategis (Strategic Planning)
R&R Recording & Reporting
RI Republic of Indonesia
Risti Risiko Tinggi (High Risk)
Rutan Rumah Tahanan (Prison)
RS Rumah Sakit (Hospital)
RSUD Rumah Sakit Umum Daerah (Local Public Hospital)
RPJM Rencana Pembangunan Jangka Menengah (Mid-term Development Plans)
RPJMD Rencana Pembangunan Jangka Menengah Daerah (Local Mid-term Development Plans)
SCP Survei Cepat Perilaku (Rapid Behavioural Survey)
SDM Sumber Daya Manusia (Human Resources)
SK Surat Keputusan (Decision Letter/Decree)
SKN Sistem Kesehatan Nasional (National Health System)
SKPD Satuan Kerja Pemerintah Daerah (Local Government Work Unit)
SIHA Sistem Informasi HIV/AIDS (HIV/AIDS Information System)
SI NU Sistem Informasi Nahdatul Ulama (Nahdatul Ulama Information System)
SI PKBI  Sistem Informasi Perkumpulan Keluarga Berencana Indonesia (Family Planning Association Information System)
SIKNAS/DA  Sistem Informasi Kesehatan Nasional/Daerah (National/Local Health Information System)
SOP  Standard Operating Procedure
SRAN  Strategi Renconta Aksi Nasional (National Action Strategic Plan)
STBP/IBBS  Surveilans Terpadu Biologis dan Perilaku/Integrated Biological and Behaviour Surveillance
SSR  Sub Sub Recipient
SUFA  Strategic Use of ARV
SUM  Scaling Up for Most-At-Risk Populations
TB  Tuberculosis
TRM/MMT  Terapi Rumatan Metadon/Methadone Maintenance Treatment
Tupoksi  Tugas Pokok dan Fungsi (Main Function and Duty)
WM  Wawancara Mendalam (In-depth Interview)
WPA  Warga Peduli AIDS (AIDS Concerned Citizen)
WPS  Wanita Pekerja Seks (Female Sex Worker)
WPSL  Wanita Pekerja Seks Langsung (Direct Female Sex Worker)
WPSTL  Wanita Pekerja Seks Tidak Langsung (Indirect Female Sex Worker)
WHO  World Health Organization
UA  Airlangga University
UGM  Gadjah Mada University
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNFPA  United Nations Population Fund
UNICEF  United Nations Children’s Fund
Uncen  Cendrawasih University
Unhas  Hasanuddin University
Unika  Atmajaya Catholic University
USU  University of North Sumatra
UU  Undang Undang (Law)
Unud  Udayana University
Unipa  Papua University
USAID  United States Agency for International Development
Executive Summary

Funding and policy direction of HIV and AIDS responses in Indonesia are highly influenced by global health initiatives. Along with gradual reduction of supports from the global initiatives, efforts to integrate the HIV and AIDS program into the framework of the national health system would be an important path as it offers a great opportunity to synchronize resource mobilisations and improve the effectiveness and sustainability of the HIV and AIDS program.

This study addressed issues of integration between HIV and AIDS and the health system in Indonesia. It evaluated the dynamics of policy process and resource mobilisation as well as other relevant factors affecting the HIV and AIDS responses in the country. There are two major objectives of the study: 1) to map out the current level of integration of HIV and AIDS programs into the Indonesian health system; and 2) to provide recommendations to improve the system and performance of HIV and AIDS response for the next 5-10 years. This study used a qualitative analysis on rigorous information and evidence collected by the research partner teams from major universities in 11 cities/districts in Indonesia. Framework for the analysis and conclusion was derived from Atun et al.’s framework, (2010).

The study found that the current level of integration of HIV and AIDS programs into the national health system was low. In general, there is a certain level of integration on regulatory and policy function of the health system as shown by some local regulation and policy formulation. However, the accountability and responsiveness aspects of it were still weak because local governments did not have a structured mechanism to substantially involve key populations in the processes of planning, implementation and evaluations of HIV and AIDS programs. This finding emphasized that the problem related with HIV response is not on the inability to develop policy. Rather it is the lack of capacity in policy implementations. Therefore, there is a need of a comprehensive strategy to remove barriers and leverage the capacity of local governments in developing HIV and AIDS programs.

The service delivery function of the health system seemed to be the most possible pathway for integration. Service delivery has also reflected a continuum of care which encompassed prevention, care, support and treatment (CST) as well as impact mitigation. This integration takes place because the service provider works by following mechanisms which could easily adopt HIV and AIDS services. The infrastructure, resources and standards of the existing services enable the service providers to include some components of HIV and AIDS programs. Unfortunately, other health system functions such as funding, healthcare resources, strategic information and community participation have not been able to accommodate HIV and AIDS components.

There was a huge variation in the implementation of HIV and AIDS programs amongst studied districts in relation to integration. Many factors have influenced this variation such as local political commitment which generally is still low. Consequently, the HIV and AIDS programs were not a priority for health development at the district level. This was indicated by high reluctance to allocate funding for HIV and AIDS programs and instead, local governments are still relying heavily on International Development Partners’ funds. Moreover, these local governments have not been able to stimulate local private sector’s contribution in HIV and AIDS response. Lack of capacity to understand the local HIV epidemic was also among the key factors which then has led to overreliance on programs and funding from the central government, who supposedly know better about the epidemic nationally and run the response centrally.

Another factor affecting the current level of integration is on the interaction between relevant key stakeholders. With low interest in HIV and AIDS issues especially among policy and decision makers, one major challenge is on how to improve awareness, knowledge and capacity of key
stakeholders notably local parliament representatives, mayors, and local planning agencies in developing and implementing strategic policies as a response to HIV epidemic in their areas. More intense and productive interactions between key stakeholders, with NGOs as catalysts, will help create better enabling environment to scale up the prevention and control measures, CST, and impact mitigation. However, in most districts and provinces, social, cultural and political stigma and discrimination were still a major barrier towards developing an effective HIV and AIDS response, and therefore the stigma and discrimination need to be addressed.

The study, however, analysed that correlations between current levels of integration, key stakeholders, and other factors have little influence on the effectiveness of HIV and AIDS response. A strong health system at the local level does determine effective integration of HIV and AIDS response into the health system. The current state of integration of HIV and AIDS response into the health system studied by this research could not be used to assess the effectiveness of HIV and AIDS response programs in general.

In summary, to achieve integration as an ideal indicator to ensure effectiveness and continuity of HIV and AIDS response, there would certainly be required a stronger health system that would provide the following: 1) achieving synergy between strategic stakeholders (i.e. local planning agencies, Regents/Mayors, local parliament and non-structural units within the government bodies) in responding to HIV and AIDS issues as local health issues; 2) strengthening the regulatory function through development of technical guidelines at the local level and synchronised with national regulations; 3) increasing local autonomy districts to manage program and epidemiological data as a basis to exercise administrative authority (including planning and budgeting), and strengthen the provision of preventive care, CST, and impact mitigation at local level; 4) increasing the willingness of central government and IDPs to delegate the administrative authority in HIV and AIDS response in accordance to the local capacity; 5) increasing commitment from local governments to assume a greater role in HIV and AIDS prevention by funding community-based activities previously funded by IDPs; 6) replicating best practices in HIV and AIDS policies at the local and national levels; 7) redirecting the technical and financial support from the central government and IDPs to strengthen the local and provincial health system by developing a roadmap and implementation plan to integrate HIV and AIDS into the health system.

Finally, involvements of higher education institutions in the provinces to provide evidenced based policy drafting support would benefit the local institutions such as KPAD in coordinating its member institutions for the success of addressing HIV and AIDS issues on the field. On the other hand, the universities would be required to take concrete steps in disseminating the results of their research to stakeholders in HIV and AIDS response in the districts. These results of the researches could technically be translated into agendas of collaboration efforts between the KPAD and the universities.
I. Introduction

A. HIV and AIDS Response in Indonesia
In the early years since the first AIDS cases was reported almost three decades ago (1987), HIV and AIDS response in Indonesia were still limited and focused in the health sector. The increase in infection rates was still slow until a sharp increase was evident in the mid-1990s. At the same time, a consensus that HIV and AIDS constituted an urgent development problem requiring serious attention from the government was created at global level. There had been a significant increase in investment from international donors and pressure on national governments across countries to establish responses that are not just limited to the health sector but also involving collaboration between various sectors including non-governmental organizations (KPAN, 2014).

The Indonesian government responded to these developments and pressures by issuing the Presidential Decree No. 36 of 1994 that regulated the establishment of a cross sectorial body, i.e. the National AIDS Commission (Komisi Penanggulangan AIDS Nasional - KPAN). KPAN is responsible for the coordination of HIV and AIDS response efforts in Indonesia. Not long after its establishment, the PAN developed the first National Strategic Action Plan (Strategi Rencana Aksi Nasional - SRAN) for HIV and AIDS response, covering a period of five years from 1995 to 2000. However, the strategic plan was not supported by allocation of sufficient funds from the Indonesian government. Instead, because of pressure from global health initiatives, various international donor agencies including USAID, AusAID (now: DFAT), the World Bank and multilateral agencies such as UN agencies contributed almost 60 million dollars during the period of the SRAN. Funding from the Indonesian government at the time only amounted to around 20 million dollars (KPAN, 2014). This implied that the Indonesian government was dependent on the support of international donors.

The enactment of the decentralized government system or local autonomy in the beginning of the 2000s became an important momentum which significantly influenced the national HIV and AIDS response. The transfer of authority from the national level to the local government level also complicated the power and authority relations in terms of planning and funding in HIV and AIDS response. At the same time, this period witnessed an increasing amount of funding from various international donors. For example, the Global Fund (GF) has been a key player since 2003 in HIV and AIDS response in Indonesia by providing funding and technical assistance in five provinces (GF Round 1). Support was increased to include 19 provinces between 2005 and 2010 (GF Round 4). Through a bilateral agreement, the US and Australian governments also provided funding support, each was around 10 million dollars during this period (KPAN, 2011).

From the programmatic side, the HIV and AIDS policy in Indonesia was aimed at achieving universal access, in which promotive, preventive, curative, and rehabilitative health services related to HIV and AIDS can at least be used by 80% of the population affected by HIV and AIDS. The efforts in promotion and prevention is aimed at changing the behaviour of key population groups through the increase in the use of sterile syringes, the use of condoms, treatment for Sexually Transmitted Infections (IMS), and counselling and testing for HIV in those communities through a series of communication, information, and educational activities (KPAN, 2011). Efforts in care, support, and treatment is aimed at removing various obstacles of obtaining access to health services for people with HIV and AIDS, including eliminating stigma and discrimination. It was targeted that the prevalence of HIV could be decreased to less than 0.5% by 2015 (KPAN 2011). To achieve this goal, the KPAN, through the 2010-2015 SRAN for AIDS had selected 137 districts/municipalities in 33 provinces as priority areas for the program. It was targeted that 80% of the key population in these areas could be approached and provided access to HIV and AIDS services. These interventions was also supported by policies which
addressed coordination in planning, implementation and monitoring and evaluation (M&E), involvement of civil society, commitment and funding support from the national and local governments and international partner agencies as well as institutional strengthening of local AIDS commissions.

An external analysis by WHO in 2012 showed that the development of policies and programs have contributed to significant progress and interventions, however, there are still huge gaps across areas. The type of interventions was also significantly differed across areas districts (WHO, 2012). The HIV and AIDS response policies and programs of today and in the future face a major challenge to reduce the HIV transmission and improve the quality of life of People Living with HIV/AIDS (PLWHA). More effective efforts in preventing HIV transmission both in key populations and general populations with lower risks are needed. Future AIDS prevention efforts also face the challenge of providing long term care for people with HIV and AIDS as the increased effectiveness of antiretroviral therapy (ARV) may reduce AIDS-related mortality rates and prolong the lives of PLWHAs. These two major challenges require a collaborative and continuous effort in both upstream and downstream sectors of HIV and AIDS response. At the upstream level, HIV policies and programs need to be integrated into the health system. Intervention at the downstream is aimed at developing a model of health service and operational system that involves multi-sectorial and program collaborations to ensure that the provision of high-quality service is aligned with the continuum of care of HIV and AIDS response.

B. The Health System and HIV and AIDS Response

The role of global health initiatives since the early days of the HIV and AIDS problem in Indonesia has improved the availability of funding and consequently scaled up the scope of service related to HIV and AIDS. Although funding from these global initiatives started to decrease from year to year, the funds available for HIV and AIDS response especially for prevention is still largely dependent on bilateral or multilateral grants as the available government funding only amounts to 40% of the total funding required (Nadjib, 2013). The significant role of donor in HIV and AIDS response in most developing countries had brought many consequences both positive and negative for the country health system (Atun et al., 2010a; b; Conseil et al., 2013; Desai et al., 2010; Dongbao et al., 2008; Kawonga et al., 2012; Shakarishvili et al., 2010). The health system refers to individuals, organizations or resources that are managed together based on a series of policies with the aim of protecting against the effects of health problems according to the expectations of the community (WHO, 2000).

Previous studies have identified a number of negative consequences of donor influence to health system responses including; (1) development of a double system, i.e. the HIV and AIDS response system and the general health system; (2) low incentives from the health system to support HIV and AIDS response efforts; (3) limited integration of HIV and AIDS services with other health services; (4) disintegrated planning, coordinating and monitoring system from other health programs; (5) growing concern that this situation can worsen the health system because resources are eroded for HIV and AIDS response.

Most HIV and AIDS programs are managed outside or parallel to the existing health system. This led to an attempt to integrate HIV and AIDS programs into the health system in order to strengthen the health system and ensure the sustainability of the programs as the technical support and funding from global health initiatives decreased (Atun et al., 2010; Coker et al., 2010; Kawonga, 2012). Integration is an organizational and managerial framework to adopt and assimilate efforts in HIV and AIDS response into the key functions of the health system. As an example for integration in service delivery function is integrating HIV and AIDS service into the general health services. Merging of financing mechanism for HIV and AIDS response into the general health financing is an example for integration at health financing function.
A study on the integration of HIV and AIDS and Tuberculosis (TB) programs in Indonesia shows that HIV AIDS and TB programs are not well integrated into the general health system. One of the reasons was because administration, M&E system, planning, funding, and health provision of HIV and AIDS were developed differently from the system that is commonly applied in infectious diseases control programs (Desai et al., 2010; Coker et al., 2010). A document study on HIV and AIDS policy and programs from 1987 to 2013 (CHPM, 2015) showed that the management of HIV and AIDS programs in Indonesia is disintegrated from the existing health system as indicated by the following situations: (1) HIV and AIDS response efforts in Indonesia are regulated by vertical policy initiated and developed by the central government with the support from global health agencies; (2) in the decentralization era, the local governments did not local exert any political commitment or a significant role in the formulation of HIV and AIDS response policies and programs, either in prevention, CST, or in impact mitigation; (3) the central government and beneficiaries tended to position the local governments as program implementers; resulting in the lack of capacity of local governments districts for planning, budgeting, and managing programs; and (4) the development of structures and systems that are different from existing infectious disease control programs.

The integration of HIV and AIDS programs into the health system by maximizing the use of existing infrastructure and resources is not an easy task. It involves many actors (and their pragmatic interests), institutions and policies (Dudley and Garner, 2011, Atun et al., 2010). The effort to integrate “integration” and “vertical approaches inherently carried some risks. Results and innovations produced by vertical approaches may become less visible or even disappearing because they cannot be accommodated by the health system. In contrast, the vertical approach might be retained because the existing health system is still weak, leading to reluctance in adopting innovations offered by vertical interventions (Godwin and Dickinson, 2012).

Nevertheless, the effects of integrating specific interventions into the health system on health outcomes are still unclear. Only few studies have examined the integration of specific programs into a health system. Moreover, existing studies showed a lack of sufficient methodology (see Kawonga, 2012 and Coker et al., 2010). The issue is not whether integration is better than vertical approach. Rather, it should be discussed whether the combination of the two approaches can provide better results for health status of the population in the light of the complexity of health service provisions. It should also be based on an effective planning, coordination, and management (Dudley and Garner, 2011; Atun et al., 2010). The major challenge is to determine the right combination and composition of these two approaches, which requires careful considerations.

These situations raised several policy questions that require attention when examining the association between HIV and AIDS response and the health system as follows: (1) What is the extent of integration of HIV and AIDS policies and programs into the national health system (2) What is the best combination and composition between vertical and integrated approaches in order to improve the effectiveness and sustainability; taking into consideration the various functions in the health system, the characteristics of stakeholders involved in the health system and HIV/AIDS response as well as the political, economics and socio-cultural context in which these interactions take place.

In order to answer these two policy issues, the Centre for Health Policy and Management Faculty of Medicine, Universitas Gadjah Mada with the support of the Australian government through the Department of Foreign Affairs and Trade (DFAT), in collaboration with nine universities in eight provinces in Indonesia, conducted a study on the Integration of HIV and AIDS Response Efforts into the Health System. This study aims at mapping out the strengths and weaknesses of the Indonesian health system in supporting and responding to the HIV and AIDS...
issues in order to identify potentials and opportunities of integrating HIV and AIDS response into the existing health system.

C. Research Questions and Objectives

a. Research Questions

To what extent has the HIV and AIDS response efforts been integrated into the Indonesian health system?

The specific research questions of the present study were as follows:

1. What are the context, process and substance of policies and programs in HIV and AIDS response within the existing health system at national level?
2. To what extent has the synergy between functions and roles of the AIDS Commission, Provincial/District Health Offices, NGOs and other sectors at national and local level taken place to respond to HIV and AIDS threats?
3. How consistent are the HIV and AIDS regulations at the national and local level?
4. How much are the proportion, suitability, distribution and sustainability of current the funding (e.g. foreign donors, APBN/D and community funds) for HIV and AIDS response at the national and local level?
5. To what extent have the working relations, workforce and capacity building between non-governmental workers and healthcare workers at the national and local level taken place?
6. To what extent has the HIV and AIDS reporting system been integrated in the strategic information system at the local and national level? To what extent have the HIV and AIDS related data been used as 'evidence' in developing and implementing policies and programs?
7. What is the current state of the availability, distribution chain and portability of HIV and AIDS preventive, diagnostic and therapeutic materials at the local and national level in the contexts of the national health insurance policy (Jaminan Kesehatan Nasional - JKN)?
8. To what extent have the affected member of the community participated in HIV and AIDS response?
9. What is the relationship between universities and the HIV and AIDS response at local and national levels, particularly in providing information and human resources?

b. Research Objectives

This study aimed at analysing the integration of HIV and AIDS policy into the Indonesian health system in order to develop recommendations to improve the performance of HIV and AIDS response programs for the next 5-10 years. In particular, the research objectives were as follows:

1. Analysing the context, process and substance of HIV and AIDS policies and programs at the national and local level within the framework of existing health system;
2. Identifying and measuring the synergy of functions of AIDS Commissions, Health Offices, NGOs and other sectors in HIV and AIDS response at the national and local level;
3. Measuring the alignment of HIV and AIDS regulation between national and local levels;
4. Measuring the proportion, suitability, distribution and sustainability of available funding (e.g. foreign donors, state/local government budget and community funds) for HIV and AIDS prevention at the national and local level;
5. Identifying the working relations, workforce and capacity building between non-governmental AIDS workers and healthcare workers at the national and local level;
6. Measuring the integration of HIV and AIDS reporting in the strategic information system at the local and national level and the use of 'evidence' in developing and implementing policies and programs;
7. Measuring the availability, distribution chain and portability of preventive, diagnostic and therapeutic materials in the local and national level in the contexts of the national health insurance policy;
8. Measuring the active participation of affected communities in HIV and AIDS response;
9. Measuring the relationship between universities and the needs of HIV and AIDS response at local and national level, particularly in providing information and human resources.

D. Conceptual Model
This research attempted to measure the extent of HIV and AIDS response has been integrated into the health system. This research used a modified analytical framework developed by Atun et al., (2010a) and Coker (2010) to measure the integration of an intervention developed to respond to a certain health problem into the health system as a conceptual model to be used in the data collection and analysis (see Figure 1).

Figure 1. Conceptual Framework

Following Atun et al., (2010), integration in this conceptual model is defined by the level of adoption and assimilation of a specific health intervention into various key functions of the health system. The concept of adoption or assimilation is used as an indicator of the level of integration. It is based on the assumption that a specific health intervention (including HIV and AIDS response) is an innovation in health intervention which consists of perspectives, practices or institutional management that is considered different from other health intervention. From the health system perspectives, integration indicates to what extent the various key functions of the health system has been employed to support innovations in solving certain health problems by building commitment between actors in the health sector and using available technology and resources (WHO, 2007). In the context of Indonesia, the various key functions include management and health regulation; financing; human resources; strategic information; service delivery; and community empowerment, as described in the Indonesian national health system (Presidential Decree No. 72 of 2012).
The conceptual framework showed that the extent of integration of HIV and AIDS response into the health system is influenced by: (1) characteristics of the HIV and AIDS issues and the policies and programs related to prevention, care, support and impact mitigation; (2) interaction of various actors and interests within the health system and HIV and AIDS response; (3) the implementation of key functions within the health system; and (4) the political, economic, legal and regulation context as well as health problems in which HIV and AIDS response is taking place. Hence, the present study focused on exploring the implementation of key functions of the health system within HIV and AIDS response such as management and regulation, financing, human resource management, provision of pharmaceuticals and medical equipment, management of strategic information, mobilization of community participation and the interactions between all functions.

Therefore, the dynamic interaction of these four components may indicate the level of integration in the provision of health services related to the disease (prevention, care and treatment, and impact mitigation). The extent to which integration contributes to the effectiveness of the program will be measured by the performance of the provision of HIV and AIDS services as follows: (1) whether the community are able to use the services (coverage); (2) whether the community are able to access the services (accessibility); (3) whether the service provided by the AIDS program contributes to the reduction of HIV-risk behaviours and improve the treatment compliance of PLWHA.

E. Research Methods
The present study was conducted in several sites by different research teams between 2013 and 2016. The study location included North Sumatera, East Java, Bali, South Sulawesi, Papua and West Papua Provinces. In all provinces except West Papua, two districts/municipalities were selected as study location.

Each research team produced a local research report which described the level of integration of HIV and AIDS programs into the health system in the respective districts or municipalities. These local reports were used as a basis to develop a final report to describe the levels of integration of HIV and AIDS programs into the health systems in six provinces and identify factors that influence the level of integration and uncover the implications of integration on the effectiveness of HIV and AIDS programs.

a. Research Design and Procedure
This is a descriptive research using qualitative methods to gain a deeper understanding of the level of integration of HIV and AIDS programs in to health system. The research uses phases of qualitative research described by Creswell (2003), which include the following:

1. **The first phase**: collection of **main data (primary)** and **additional data (secondary)**. The primary data collection employed focused group discussions and in-depth interviews using a standardized data collection instrument.

2. **The second phase**: verbatim transcripts were categorized based on the four main themes illustrated in the conceptual framework (see Figure 1), i.e.: (a) contexts of HIV and AIDS programs; (b) role of actors in HIV and AIDS programs and local health systems; (c) implementation of the health system functions in HIV and AIDS response; and (d) the performance of health services in HIV and AIDS response. These four main themes were further developed into detailed sub-themes to understand the data.

3. **The third phase**: triangulation between the matrix of themes with the secondary data or from the interview with relevant informants.

4. **The fourth phase**: scoring of the level of integration of HIV and AIDS programs into the health system using a scoring system that had been employed in previous studies (Conseil et al., 2010; Desai et al., 2010).

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The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT 19
5. The fifth phase: report was written based on the analysis of the four main themes to obtain a description of integration level of HIV and AIDS programs into the health system in each province. Six reports were compiled to represent the level of integration in each study location.

6. The sixth phase, the six local reports were analysed further by the core research team and then compiled into a joint report. The additional analysis was also supported by primary and secondary data to ensure the consistency of the analysis. The joint report was a synthesis of the findings on the level of integration. In addition, the joint report also covered factors that influenced the level of integration of HIV and AIDS programs at the local level and their implications to the effectiveness of these programs.

b. Study locations
The study locations were chosen based on a number of criteria, such as: 1) being classified as a concentrated or generalized epidemic; 2) having active HIV and AIDS programs; and 3) having university research institute with qualified researchers.

Six provinces selected as study locations were: North Sumatera, East Java, Bali, South Sulawesi, Papua, and West Papua. In each province, two districts/municipalities were chosen based on the list of 137 priority districts/municipalities from the National AIDS Commission (KPAN, 2010). For West Papua, only one district was selected. In total, the study was conducted in 11 districts/municipalities from 6 provinces in Indonesia.

At first, DKI Jakarta and East Nusa Tenggara were also selected as study location, however, the data collected from the study locations in these two provinces could not be compared to the other six provinces. Therefore, results from these two provinces were not included in this report.

The present study was conducted by a group of researchers from the following universities: University of North Sumatera (USU), Airlangga University (UA), Udayana University (Unud), Hasanudin University (Unhas), Cenderawasih University (Uncen), and University of Papua.

c. Participants
The participants were purposively selected from all stakeholders involved in HIV and AIDS response. The number of informants varied for each province, depending on the type of programs and the number of institutions/agencies involved in the program implementation. The selected participants were as follows:

1. Members of Provincial/Local AIDS commissions
2. Local Government Task Force (Satuan Kerja Pemerintah Daerah - SKPD) that have functions and tasks related to HIV and AIDS response;
3. Civil society organizations or CSO (Organisasi Masyarakat Sipil - OMS) and community based organizations and CBO (Organisasi Berbasis Masyarakat - OBM) such as Peer Support Groups and other key population groups; and
4. Representatives of key populations (e.g. People Who Inject Drugs or IDUs - Penasun, Direct and Indirect Female Sex Workers - WPSL/TL, Men who have sex with men – MSM, and waria). These participants were recruited by CSOs.

d. Instruments
Based on the conceptual framework of the study, the data collection were focused on the following aspects:

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1 The core research team consists of researchers from PKMK FK UGM and PPH Atmajaya University.
a) **Contexts** of HIV and AIDS response: interests and political commitment in the province, district laws and regulations related to HIV and AIDS programs, the economic situation and general health problems in the region.

b) **The role of actors in AIDS programs and the health system** in the province: the role of local governments, local AIDS commission, IDPs, CSOs and other strategic stakeholders in the implementation of HIV and AIDS programs in the region.

c) **Implementation of the functions of the health system in HIV and AIDS response**: function of management and regulation, funding, human resource management, provision of pharmaceuticals and medical equipment, strategic information management, mobilization of community participation and provision of health services. All these functions were classified according to the dimensions of their functions in the health system’s implementation. In total, the seven functions covered 10 dimensions/sub-themes.

d) Performance of health service in HIV and AIDS response: coverage, accessibility, quality, and sustainability of services.

The study instrument was adapted from the instrument used to evaluate the performance of health systems conducted by USAID 2012 in the *Health System Assessment Approach: How to Manual* and the SYSRA Toolkit (Mounier-Jack, 2008) that evaluated the level of integration of a specific intervention into the health system. The instrument had been tested in a number of countries including Indonesia to examine the effectiveness of specific interventions related to Millennium Development Goals such as maternal and child health (MCH), HIV/AIDS, tuberculosis (TB) and Malaria.

e. **Data Management**

Data management was first conducted by the local research team level and by the core research team. All interviews and FGDs were audio-recorded. Every recording was transcribed verbatim. Each transcript was then coded based on the categories of themes relevant to the research by the local research team. The categories were entered into a matrix to identify topics that recurrently emerged. The topics identified during the analysis were validated through a validation meeting with informants. The secondary data were also analysed using the same methods, i.e. coding and grouping according to the categories. The secondary data were used as additional data and for validating the information collected during the interviews and FGDs.

At the level of the core researcher team, the source of data was reports collected from each province. Reports were combined based on the categories, which consisted of stakeholder analysis and the description of each health system key functions. The description of each category was summarized into matrix of findings that was divided based on the dimension of the health system key functions.

The core researcher team validated the findings from provincial reports with the secondary data in order to validate the results. In addition, the secondary data were also used to evaluate the performance of HIV and AIDS programs from the various aspects including coverage, behaviour modification and compliance based on the number of PLWHA that are on treatment.

f. **Data Analysis**

Data analysis was conducted by grouping data into main themes and sub-themes in each dimension of health system key functions. The process of categorizing and classifying data was a continuous process throughout the analysis until a detailed description of the main themes was set. The credibility of the data was controlled through informational and subject triangulation. The process of stakeholder analysis and integration analysis is described in detail below.

1. Stakeholder analysis was conducted through the following steps:

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2 Downloaded from http://www.healthsystemassessment.com/health-system-assessment-approach-a-how-to-manual/
a) The local researcher identified the role and function of stakeholders HIV and AIDS response in the province (local government, local AIDS commission, CSOs, CBOs, IDPs, and community leaders).
b) The local researcher described the role and function of each stakeholder based on their interests and power in the development of HIV programs and policies in the respective province. Interest was defined based on the roles assumed by the stakeholders or expectations on the development and implementation of HIV and AIDS programs in the province. Authority was defined by the resources possessed by the stakeholders making decision or influencing the development of HIV and AIDS programs and policies. The interaction between stakeholders was also described.
c) Based on the description, the stakeholders were classified based on the stakeholders’ interests and power into the following categories: 1) high interest and high power, 2) high power and low interest, 3) low power and high interest, and 4) low power and low interest. The implication of the stakeholders’ position on HIV and AIDS response in the province was analysed.
d) Based on the stakeholder analysis and the mapping of authority figures in the province, the core researcher team conducted additional data collection to map the strategic stakeholders involved in HIV and AIDS response in the respective province. The most strategic stakeholders were identified from the most commonly mentioned stakeholders during interviews and FGDs in the 11 districts/municipalities. The position of each stakeholder can be identified in the matrix.

2. Analysis of the level of integration Levels was conducted using the methods suggested in the SYSRA (Mounier-Jack et al., 2008) and previous studies (Conseil et al., 2010; Desai et al., 2010). The steps to determine the level of integration was as follows:

a) The seven key functions of health system and the respective dimension. This description provided a detailed picture of the implementation of each health system key function district according to 3 types of HIV and AIDS programs which included promotion and prevention (PP); care, support and treatment; and impact mitigation (MD) as shown in the table below:

<table>
<thead>
<tr>
<th>Functions</th>
<th>Dimensions</th>
</tr>
</thead>
</table>
| 1. Management and Regulation | 1. Regulation  
2. Policy formulation  
3. Accountability and responsiveness |
| 2. Financing | 4. Management of funding sources  
5. Budgeting, proportions, distribution, and spending  
6. Mechanism for financing of services |
| 3. Human Resources | 7. Policy and management system  
8. Financing  
9. Competence |
| 4. Provision of Drugs and Medical Equipment | 10. Regulation of provision, storage, diagnostics and therapy  
11. Resources |
| 5. Information System | 12. Synchronization of information system  
13. Dissemination and utilization |
15. Access and utilization of services |
| 7. Service delivery | 16. Availability of services  
17. Coordination and referrals  
18. Ensuring quality of service |
b) Based on the description of the implementation of the health system key functions in HIV and AIDS response, a scoring was used to determine the level of integration of each dimension of health system function for each type of interventions in HIV and AIDS response. An evaluation manual was developed for the local researcher team to determine the score for each dimension (see Appendix 3). The classification of the level of integration used in the present study is as follows:

i. Full integration: the implementation of the dimension has been in line or oriented to the implementation of the corresponding dimension for infectious disease control.

ii. Partly integrated: the implementation of the dimension has been partly oriented or in line with the implementation of the corresponding dimension for infectious disease control.

iii. Not integrated: the implementation of the dimension is completely different from the implementation of the corresponding dimension for infectious disease control.

iv. No data (NA): There is no data available to evaluate the integration of HIV and AIDS health function systems into the existing systems of disease control.

c) To determine the level of integration in each health system function (the evaluation score for all dimensions within each health system function for each intervention was summed. The total score was used to identify the level of integration based on the argumentation constructed by the researcher. The same method was used to evaluate the integration of each dimension of whole HIV and AIDS response including PP, CST and MD.

d) The total score of the level of integration of HIV and AIDS response into the health system all study locations was further analysed by the core researcher team to obtain an aggregate score of the level of integration. Using the Delphi method, the core researcher team evaluated the level of integration of each dimension of the health system function based on the description provided in the local reports.

g. Structure of the Report

This joint report consists of five chapters. Chapter 1 presented the background and the research methodology. Chapter 2 discussed various contexts that enable or hamper the HIV and AIDS response in the province, such as political commitment, economic situation, health problems as well as the situation of the AIDS epidemic in each province. Chapter 3 presents the analysis of the roles and functions of local stakeholders in HIV and AIDS response in the province and the interaction between these stakeholders in shaping or influencing HIV and AIDS programs and policies in the province. Chapter 4 details the implementation of the health function in HIV and AIDS response. The description in Chapter 4 is the foundation for the evaluation of level of integration from the aspect of health system functions, the type of intervention, or the study location. The evaluation of the level of integration, factors that influence the level of integration, as well as the implications of the level of integration on the effectiveness of HIV and AIDS programs in the province is presented at the end of Chapter 4. The report is concluded by Chapter 5, that summarizes the key findings and their implications. Conclusion and recommendations are presented for the development of HIV and AIDS policies and programs in Indonesia.
II. Context

A. The Context of HIV and AIDS Policies and Programs at the National and Local Level

Context refers to the external factors that influence the implementation of a certain program in dealing with an infectious disease. Context usually consists of a number of key aspects such as politics, laws and regulations, economics and health problems (Cooker et al., 2010). In the present study, the context of policy reflected the wide variation in the practice of decentralization in the districts province, which included factors of political commitment, laws and regulations, economics, and health problems. This section will describe the context, process and substance surrounding the HIV and AIDS policies and programs at the national level within the framework of the existing health system. The influence of these factors on the integration and effectiveness of the HIV and AIDS programs will also be described.

a. Political Commitment

HIV and AIDS is a complex issue, for which an adequate and effective response will require the involvement of various parties in a multi-sectoral collaboration and partnership. Political commitment of local leaders to mobilize this multi-sectoral response is crucial for HIV and AIDS response. In most of the study locations, there is a lack of political commitment from local governments to HIV and AIDS response. Although most of the local governments had shown early commitments by developing policies on HIV and AIDS response, districts HIV and AIDS remained not being prioritized districts. This was indicated by the reluctance of local governments to allocate sufficient funding for HIV and AIDS programs. In the majority of the study locations, funding for HIV and AIDS programs allocated in the local government budget through the relevant government working unit is still limited. It was apparent that the commitment of funding is merely a formality rather than aiming to meet the actual needs of HIV and AIDS programs. Consequently, inadequate allocation of funding became a problem in most provinces, for example South Sulawesi.

“This year, 2014, we only get 46 million from the APBD (local government budget). What can we do with only 46 million? So we’re still very dependent on the Global Fund (GF)”. (FGD, South Sulawesi Provincial Health Office, in Unhas Team report, 2014)

In Surabaya, the funding commitment has been realized, although it has not been sufficient to cover all planned activities. The amount of budget for HIV and AIDS response proposed by the Surabaya AIDS Committee was IDR 10 billion, however, only 3 billion was approved by the local parliament. This significant budget cut highlights the fact that HIV and AIDS programs are not yet a priority in the districts.

In 2013, the funding from the APBD received by the Surabaya KPA decrease, while the funding from GF increased compared to the previous year, from Rp 80.860.000 to Rp 84.203.000. In the same year, Bhakti Dharma Husada hospital received Rp 20.475.000. from GF (Unair Research Team, 2014)

In addition to budget cuts, there was a limited understanding among the local governments that to address HIV and AIDS issues, a multi-sectoral response is required. HIV and AIDS response is still perceived as only a health problem that should be solely addressed by the Province/District Health Office and the various units in healthcare services. As a consequence, there was a minimal or even absent involvement of the other government working units or other non-health government agencies in the districts or province. There was a very small amount of funding from the local government budget for HIV and AIDS programs in non-health sector government working units. While some government working units were assigned as part of Local AIDS Committee, many of these government working units were not active.
This situation is worsened by the fact that within the local political and governance system, the Local AIDS committee does not have a clear structure and authority. The local AIDS committee is typically led by a local official who holds a strong authority and influence, which should enable to encourage more commitment to prioritize HIV and AIDS issue in the local political agenda. However, the presence of such a figure within the structure has not been strong enough to stimulate commitment and funding allocation for HIV and AIDS programs. In some cases, the main driving force to prioritize HIV and AIDS a priority is often the personal interest of the local AIDS committee official, was found in Makassar.

“The regulations are important, but the most important thing is to make HIV and AIDS programs a priority for mayors or regents... So our ability to convince them is very important. It is very important to convince them that this is dangerous... Practically, the commitment of mayors is actually more important than the regulations.” (In-depth Interview, Makassar City Finance and Asset Management Body, in the Unhas Research Team report, 2014).

Because there is a lack of multi-sectoral support from local government agencies, the local AIDS committee and the health sector have to bear huge responsibilities. However, because of the unclear position of the local AIDS committee within the local government structure, the committee has limited capabilities in coordinating and influencing the policy on HIV and AIDS. With this context of local politics and governance, it is difficult for HIV and AIDS to become a priority issue in the districts and provinces.

b. Laws and Regulations
At the local level, many regulations were counterproductive towards HIV and AIDS response efforts. Instead, these regulations tend to limit the access of key populations to health services. There is a number of local policies (Perda) which regulates morality and social order such as local regulation on anti-prostitution, social disorders, or closure of brothels and the criminalization of sex workers. The enactment of these policies brought several consequences. For example, because of the closure of brothel complex in Surabaya (Perda No. 7 tahun 1999), many sex workers who were targets of location-based PMTS programs were dropped out from the program. Many sex workers moved to various scattered places, making it harder for healthcare workers to reach them. As a result, many HIV and AIDS program that were targeted to reduce sexual transmission became ineffective. Because of the closure of brothel complex in Surabaya, many sex workers moved to other districts and provinces such as Bali and the surrounding islands. As they were often not registered as resident in the province and having no local identity card, it was often difficult for them to access the health service using the National Health Insurance (JKN). Such a problem occurred because the National Health Insurance requires people to access health services at the same residence as their address information on the cards.

In Papua, the Special Autonomy Law provides native Papuans with rights to access the health care and also more employment opportunities as civil servants. However, this policy has the potential to be discriminative since it may prevent non-native residents from obtaining health care. In addition, there was a lack of sanction mechanism to government working units that did not their responsibilities in HIV and AIDS response. In many districts and provinces, local policy on HIV and AIDS only set sanctions against the health professionals, health service providers, and managers or owners of entertainment venues. As a result, there is no incentive or disincentive for the government working units to actually fulfil their responsibility in HIV and AIDS response.

c. Economics
HIV and AIDS cases are typically more prevalent in major cities which are characterized as economic centre of a province such as Medan, Surabaya, Makassar and Jayapura. These cities are centre for trades and industries with relatively high number of HIV and AIDS cases.
However, the high number of HIV and AIDS cases in these provinces had not elicited adequate responses from the local governments. Consequently, HIV and AIDS response efforts in these provinces were often initiated by IDPs. The presence of IDP in these provinces had scaled up the development of HIV programs and services, increased the coverage and use of health services.

However, because of the support of IDPs, the local governments were increasingly more reluctant to allocate funds for HIV and AIDS programs. Because of the high dependency to IDPs, significant reduction in HIV and AIDS programs were often observed after the IDP support had been withdrawn. Such a phenomenon had been observed in South Sulawesi or Papua.

“We are still dependent on donors. Around 80 percent of funding is from donors. Like in 2014, from the APBD we only get 46 million. What are we going to do with only 46 million? So we are still very dependent on Global Fund (GF). However, even with that I have to be creative with GF funds because it is still not enough. For example, in supervision if I have to go to certain district... sometimes I modify it by changing to other district that is more of a priority for development.” (FGD, South Sulawesi Provincial Health Office, in the Unhas Research Team report, 2014)

Moreover, in most major cities, the private sector has not been actively involved in HIV and AIDS response. In some provinces, funding from the private sector was available through the company’s Corporate Social Responsibility (CSR) activities. For example, in Sidoarjo, a rapidly developing industrial city, there was a huge potential to mobilize the private sector to participate in HIV and AIDS response and contribute in the funding scheme. In Makassar, a number of companies including PT. Angkasa Pura, Bosowa Cement, BNI, BRI and PT. Vale in East Luwu district allocated CSR funds for HIV and AIDS activities. However, the implementation of these programs is still conducted by the private sector with limited collaboration with government sector. These activities often focused on prevention, such as inviting speakers from District/Provincial Health Office or the local AIDS committee to give public lectures or seminars. Activities were also limited to incidental events and cannot be part of a strategic and sustainable HIV and AIDS response.

d. Local Health Problems

In the context of health sector development, it was found that most local governments have not prioritized HIV and AIDS as an issue in health development. There was a limited local capacity in developing policies based on the health situation of the community. There was a lack of capacity to produce accurate health-related data. Furthermore, the local government often did not have ownership of the data that will be useful for health planning, such as data from demographic health surveys or population health surveys. For example, while local governments through the District and Provincial Health Offices routinely collect data such as the STBP (Survey Terpadu Biologi dan Perilaku), these data are owned by the central government. Local governments had limited access to these data, let alone to use the data as the basis for planning and decision making in the districts.

This situation resulted in several consequences. First, as the local governments had limited knowledge on the actual epidemiological profile of HIV and AIDS in their region, there is a lack of initiative from to develop policies and programs as a response to HIV and AIDS issues. There was a tendency that the local governments only implement programs designed by the central government (Ministry of Health) or by donors. HIV and AIDS programs were often seen as vertical programs from the central government. The targets were determined at the national level, although in the decentralization era, districts have the authority to formulate their own targets based on the local situation.

Second, the weak planning ability also led to the budgeting capacity in allocating funds for HIV and AIDS programs. There were of course some provinces which had adequate capacity to develop local data and had sufficient health sector funding, such as Bali province. However, many areas such as Makassar and Sidoarjo did not have planning documents such as the Local Strategic Action Plan (Strategi dan Rencana Aksi Daerah - SRAD). This document is vital and
The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT

should be available at districts/provinces as it functions as the basis for multi-sectoral budgeting. As a result, HIV and AIDS budget request for non-health sector is often rejected by the local planning agency because it is not regarded as the tasks of the respective sector. Even for the overall health sector, the budget allocation is short from the 10% of the total local government budget (without salary component) as mandated by the Health Law No. 36, 2009 (Article 171 line 2).

B. HIV and AIDS Epidemiological Profile and Pattern of Risk Behaviours in Study Locations

The epidemiological situation of HIV and AIDS in each province should highly influence the level of HIV and AIDS response efforts of by the local government. The number and distribution of study location HIV and AIDS cases in the study location varied significantly. Based on the 2014 Ministry of Health data, Papua has the highest prevalence of HIV and AIDS (566.50 cases per 100,000 population), followed by West Papua (356.91 cases per 100,000 population). A study location in East Java showed the lowest prevalence of 51.36 cases per 100,000 population.

Figure 1. HIV Prevalence per 100,000 people in the study locations

Source: Ministry of Health 2014

In terms of the distribution of cases, each study location showed a huge variation. In Papua and West Papua, HIV and AIDS cases have been found in the general population, which implies that these two provinces have experienced generalized epidemic situation. In other provinces, HIV cases are more concentrated in key populations such as female sex workers, waria, men who have sex with men, IDUs and customers of female sex workers. This situation refers to concentrated epidemic.

The pattern of behavioural risk factors also shows wide variations between provinces (Figure 2). The highest prevalence of injection drug use was found in Surabaya (48.6 %), followed by Medan (39.2%), and the lowest was found in Sidoarjo (6%). The highest prevalence of indirect sex workers was found in in Denpasar (8.8 %), followed by Jayapura and Medan (3.2 %). The lowest prevalence was found in Makassar and Surabaya (2 %). The indirect sex workers are commonly found in city centres with entertainment business such as bars, karaoke, massage parlours, night clubs and spa (Undana Research Team, 2014).

- The highest prevalence of direct sex workers was highest in Denpasar and Jayapura (16%), followed by Makassar (13%), Surabaya (10.4 %), Sidoarjo (10 %) and Deli Serdang (3.6%). The direct sex worker group is found in almost all areas hotspot areas, which is a centre of sexual transaction between sex workers and their customers.
It can be concluded that the number and distribution HIV and AIDS and behavioural risk factor in each study location showed different characteristics. Responses to HIV and AIDS in terms of intervention model and target population should be tailored in proportion to the epidemiological characteristics in the area.

C. Local Response to HIV and AIDS

Although the epidemiological situation in each study location, it seems that HIV and AIDS responses in the study location showed the same pattern, especially in the model of intervention and target populations for outreach and support. For example, in Papua and West Papua, the focus of prevention is targeted at key populations with the same targets and outreach model as districts in other provinces outside of Papua. There is no model of
community education that specifically address the transmission in the general population. One of intervention which stands out in Papua is the district’s Prevention of Mother to Child Transmission (PMTCT) in several districts and municipalities in Papua and West Papua provinces.

The types of preventive responses found in the districts’ study locations included tests and counselling for HIV, PMTCT, prevention of HIV through sexual transmission programs through distribution of condoms, LASS programs and methadone therapy for IDUs, as well as a wide variety of communication, information and education programs targeting the general population especially teenagers, housewives and low risk men. NGOs are one of the most important players in these preventive programs. The activities conducted by NGOs study locations included outreach to the key population groups, support for PLWHA, community education such as HIV and AIDS education for individuals, groups and community, psycho-social support, and policy and program advocacy.

The CST programs in all study locations showed the same delivery pattern, model and target because of their emphasis on the medical and curative aspects. For example, ARV therapy in all districts and provinces is delivered through the same mechanisms, because the procurement, provision and distribution of ARV therapy are performed following the vertical mechanism from the central government through state budget. However, readiness of health facilities and health professionals in meeting the standard of ARV services as formulated by the Ministry of Health showed variation. The psychosocial aspects of PLWHA has not received adequate attention due to the limited capacity of health service facilities in providing this service. The availability of psychosocial support in ARV treatment becomes important, especially with the high drop-out levels and low compliance to medication. Based on data from the Ministry of Health (2014), the drop-out cases were highest in Papua (33.1%), North Sumatera (27.06%), Bali (25.07%), West Papua (23.40%), East Java (27.77%), and South Sulawesi (15.66%). The number of PLWHA on treatment was highest in East Java (4885), Bali (3784), Papua (3528), North Sumatera (2336), Sulawesi (1329), and West Papua (765).

Some provinces in this study already set up the Comprehensive and Continual Care approach. This approach develop an integration of services, including coordinating key HIV and AIDS stakeholders across sectors with active involvement of the community. The approach have been developed in a number of locations such as Surabaya, Sidoarjo, Denpasar, Badung, Makassar and Parepare. This approach provides a pathway to integrate AIDS services to the level of primary care, including diagnostic services, HIV tests (VCT/PICT), link to care and compliance support for PLWHA on ARV therapy. However, in practice, the number of primary health services that can provide and continue ARV therapy is still very limited, because of the scarce availability of health resources in the province to support the integrated approach.

The Strategic Use of ARV (SUFA) approach has also been implemented in the districts in order to ensure that more PLWHA enter the treatment. As shown in Figure 3, however, a large gap remains between the number of PLWHA entering HIV treatment and the estimated total number of PLWHA. The pre-medication phase of ARV requires a long and costly process and procedure, which prevents many PLWHA to obtain immediate treatment.

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3 Consisting of loss to follow up and withdrawal from ART.
4 Calculated from the proportion of individuals that enter ART minus the number that die, the number that stop, loss to follow up and out-referrals.
In the majority of provinces, impact mitigation is the most poorly developed program. In almost all of the study locations, the impact mitigation response is not yet functional and still poorly coordinated in the study locations (11 districts and municipalities). This indicates that there was a limited understanding among the respective government working units on the importance of continuum of care in supporting PLWHA. In addition, the role and responsibilities of government working units as member local AIDS committee is still unclear. Support for PLWHA mainly comes from NGOs and community leaders, who have little coordination with the relevant government agencies.

Compared to the other districts, the impact mitigation program in Papua is relatively functioning because of the presence of the Special Autonomy Law (Otsus). In Manokwari for example, the impact mitigation effort focused more on providing support and counselling of PLWHA and their families. Using the Special Autonomy budget, this program also provided financial and food assistance for PLWHA. In Merauke, PLWHA were supported by food and nutrition supplementation initiated by community, especially activists, church leaders and traditional institutions. Strong support from the communities was also observed in Parepare and Makassar. In these areas, impact mitigation programs were delivered by NGOs with the support of donors. Support from private companies through CSR programs were also available. Community-based impact mitigation programs were also observed in Bali, especially in Denpasar and Badung. These programs were conducted by the community through empowerment programs for FSWs and rehabilitation programs for IDUs. Many different groups conducted various impact mitigation programs, however, these programs were conducted in isolation. There was a lack of coordination to deliver comprehensive and systematic impact mitigation program.
III. Key Stakeholders in HIV and AIDS Response

A. Introduction

Stakeholder analysis is a method to understand the behaviour, interests, interrelations between stakeholders and to know how stakeholders influence the formulation and implementation of policy (Varvasovszky and Brugha, 2000). In the present study, stakeholder analysis is used to map out the position of stakeholders who influence the development and implementation of HIV and AIDS programs. Stakeholders are actors who directly influence or can influence the authority of key decision makers and influence the implementation of programs (Brinkerhoff and Crosby, 2002; Varvasovszky and Brugha, 2000). In general, stakeholder analysis is based on two key elements, namely the interests and power that are yielded by each stakeholder.

In our study, power was defined as the extent of resources possessed by the stakeholders, including political, economic, and socio-cultural, as well as the ability to mobilize resources to influence the policy. To measure the level of power, the present study examined the authority and control of resources possessed by the stakeholder based on their formal position in the decision-making process and the resources. Stakeholders are defined as having high level of power if they have a lot of resources and were able to mobilize those resources in developing HIV and AIDS policies and programs.

Interests were defined by the roles that are sought or expected to benefit stakeholders in the HIV and AIDS response. The level of interest was identified from the background and position of the stakeholders in the HIV and AIDS response efforts. Stakeholders with high interest were defined as stakeholders whose current role was highly beneficial to policy and implementation of HIV and AIDS responses in the study location.

Roles and Interactions of Stakeholders in HIV and AIDS Response

It was found that the interest of the stakeholders in all provinces including local AIDS committee, District/Provincial Health Office and NGOs was high. The interest of district hospitals, community health centers (Puskesmas) and key populations was high in 10 study locations. Meanwhile, the interest of local parliament, government working units and local planning agency was low in 10 study locations. In terms of power, the District/Provincial Health Office in all study locations showed high power. The power of mayors/regents was high in 9 study locations. The power of IDPs is relatively high in all study locations with an average score of 8.5. The power of Puskesmas, NGOs, key populations, government working units and traditional/religious institutions is shown in the following figure:
Based on the stakeholder analysis, the interaction between power and interest can be categorized into four categories as follows: (1) High Interest and High Power; (2) High Interest and Low Power; (3) Low Interest and High Power; and (4) Low Interest and Low Power. Figure 2 shows the position of key stakeholders in HIV and AIDS response based on these categories:

**Figure 2. Position of Stakeholders in the Region**

The position of stakeholders based on their interests and power as shown in Figure 2 determined the role and interaction of the stakeholders to influence decision making and budget allocation related to HIV and AIDS response.
1. Stakeholder Positions

a. High Interests and High Power
Stakeholders with high interest and power are very influential during the decision making process on budget allocation. Most of the mayors/regents, IDPs and District/Provincial Health Offices are actors with high interest and high power. However, the interest and power in normative sense were different from manifested interests and power in reality.

Mayors/Regents
According to the principle of decentralization, mayors/regents should have high interest and power in developing HIV and AIDS policies and programs in their areas. As the highest structure in the local government authority, mayors/regents are institutionally the head of the local AIDS committee. Therefore, mayors/regents possess a strategic position in the decision-making and implementation of HIV and AIDS programs. The normative role of Mayors/Regents is explained in detail in the local regulation on HIV and AIDS response. This local regulation represents a formal commitment from the local government, for example in the Perwali AIDS in Surabaya and the Perwali Jayapura No. 11/2012. In Denpasar, the Mayor included HIV and AIDS response into the medium term development plan, so that the relevant government working units can create activities related to HIV and AIDS according to their main tasks.

However, these policies had little political influence in the provinces and were not given adequate priority in the development agenda. As a result, these local regulations were not fully implemented, since these policies were not translated into implementation and resource allocation plan. For example, there was limited or even absence of budget for the government working units to undertake their role as members of the local AIDS committee. Furthermore, there was no operational policy on human resource allocation from the local government to meet the workforce demands in HIV and AIDS response, such as outreach workers. It can be implied that HIV and AIDS response had not been a priority of the local governments. Support of the local government was limited to the legal and formal aspects and was not translated into technical and operational guidelines.

International Development Partners (IDPs)
IDPs had high interest and power in HIV and AIDS. IDPs had a larger technical and financial resources, which enabled them to be the most influential stakeholder in HIV and AIDS response. IDPs made decisions on the target areas and population and funding allocation. IDPs also provided capacity building activities, which enabled them to initiate HIV and AIDS policy and programs. IDPs with high interest and power were Global Fund (GF), HCPI, SUM, UNICEF, UNFPA and CHAI. The financial and technical support in the study locations provided by IDPs are detailed in the table below.

Table 2. Forms of Assistance from MPI and Location

<table>
<thead>
<tr>
<th>MPI</th>
<th>Form of Assistance</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Fund</td>
<td>Financial and technical support</td>
<td>Medan, Denpasar, and Badung</td>
</tr>
<tr>
<td>AusAid (HCPI)</td>
<td>Financial and technical support</td>
<td>Badung and Denpasar</td>
</tr>
<tr>
<td>SUM CHAI</td>
<td>Financial and technical support</td>
<td>Medan</td>
</tr>
<tr>
<td></td>
<td>System empowerment, capacity and service development through training of doctors and nurses.</td>
<td>Jayapura, Manokuwari, Merauke</td>
</tr>
<tr>
<td>UNFPA</td>
<td>Financial support</td>
<td>Merauke, Manokuwari</td>
</tr>
<tr>
<td>UNICEF</td>
<td>Funding for trial program of 'I'm Papua' books, in 17 high schools that are about sexual reproduction for</td>
<td>Merauke</td>
</tr>
</tbody>
</table>
the integration of HIV/AIDS response into the health system: PKMK FK UGM - DFAT

The position of IDPs has implications on the local HIV and AIDS programs. First, IDPs put a pressure on the local government in developing and improving services related to HIV and AIDS, which resulted in an increase in the number and types of available services. Second, using their financial support, IDPs increased the involvement of various parties such as the health service facilities (district hospitals and Puskesmas), NGOs and religious leaders in HIV and AIDS efforts. Third, IDPs indirectly influenced the level of political commitment of Mayors/Regents and the local parliament in determining resource allocation in HIV and AIDS programs. With the availability of funding from IDPs, there is a minimal pressure on the government to allocate larger amount of funds.

**District and Municipality Health Offices**

Referring to the Government Law No 41/ 2007 on Local Government Organization, the district/municipality health offices are assigned the highest authority in the health sector at the district level. This is also stipulated in the Law No 23/2014, Appendix B. As the main agency in charge in the health sector, the main task of the Health Office is to implement the local authority in the health sector and to implement supporting tasks mandated by the government and/or the provincial government. district/municipality health offices are also to formulate technical policies, decide and implement programs, and to provide support in the health sector including HIV and AIDS policy and programs. This was also emphasized during the interview with participant in Bali province.

*District health office has various roles and functions in HIV and AIDS policy. For example, the role of the Denpasar Health Office is responsible to formulate the strategic plan of the Denpasar Health Office 2010-2015 which includes HIV and AIDS as a strategic issue and new emerging disease. The Denpasar Health Office also formulates and implements programs and allocates funds for HIV and AIDS response. (Unud Research Team, 2014).*

In other provinces such as in Jayapura, the District Health Office provides HIV and AIDS related services such as clinics for Reproductive Health. This clinic STI to provide prevention measures and early identification of cases for key population (especially direct and indirect sex workers). Routine health examination was provided in bars and massage parlours. In Surabaya, the Municipality Health Office plays an important role in strengthening the epidemiological surveillance of HIV and AIDS, providing treatment programs in collaboration with hospitals and Puskesmas, and strengthening the health service system, and managing the HIV and AIDS programs with all available resources. In the Sidoarjo district, the District Health Office contributed in the prevention, promotion, early detection and treatment in HIV and AIDS response.

In Merauke, the District Health Office was responsible to translate the local regulation on HIV and AIDS into programs such as STI sexually transmitted disease (STI) prevention and VCT services. These services were provided by the Centre for Reproductive Health, Puskesmas and other agencies. Person tested positive will be followed up with ARV treatment through the HIV and AIDS Working Group in eMerauke District Hospital Merauke district. The Manokwari districtDistrict Health Office has three main activities in HIV and AIDS program: prevention, CST and impact mitigation for PLWHA. In North Sumatra, The Medan and Deli Serdang Health Office were responsible to coordinate all issues on HIV and AIDS in terms of program activities, funding and health services.

The above description showed that government health offices have high interests supported by high power. Nevertheless, it was found that HIV and AIDS response efforts performed by the health offices are also financially supported by IDPs, especially GF. GF programs were even
more acknowledged by the community than the government programs. With the huge amount of support from IDPs, at operational level there was an impression that the Health Office is an implementer of IDP programs together with NGOs or communities. Health office in most provinces was still highly dependent on IDP support, which has implications on the Health Office’s capacity on performing their roles in local HIV and AIDS response.

b. High Interest and Low Power
This category included stakeholders with high interest because their technical capacity is highly related to AIDS efforts but have low power because they rely on others for resources. Stakeholders that are included in this group were local AIDS committee, district hospitals, Puskesmas, NGOs and key populations.

Local AIDS Committee
The local AIDS committee has a high interest because it is the agency which coordinated all HIV and AIDS efforts conducted by the respective government working units. The local AIDS committee is also in charge to liaise between the key populations groups and other stakeholders and to define the responsibilities of each party in program implementation. The mechanisms of coordination typically includes meetings on planning, implementation and monitoring of programs involving the health office, government working units, NGOs, PLWHA and key populations.

“So far the closest partner for the KPAD to run various programs are NGOs and they have been very cooperative in the program implementation.” (In-Depth Interview, KPP Malas, in the Unad Research Team report, 2014).

The interaction between actors in the HIV and AIDS response in Medan has gone well under the coordination of the KPAD of Medan. This can be seen from the attendance of SKPD representative in the meetings held by the KPA of Medan. The interaction can also be seen in the cooperation between SKPD, for example between the Health Office and Social Office in following up if there is a Mr. X patient, meaning if there is a Mr. X patient then the financing will be the Social Office’s responsibility (USU Research Team, 2014).

Nevertheless, the study also found that the local AIDS committee has not been consistent in performing its role as the coordinator of HIV and AIDS response as mandated in the regulations. In some of the study locations, the local AIDS committee played a double role that did not suit their mandate. For example, in Sidoarjo district, the local AIDS committee acted as the implementer of HIV and AIDS program, for example the distribution of prevention tools and training on service delivery techniques. These tasks should be performed by the health office. The local AIDS committee in Merauke district perform procurement and distribution of prevention supplies such as condoms. In Jayapura, the local AIDS committee conducted training of counsellors and staff that work at the Centre for Reproductive Health. In some study locations, the local AIDS committee also implemented programs funded by IDPs, such as in Denpasar, Badung district, Medan and Surabaya. The involvement of the local AIDS committee in the coordination and implementation of HIV and AIDS response districts implied a high level of interest. However, the high interest is not accompanied by high power because of the structure of the organization. In the government structure, the local AIDS committee is not part of the local government institutional structure as

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5 The formulation of the City/Regency KPA is the enactment of the Minister of Home Affairs Regulation No. 20, 2007 Article 2 and also Presidential Regulation No. 75, 2006 Article 8. The Minister of Home Affairs Regulation No. 20, 2007 Article 2 states that the City/Regency KPA has nine tasks and two issues of authority. A number of variations in the implementation was found in the study locations.
it is an ad hoc agency with an ex-officio leadership. As a result, it was difficult for the local AIDS committee to obtain sufficient local government budget. This threatens the sustainability of funding for local AIDS committee. At the time of the study, the local AIDS committee in Merauke district still received financial support through the local government grant which was earmarked from the province’s Special Autonomy budget.

The source of funds for KPAD comes from the Special Autonomy (Otsus) APBD which is disbursed through the Social Office. The planning and budgeting proposed by KPAD is submitted to the DPA of the Social Office every year. The implementation of activities or the realization of the budget is done by the KPAD and made accountable through the Social Office. The size of the APBD funds increased over the years, especially in 2014. (Uncen Research Team Report, 2014).

The position of the local AIDS committee has brought a number of implications for the HIV and AIDS response districts. First, the coordination activities by the local AIDS committee was still limited to coordination of operational aspects of the programs. There was an absence of strategic coordination activities to push a multi-sector collaboration for HIV and AIDS response. The responsibilities of the local AIDS committee to push all the government working units other than the health office to access the local government budget has not been fulfilled. The local AIDS committee should also be able to take the role as advisor in planning programs which are relevant to the main tasks of the government working units. Second, there was a conflict of interest between the local AIDS committee and its members. The local AIDS committee is supposed to be the coordinator of HIV and AIDS response, while the members would implement the program. Third, as the local AIDS committee is an ad hoc agency, it is highly dependent on other actors, especially in financial access. High demands are often placed on the secretary of the committee who is responsible for operational activities in HIV and AIDS response. The secretary often had to personally approach or advocate the committee members such as the government working units to request for funding.

Non-Governmental Organizations (NGOs/LSM)

NGOs are members of the community with strategic positions to outreach, support and translate the needs of the populations they represent, as well as to call for the fulfilment of rights and health needs of that population. Thus, NGOs have a high interest at the level of implementation of HIV and AIDS response. NGOs have specific abilities that other sectors cannot accomplish, for example reaching key populations such as IDUs, FSWs, MSMs, waria and other marginalized populations. In all study locations, the majority of NGOs focused their work on preventive programs.

The resources of NGOs varied widely, however, most NGOs relied on external donors especially IDPs such as GFATM, HCPI, SUM and others (PKMK, 2015). A specific scheme, which enabled NGOs to regularly access government funds such as the state and local government budget, had not been in place. NGOs personnel who were involved in government activities or events may obtain stipends or grants, however this type of financing only occurred incidentally.

Capacity building for NGO personnel was still highly dependent on training programs initiated by the IDPs, implying that NGOs have in fact low power. From all study locations, only one NGO in Badung district reported to have high power. This NGO has qualified human resources consisting of a team of professionals such as doctors, epidemiologists, public health experts, anthropologists and trained nurses. This particular NGO became a model for similar organizations in health research and thus has relatively large influence in the area. However, the majority of NGOs in the study locations did not have this power.

This particular position of NGOs created a number of implications towards HIV and AIDS response in the region. First, because of their high interest and technical ability, NGOs became
the frontline service provider to reach key populations and mobilize key populations and PLWHA to access health services. Second, because of their limited resources, especially financial resources, NGOs were highly dependent on IDPs as the main source of funding. Consequently, instead of being the driving force of HIV and AIDS response districts, NGOs often only focused on implementing IDP programs and meeting programmatic targets. As a consequence, NGOs cannot play their role to provide input and criticism on HIV and AIDS policies and programs.

**Key Populations**

Key populations should be the centre of all HIV and AIDS policies and programs including planning, implementation, monitoring and evaluation. Key populations have a strategic role not just as target group and beneficiaries, but also as the one who determine the needs and directions of the program. Therefore, key populations have high interest.

However, the majority of key populations have low power because they have limited resources. There are no sustainable mechanisms to facilitate them to access funding resources and capacity building activities. Service provision for the key populations is mostly planned and determined by other stakeholders. For example, the Jayapura Health Office established a Centre for Reproductive Health as a technical implementation unit. This clinic determined the type of the services provided for the key population in Jayapura. In addition, there were still very few events that involved key populations. In the majority of events, they become passive beneficiaries. For example, the Merauke Health Office provided vocational training for FSWs to prepare them to leave the commercial sex works. However, the training might not necessarily meet the needs of the FSWs (Uncen Research Team, 2014).

As beneficiaries and targets of programs, the bargaining position of key populations was low that they do not have influence over other stakeholders. For example, key populations who live in remote districts without CST services often have to go to the major cities to access health service.

*The key population in Deli Serdang cannot demand service delivery in Deli Serdang. They always have to go to Medan for treatment. In Medan key populations are involved in planning forums because there is a push from donors to the local governments. Their weak bargaining position is related to their status as beneficiaries (USU Research Team, 2014).*

Until now, key populations remain only the objects and targets of program objectives. It seemed that the key populations only played the role as “an accessory”. They have not become the active subjects of HIV and AIDS programs and actively involved in planning and identifying their own needs. This indicated that the existing programs have not reflected the needs of the key population.

**Local Public Hospitals (Rumah Sakit Umum Daerah - RSUD)**

District hospitals have high interest as they have function and technical capability to provide medical treatment, nursing care, medical referrals, education, research and financing. In HIV and AIDS response, RSUDs are the secondary referral hospital to which Puskesmas will refer HIV and AIDS patients. Table 3 shows the HIV and AIDS services provided by district hospitals in the study locations.

<table>
<thead>
<tr>
<th>Location</th>
<th>Hospital Name</th>
<th>Type of HIV and AIDS Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medan</td>
<td>RSUD Pringadi</td>
<td>VCT, PITC, ARV, IMS, PTRM</td>
</tr>
<tr>
<td>Deli Serdang</td>
<td>RSUD Deli Serdang</td>
<td>VCT, PITC, ARV, IMS</td>
</tr>
<tr>
<td>Makassar</td>
<td>RS Daya</td>
<td>VCT, PITC, PMTCT, IMS, ARV</td>
</tr>
<tr>
<td>Pare-pare</td>
<td>RS Andi Makassau</td>
<td>VCT, PITC, IMS, ARV</td>
</tr>
</tbody>
</table>

*The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT*
As the secondary referral centre for ARV treatment, district hospitals have various duties as have been specified on Ministry of Health Decision Letter (SK) No. 451/Menkes/SK/XII/2012. In the study locations, however, study location there was a variety of other functions that these referral hospitals provide in relation to HIV and AIDS services. For example, Daya Hospital in Makassar is a referral hospital for patients from Andi Makassau Hospital in Parepare, because this treatment is not available in Parepare (Unhas Research Team, 2014). Merauke Hospital is a referral hospital which also has an HIV and AIDS working group. Within this HIV and AIDS working group, the hospital accepts referrals and provides treatment for patients, provides support to patients and families, and also provides treatment to all STI/HIV positive patients STI (Uncen Research Team, 2014).

Despite high interest, the power of district hospitals in HIV and AIDS response can be categorized as low. Some of the administrative authorities of district hospitals are still dependent on the central government, including planning, financing, as well as the provision of logistics such as ARV and reagent. Funding for capacity building of human resources related to HIV and AIDS is still highly dependent on donors especially GFATM, as reported in Jayapura.

.....related to the efforts in improving capacity through training, when Global Fund were still present, training was always conducted. But now it is no longer available. Training is always planned and suggested to the hospital management, but up to now it still has not been responded to (Research Team, Uncen 2014)

Limited planning and financing capabilities of district hospitals resulted in a number of implications. First, the role of hospitals in HIV and AIDS response becomes limited to delivering traditional health care services. Hospitals tend to be passive, as they only wait for HIV/AIDS patients to present to hospitals or be referred by community health centres. Second, because of financial dependency to central government and donors, district hospitals are vulnerable to political changes in the local government level or technical changes due to alterations in the financing composition from IDPs. Termination of financial support from donor agencies may disrupt the provision of existing services.

**Community Health Centres (Puskesmas)**

Puskesmas has high interest because Puskesmas functions as the primary health facilities in the community as well as the frontline health care facility for HIV and AIDS services. Puskesmas are responsible for improving health status of the community health in its catchment areas

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6 The duties of RSUD as a referral for ARV includes compiling a Standard Operating Procedure (SOP); ensuring availability of ARV medication and medication for Opportunistic Infections (IO) that is directly distributed by the Ministry of Health according the existing special procedure; preparing means, infrastructure and facilities that are in accordance to the guidance; preparing a health care workforce consisting of specialist doctors, doctors/dentists, nurses, pharmacists, medical analyst, counselors and case managers; forming work teams especially for HIV and AIDS that is made up of medical professionals and other health care professionals that have been trained through special HIV and AIDS training; and reporting the implementation of medical service to ODHA to the Ministry of Health through the Directorate General of Health Maintenance.

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<table>
<thead>
<tr>
<th>Surabaya</th>
<th>RS Mohammad Soewandi</th>
<th>VCT, PITC, PMTCT, ARV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sidoarjo</td>
<td>RSUD Sidoarjo</td>
<td>VCT, PITC, ARV</td>
</tr>
<tr>
<td>Denpasar</td>
<td>RS Wangaya</td>
<td>VCT, PITC, PMTCT, ARV</td>
</tr>
<tr>
<td>Badung</td>
<td>RSUD Badung</td>
<td>VCT, PITC, ARV, HR</td>
</tr>
<tr>
<td>Merauke</td>
<td>RSUD Merauke</td>
<td>VCT, PITC, ARV</td>
</tr>
<tr>
<td>Manokwari</td>
<td>RSUD Manokwari</td>
<td>VCT, PITC, ARV</td>
</tr>
<tr>
<td>Jayapura</td>
<td>RSUD Dok II Jayapura</td>
<td>VCT, PITC, ARV</td>
</tr>
<tr>
<td>Abepura</td>
<td>RSUD Abepura</td>
<td>VCT, PITC, ARV, CD4 test</td>
</tr>
</tbody>
</table>

Source: University Research Team Report, 2014
The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT

including HIV and AIDS response (Unair Research Team, 2014). In HIV and AIDS programs, there are variations in the activities conducted by Puskesmas in each province. For example, the Madising Na Mario Puskesmas in Parepare provided preventive care and CST, while some Puskesmas in Medan conducted preventive activities i.e. VCT and LASS (Unhas and USU Research Team, 2014). In Kotaraja Puskesmas, HIV and AIDS prevention programs i.e. VCT and PPIA are integrated into routine outreach activities in the general community, in high-risk areas, schools, and religious centres in every village (Uncen Research Team, 2014).

However, Puskesmas has low power in HIV and AIDS response, because as a technical implementing Unit of the District Health Office, puskesmas does not have authority to make decisions on human resource, financing and logistic allocation. Furthermore, puskesmas as the frontline of health care facilities does not have access to contribute more significantly in formulating policies that are relevant with the needs of the population. The low power of puskesmas is was partly due to the lack of trained human resources and financial resources.

The financing source for the Kotaraja Puskesmas originally came from Global Fund, but at the moment there is no funding allocated from the Provincial Health Office, whereas the Municipality Health Office only provide 2,500,000 rupias for three people a year, divided into 9 HIV and AIDS program staff. There are 7 staff members for the HIV and AIDS program, with one trained doctor, 2 trained nurses, 2 trained laboratory technicians, 1 trained midwife and 1 untrained pharmacist (Uncen Research Team, 2014).

There were several implications resulted from this Puskesmas position: 1) provision of HIV and AIDS services such as prevention and CST in puskesmas has brought the health services closer to beneficiaries, however, it is not yet optimal because of limitations in resources and facilities; 2) provision of HIV and AIDS services in puskesmas has not been self-sufficient, because puskesmas has limited authority to access funding and to recruit human resources; 3) The sustainability of HIV and AIDS service in puskesmas is very dependent on the Puskesmas' ability to integrate the existing services into the local health system within the local government budget funding scheme. The capacity of puskesmas in formulating routine planning by involving other stakeholders through a mechanism such as a mini-workshop becomes very important.

c. High Power and Low Interest
Stakeholders in this category are those that normatively have high power especially in planning and local government budgeting, but have low interest in HIV and AIDS. Stakeholders in this category are District and Municipality Parliament (Local House of Representatives or DPRD) and the Local Development Planning Body (Bappeda).

Local House of Representatives of Districts/Municipalities
The role and functions of the DPRD related to HIV and AIDS response is formulating legislation and decision on budget allocation. We found that the interest of the local parliament is low, because they do not view HIV and AIDS as part of a profitable political interest. HIV and AIDS problem is perceived as unpopular and sensitive issues. The local parliament has the political power to agree and pass on budget plan proposed by the local government. In reality, the budget proposals for HIV and AIDS response districts were often not supported by the local parliament.

The budgets for HIV and AIDS programs in SKPDs outside of the health sector are also often not passed on especially in Bappeda and DPRD, because HIV and AIDS are often not viewed as part of the main tasks of SKPD (Unhas Research Team, 2014).

As a result, it was difficult for HIV and AIDS response to be a priority issue in the districts. Although local parliament issued local regulations on HIV and AIDS, however, but this was
usually pushed by other actors who were more superior in terms of financing and human resources, especially those at the national level (e.g. donors and central government). Because the local parliament often refused budget proposals for HIV and AIDS programs, the province would consequently be dependent on financing from donors. Consequently, IDPs had large power and influence. Moreover, there was a limited control from the local parliament. The interest of the local parliament towards HIV and AIDS issues can be increased with strong advocacy from the local AIDS committee and other stakeholders during planning and budgeting processes. However, the advocacy skills of local AIDS committee and other stakeholders in most provinces were limited.

Local Development Planning Body (Bappeda/Bappeko)
As a technical agency that is responsible for development planning in the districts, Bappeda is supposed to have high interest in HIV and AIDS response. However, in all the study locations except Parepare, it was found that Bappeda/Bappeko has low interest towards HIV and AIDS response, because HIV and AIDS response is not assumed as part of the main tasks of the Bappeda.

Because the main tasks of Bappeda is not directly related to health and HIV/AIDS, their interests are not as high as other health-related agencies or government working units. Because of limited access to training (both technical and managerial) on HIV and AIDS, the resources of Bappeda is relatively lower than other agencies of health government working units (Unhas Research Team, 2014)

There was a few example of Bappeda support to HIV and AIDS response. In Jayapura, there was a long history of Bappeda support for HIV and AIDS response. Bappeda routinely gave their approval and allocated budget to to local AIDS committee, the Health Office and other government working units (Uncen Research Team, 2014).

Despite low interest, Bappeda is reported to have high power in all study locations except Sidoarjo district district. The Bappeda/Bappeko have high power because they are authorized to give approval to proposals from the District Health Office and to submit it to the local parliament, such as in Surabaya.

The Bappeko accommodates proposals related to HIV and AIDS from the government working units. They are authorized to decide whether the proposals are approved and translated into the annual Surabaya city development plans (Unair Research Team, 2014).

In Denpasar, Bappeda had high power because they are authorized to develop budget plans, to examine any gaps or overlaps in budget, and to ensure accountability of, and to conduct evaluation towards the budget plans of government working units (Unud Team, 2014). The position of Bappeda/Bappeko in the district brought implications on HIV and AIDS response in terms of funding allocation. Budget proposals for HIV and AIDS response from the government working units can only be submitted to local parliament upon approval from Bappeda/Bappeko, as they coordinates the local development planning. However, because of their low interest, budget proposals from non-health government working units were often rejected. Budget for HIV and AIDS is not only limited in amount, but is also only allocated for the Health Office. As a result, there is no multi-sectoral response to HIV and AIDS. In addition, it was often observed that Bappeda/Bappeko did not undertake their role in budget planning. Instead, they passively received financing from IDPs whatever the amount.
d. Low Power and Low Interest

Stakeholders in this category have low power because they do not have large amount of resources or dominant political position in HIV and AIDS response. Their interest is low because in reality they do not exhibit much interest towards HIV and AIDS as an issue, although normatively they should have high interest and responsibility. Stakeholders in this category are traditional leaders/institutions, religious leaders/institutions and government working units other than the health office.

Religious and Traditional Leaders/Institutions

Normatively, religious and traditional leaders/institutions should have high interest and power in HIV and AIDS response in their respective areas. They have the interest to ensure the well-being of their community. They also have power i.e. influence and capacity to provide directions to the community to preserve their health including in HIV and AIDS prevention. The community typically respect and listen to religious and traditional leaders. However, in reality, in the study location it was found that the power of religious and traditional leaders/institutions was relatively low. Only in Denpasar, Badung and Papua was it reported that religious and traditional leaders had relatively high interest in HIV and AIDS response.

In Denpasar and Badung, traditional leaders became the main actors in community empowerment and influenced public opinions. In Merauke, it was also reported that religious leaders and other community leaders had a significa role in HIV and AIDS response.

*There are 4 personnel in the religious office who were recruited from community cadres, youth leaders and religious leaders who participated in the HIV and AIDS socialization in Jayapura. It is expected that once they return to their areas, they can socialize it to other religious and youth leaders in Merauke district (Cendrawasih University Research Team, 2014)*

Promotion and prevention events are carried out at important dates. For example, the World AIDS Day is commemorated through various activities, supporting NGOs, religious leaders, traditional leaders, women leaders, youth leaders and other institutions through coordination meeting and financial support, especially prevention programs and impact mitigation such as nutrition programs for PLWHA in clinics or halfway houses. We also motivate them to write books related to prevention programs and HIV/AIDS response. Examples include [written by a religious leader] Circumcision, the Bible and HIV/AIDS, [written by another religious leader] HIV-AIDS and Circumcision in the eyes of the Bible, then Rethinking Circumcision for the Health of the People [written by another religious leader] (Uncen Research Team, 2014).

By using a religious approach, the religious leaders have a strategic position to tackle the problem of stigma and discrimination attitude against PLWHA and also create acceptance in the community towards marginal populations. They also have the key position of reducing the community’s resistance against controversial preventive efforts such as the use of condoms for PMTS. However, because the interest of religious and traditional leaders towards HIV and AIDS is still low, these potentials are still uncovered. In general, the study found that they still played a passive role. Their involvement in the HIV and AIDS response still largely depended on stakeholders that have high power such as IDPs, Mayors/Regents, the Health Office, and Bappeda/Bappeko.

As a consequence, the social environment is not supportive for HIV and AIDS response in most districts of the province. Several provinces reported that there were many HIV and AIDS programs were hampered because of the lack of support from religious and community leaders. The stigma and discrimination attitude towards the disease and key populations is still difficult to erase.
Local Government Work Unit (Satuan Kerja Perangkat Daerah - SKPD)
The local regulations have stipulated that SKPDs or government working units have large responsibilities in HIV and AIDS response at district level. As part of the local AIDS committee, the government working units should have high interest in tackling HIV and AIDS issues. However, study location it was revealed that in the majority of study locations, the government working units showed low interest and power. Several government working units nonetheless showed some involvement by budgeting and conducting HIV and AIDS programs, for example, the Education Office, the Tourism Office, the Social Office and the Transportation Office.

The government working units were mostly involved in HIV and AIDS prevention activities, for example health education to community groups and socialization of HIV and AIDS prevention to the public. Table 4 shows the role of non-Health Office that were involved in HIV and AIDS prevention in the study locations.

<table>
<thead>
<tr>
<th>SKPD/Agency</th>
<th>Role</th>
<th>City/District</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Financial and Asset Management</td>
<td>Technical agency in the management of budget</td>
<td>Malassar, Ppareare</td>
</tr>
<tr>
<td>Family Planning and Women's Empowerment Body/Child Protection</td>
<td>Prevention activities in teenagers, women, and housewives</td>
<td>Parepare, Jayapura, Denpasar, Badung, Merauke, Manokwari, Deli Serdang</td>
</tr>
<tr>
<td>Social Office/Dinsosnaker/Disnakertrans</td>
<td>Impact mitigation and social rehabilitation</td>
<td>Parepare, Denpasar, Badung, Jayapura, Merauke, Manokwari, Medan</td>
</tr>
<tr>
<td>Education Office/Disdikpora</td>
<td>Prevention activities in school</td>
<td>Parepare, Surabaya, Sidoarjo, Denpasar, Badung, Merauke, Manokwari, Medan, Deli Serdang</td>
</tr>
<tr>
<td>Manpower Office</td>
<td>Prevention activities at the workplace</td>
<td>Parepare, Surabaya, Merauke</td>
</tr>
<tr>
<td>Tourism Office/Culture and Tourism Office</td>
<td>Prevention activities in entertainment centres</td>
<td>Surabaya, Denpasar, Badung, Jayapura, Medan, Deli Serdang</td>
</tr>
<tr>
<td>City Police/Polrestabes</td>
<td>HIV screening to members of the national police</td>
<td>Surabaya</td>
</tr>
<tr>
<td>Transportation Office</td>
<td>Prevention activities in the transportation sector</td>
<td>Surabaya, Deli Serdang</td>
</tr>
<tr>
<td>Communication and Information Office</td>
<td>Provision of CIE materials</td>
<td>Surabaya</td>
</tr>
<tr>
<td>Ministry of Religion Office</td>
<td>Formulation of policy in the religion sector Prevention in schools under the Ministry of Religion</td>
<td>Surabaya, Jayapura, Merauke, Medan</td>
</tr>
<tr>
<td>Civil Police Force</td>
<td>Enforcement of regulation and security to create environment conducive to HIV and AIDS response</td>
<td>Surabaya</td>
</tr>
<tr>
<td>Civil Registry and Residence Office</td>
<td>Setting up civil registry administration for residents in high risk locations</td>
<td>Jayapura</td>
</tr>
<tr>
<td>National Unity and Politics Office</td>
<td>Prevention through programs on nationalism and community resilience focusing on youth and community</td>
<td>Merauke</td>
</tr>
</tbody>
</table>
In Papua, the Education office successfully advocated the local government to develop a Perwali (Mayor’s Regulation) for mainstreaming HIV and AIDS education.

Bappeda tried to generate funding not only from the Otsus APBD but also from international donors (e.g. Unicef); this supported HIV and AIDS programs in schools. Also through advocacy to the Education Office, the provincial government of Papua and the city government of Jayapura, the Papua Governor Regulation No. 26, 2010 and the Jayapura Mayor Regulation No. 11, 2012 was issued on HIV and AIDS mainstreaming through education (Uncen Researech Team, 2014)

Although the involvement of non-health office government working units was visible in some areas, in general the interest and power of government working units was still low because they had insufficient resources and financing. that the existing system has not accommodated the role and needs of government working units as the dominant stakeholder in HIV and AIDS response. For example, the budgeting for HIV and AIDS response in government working units was difficult to accommodate, because there is no available nomenclature in the budget.

Although it is the Health Office that has the specific main task for HIV and AIDS activities, we cannot ignore the fact that other SKPD agencies should also be involved. So it is up to the SKPD, how they can formulate the program or activity but do not show it explicitly as an HIV and AIDS event in the district. They should disguise it “within” their main task. In the implementation, the activity can be related to HIV and AIDS. For example, the objectives may be improving about understanding related to HIV and AIDS in health and workplace. (Interview, Makassar City Asset and Financial Management Body, 14 August 2014 – Unhas Research Team, 2014)

There is no sustainable multi-sectoral response to HIV and AIDS. The existing multi-sectoral role is still performed by each sector without a sustainable and coordinated response with other sectors.

2. Interactions between Stakeholders

The stakeholders in HIV and AIDS response interact in a number of forums, both formal and informal forum. This interaction enables them to influence one another according to their interest and power. Four mechanisms of interactions between stakeholders have been identified:

1. Coordination mechanism in planning facilitated by the Bappeda/Bappako through a development planning meeting involving government working units. In this forum, the role of the Bappeda/Bappako was to synchronize planning and budgeting of development programs of all government working units including the Health Office. With its high power, the Bappeda might refuse funding proposals for HIV and AIDS response requested by government working units because of various reasons, for example the perception that HIV and AIDS response is not the major task of government working units other than the Health Office. The government working units, because of their low interest, did not advocate the Bappeda in order to obtain sufficient financing for HIV and AIDS response. As a result, stakeholders with high interest such as the local AIDS committee, district hospitals, NGOs and key populations had to conduct advocacy to the Bappeda to gather more interest and funding

2. Coordination mechanism facilitated by the local AIDS committee through planning meetings, implementation, and program monitoring. Stakeholders involved in this activity are stakeholders with high interest such as the Health Office, NGOs, PLWHA and key populations.
The local AIDS committee, according to its mandate to coordinate the multi-sectoral collaboration, should be able to use these meeting forums to coordinate the government working units members to develop strategic plans for HIV and AIDS programs involving other stakeholders such as NGOs, ODHA and key populations. However, in reality the coordination forum was only used to discuss progress in program implementation and target achievement from the central government that involves stakeholders with high interest. The coordinating mechanism in the local AIDS committee had not been utilized optimally to increase the low interest of government working units members in HIV and AIDS response’s districts.

3. Coordination mechanism initiated by the MPI through coordination and technical meetings. This includes preparation meeting of programs supported by IDPs, mid-term meetings and end-program meetings. Stakeholders involved in these meetings were those related to the programs, such as the local AIDS committee, Health Office, NGOs and key population networks. The high interest actors were commonly involved as the implementers of the IDP program. The IDP also interacted with stakeholders with high power such as Mayors/Regents, DPRD and Bappeda/Bappeko through lobbying and special hearings. With their resources, the IDPs had a relatively dominant role in AIDS response, including starting program initiatives and providing financial support for implementation. However, because the high power stakeholders did not have high interest in HIV and AIDS, the local government rarely adopted the IDP initiative in HIV and AIDS response. Because of the high involvement of IDPs, the local governments perceived that there was no need to show higher commitments, as IDPs and other stakeholders had provided commitment for HIV and AIDS response.

4. Mechanism of interaction between the other stakeholders. Stakeholders with the same high interest usually involved and collaborated in program implementation. For example, NGOs with outreach services interacted with district hospitals and Puskesmas through service referrals. The type of interactions between actors with high interest and actors with high power can be classified into two categories. First, there were interactions in the context of relations between beneficiaries and provider through programs, funding or other technical assistance, such as the interaction between NGOs, key populations, local AIDS committee and Health Office with IDPs, or the reciprocal relations between NGOs and district hospitals/Puskesmas with the key population. Second, there is an interaction in the form of advocacy to increase commitment of stakeholders with high power towards HIV and AIDS response. This interaction can be observed between those with high interest such as NGOs and those with high power such as Bappeda, Mayor/Regent and local parliament.

The Role of Higher Education in HIV and AIDS Response in the Districts

Institutions of higher education have a role in reproducing knowledge and developing health care resources. As institutions that have the power to find and solve health problems in a systematic and measured way, higher education play an important role as producers of knowledge for decision making and evidence-based planning. In several study locations such as Medan, Sidoarjo, Surabaya, Bali, Jayapura, and Merauke, that the local higher education institutions were actively conduct research related to HIV and AIDS.

The other strategic role of higher education institutions is as a centre of empowerment and improvement of the quality of resources through formal education. Institutions of higher education educate and produce health care workers such as doctors, specialist, nurses, community health workers, and pharmacists. They also have a role in empowering the community through the development of an information system.

“We have also established an PIK-KRR for youth (Information Centre and Reproductive Health Counselling for youth) that focuses on the prevention of drug.
abuse, HIV and AIDS, as well as premarital sex. Our services are delivered to Junior High School, High School, and tertiary education. Teenagers are trained for counselling in which teenagers are accompanied by a peer counselor and peer educator that are in the same age as the teenagers (Interview, BKBPP Staff, Parepare, Unhas Research Team Report, 2014).

There are community service by activities conducted by university students, for example research on HIV and AIDS, and activities on HIV and AIDS awareness through HIV and AIDS education to university students in cooperation with KPA such as in Sidoarjo (Unair Research Team, 2015).

However, in addition to various strategic roles of higher education institutions, it was found that these institutions have not been optimally involved in HIV and AIDS response’s districts. They are not involved in the formulation of program planning or evaluation.

“We have not involved any institute of higher education in the formulation of HIV and AIDS program planning... we have not had any cooperation so far (Interview, Health Office of Jayapura, in the Uncen Research Team report, 2014).

In addition, the commitment of higher education institutions to be involved in often only occurred at the individual level and not at the institutional level. As a result, the role of higher education institutions highly depended on the number and commitment of staff that had interests on HIV and AIDS issues.
IV. Patterns of Integration

A. Introduction
In the present study, integration was defined as a level of adoption and assimilation of HIV and AIDS programs into the various key functions of the health system in dealing with infectious diseases (Atun et al., 2010). The functions of HIV and AIDS response that were examined for their integration into the health system include Regulation Management, Financing, Human Resources, Strategic Information Management, Management of Provision of Drugs and Medical Equipment, Community Participation, and Delivery of Health Services. Various factors that enabled or prevented integration into the health system were also examined and categorized into components within or outside of the health system, such as contexts, actors, institutions, and resources.

This section will discuss three components: 1) level of integration of HIV and AIDS programs into the health system and evaluation of the level of integration based on the functions of the health system, the type of intervention, and areas; 2) factors that influenced the integration of HIV and AIDS programs into the health system; and 3) relationship between integration and effectiveness of HIV and AIDS programs. The level of integration and effectiveness of HIV and AIDS programs were evaluated and categorized into full integration, partial integration, and non-integration. The analysis of level of integration will be explained in the data analysis section of this report.

B. Dimensions of Health System Functions
The integration level of policies and programs in HIV and AIDS response into the health system was measured using 18 dimensions of the seven sub-systems in the health system functions. Before conducting an evaluation of the integration level in the end section, each dimension will be presented below.

1) Management and Regulation
Management and regulation is an administration that assembles various efforts in health policy, health administration, health regulations, as well as management of data and health information in order to ensure a strategic policy structure that is combined with oversight, partnership development, accountability, regulation, incentives and agreement with the design of the existing health system. The sub-systems consist of three dimensions: 1) regulations, i.e. district government regulations related to HIV and AIDS such as Perda on HIV and AIDS, Mayor’s or Regent’s Regulations, Strategic Plan (SRAD) on HIV and AIDS; 2) formulation of policy, i.e. process of policy development (planning, budgeting, finance allocation, and accountability) for HIV and AIDS programs within the existing mechanism of policy formulation in the study locations; and 3) accountability and responsiveness, i.e. community access to information related to HIV and AIDS programs and policies and whether those programs and policies have used the principle of good public service.

a. Regulation
Regulations on HIV and AIDS response and STI to control the stakeholders responsible in HIV and AIDS response including the resources. Regulations also functions as the control mechanism by implementing sanctions for violations of regulations. All of the study locations’ districts had regulations on HIV and AIDS response i.e. Perda, Regent’s Decree (Surat Keputusan – SK), Strategic Planning and technical policies from the government working units. These policies regulate the HIV and AIDS response efforts including PP, CST, and Impact Mitigation as well as to regulate stakeholders responsible for implementation and the required resources.
The Perda on HIV and AIDS response were found in Medan city, Deli Serdang district, Surabaya city, Denpasar city, Badung district, Jayapura city, Merauke district and Manokwari district. Meanwhile, there cities and districts that refer to provincial Perda, such as Makassar city and Parepare district. Other than Perda, HIV and AIDS Response Strategic Planning was also often used as a reference, such as in Deli Serdang district, Medan city, Denpasar, Badung, Manokwari, and Jayapura.

Nevertheless, the existing regulation were still poorly implemented.

*Speaking of HIV related regulations, there are actually quite many. Starting from SRAN, the Minister’s Regulation, and the Perda. The problem is, do they (SKPDs) read or know those regulations? In my experience as the secretary of the Provincial KPA, these regulations are often not known. As a result, it is not easy to obtain financing from the local government. It is not easy to work together across sectors. There are many agencies involved in HIV activities. HIV should not just be the problem of health SKPDs such as the Health Office (FGD, KPAP South Sulawesi, in the Unhas Research Team report, 2014).*

There are many factors contributing to the poor implementation of regulations, including the lack of socialization of existing regulations, low commitment and political will of local leaders (mayors, regents, or governors) over existing regulations, and the low level of commitment of local governments to prioritize HIV and AIDS problems in the districts. In addition, the Perda does not clearly specify the agency that will be responsible for the HIV and AIDS response, both at provincial or district/municipality level. This results in the overlap of activities and programs at the level of implementation especially in the related government working unit (Udayana Research Team, 2014).

In addition, the regulations on HIV and AIDS response were not translated into technical guidelines for implementation. For example, in Denpasar and Badung there was a regulation for prevention among IDUs, but the lack of technical guidelines resulted in uncertainty in the budgeting for logistics of LASS.

*...because there were no technical guidelines regarding the implementation, the respondents also mention that the position of HIV response in the Perda has not been explicitly formulated. More specifically, components related to the logistical and material provision for the NSP program has not been regulated clearly in the Perda on HIV and AIDS. As a result, until now the NSP program has not received funding from the APBD (Unud Research Team, 2014).*

Regardless of these implementation challenges, the HIV and AIDS response efforts have been in line with the regulations on infectious disease control. The formulation of HIV and AIDS had referred to the existing regulations as foundation. Regulations on budgeting of resources for HIV and AIDS programs including PP, CST, and impact mitigation were also founded on existing regulations. Therefore, regulations on HIV and AIDS programs had been adequately referred to legitimate regulations in the health sector in order to mobilize stakeholders and local resources in HIV and AIDS response.

b. **Formulation of Policy**

The process of formulating policy on HIV and AIDS response utilizes the mechanism of policy formulation commonly used in the local governments, involving stakeholders and key figures, including the Health Office, local AIDS committee, government working units, NGOs, representatives of key populations, beneficiaries, and IDPs. In Badung and Denpasar, the process of policy formulation including starting planning to reporting for local government
budget scheme followed the mechanism of policy formulation that was used by the local
government. Meanwhile, programs which were financed by foreign donors followed the
mechanisms of the donor (Unud Research Team, 2015). In South Sulawesi, the process of policy
formulation involved various parties, however, the finalization of Perda mainly involved
agencies directly related to HIV and AIDS such as the Health Office, local AIDS committee, and
individuals who had long been part of the HIV and AIDS program.

In the early phases of the Perda formulation, we of course invited many parties for
discussion. We conducted meetings to discuss why Perda is important, what are the
things that need to be put into the Perda and so forth. However, there is a deadline
when the Perda has to be ready so we have to make core teams. Members of these core
teams are people that know a lot about the techniques of preventing and mitigating
HIV. Of course our colleagues from the Health Office, KPAD, Unhas and also colleagues
from NGOs as they have been long involved in HIV issues... The process is like that. But
as I have mentioned, the main weakness of this regulation is the socialization. Those
who fairly understand the Perda are probably only few people I have mentioned
earlier. (FGD, Provincial Health Office of South Sulawesi, in the Unhas Research Team
report, 2014).

The mechanism for formulating HIV and AIDS policy followed the existing mechanism for policy
formulation in the district, such as coordination meeting of policy makers and program
managers, routine local AIDS committee meetings and routine reports of the Health Office. For
example, in Surabaya, the decision making process for HIV and AIDS policy is conducted
through coordination between related government working units through the Bappeko in order
to decide what programs will be implemented (Unair Research Team, 2014). In Deli Serdang,
the planning of activities for HIV and AIDS response is performed based on the reports from
routine local AIDS committee meetings and routine Health Office reports. The Health Office
reports typically summarized routine surveillance reports from hospitals, Puskesmas, and
supporting NGOs. Policies were based on the epidemiological evidence or evaluations of past
activities (USU Research Team, 2014).

The formulation of HIV and AIDS policies was commonly based on local epidemiological data
from various sources such as assessments, routine surveys, behavioural surveys, and rapid
surveys. For example, in Sidoarjo, results from assessment became the basis for determining
location for additional VCT and LASS clinics (Unair Research Team, 2015). In Denpasar and
Badung, the process of planning and developing services as well as advocacy for funding
allocation had used some epidemiological evidence such as behavioural surveys, estimations
from the Ministry of Health, data from passive surveillance and zero survey (Unud Research
Team, 2015). In Medan and Deli Serdang, mapping of key populations had been done with local
government budget funding. The result of this mapping was used to formulate policy.

In policy formulation, substantial amount of data is needed as the evidence base. The
data can be obtained through various methods, especially research and assessment.
Until now, research that has been conducted is the key population mapping that was
financed by grant from the 2014 APBD. There was also the IBBS which was funded by
the Ministry of Health (USU Research Team, 2014).

The formulation of HIV and AIDS policies in the study locations had adopted the existing
mechanism of policy formulation in the health sector. The formulation process involved various
stakeholders in the health sector, used available epidemiological data, and followed the
mechanism of local policy formulation.
c. Accountability and Responsiveness

As regulated by the Law no. 25/2009 on Public Service, HIV and AIDS programs are required to implement accountability. This is important to ensure that the public receive protection and legal certainty in the delivery of HIV and AIDS services and evaluate policies and programs. The study found that there are mechanisms that enable public to access information on HIV and AIDS programs, such as electronic media, radio, websites, printed media, and health training activities created by the Health Office, local AIDS committee, NGOs, and service providers.

In order to support public access to information on HIV and AIDS programs, the public may access information on these programs through health promotion media at health care facilities, training and socialization to the public through Community Health Nursing activity, through the municipality government website, electronic media (radio) or bulletins and newspapers. Key populations may access information about program and service through NGOs and outreach. As the Leading Sector, the Surabaya Health Office and the KPA have a role in public access to information on HIV and AIDS programs (Unair Research Team, 2014).

To enable the community to obtain the latest information, HIV and AIDS socialization needs to be conducted through radio, pamphlets, banners, billboards and socialization, especially on important days such as the World AIDS Day, which was conducted by the KPA and Health Office through the health promotion section in collaboration with NGOs and donor agencies (Uncen Research Team, 2014).

In terms of responsiveness, efforts to involve the community in monitoring and evaluation of strategic program implementation on HIV and AIDS were still lacking. There was no mechanism which enabled the public to evaluate the implementation of HIV and AIDS policies and programs in the study locations. The monitoring and evaluation systems were present but these were internal mechanism. Monitoring and evaluation were only available at the level of program implementers such as the Health Office and local AIDS committee. However, the results of the monitoring and evaluation were only used for the internal purposes of the program implementers. In addition, there was no forum to involve the public or key population to participate in the evaluation of HIV and AIDS policies and programs.

2) Financing

Financing was defined as the management of various efforts in collecting, allocating and spending of health funding to support health sector development in order to achieve an optimal level of population health. The components of financing consist of: 1) management of financial sources, including the coordination, collection, and management various sources of funding in HIV and AIDS response such as local government budget, state budget and donor funding; 2) budgeting, dividing and distributing expenditures in financing HIV and AIDS response, i.e. whether the budget or HIV and AIDS response by the local government is allocated proportionally 3) mechanism for financing of service, i.e. financing the health services within the scheme of the National Health Insurance system. The financing of HIV and AIDS programs in this study was focused on PP, CST, and Impact Mitigation programs.

a. Management of Financial Sources

HIV and AIDS programs at district and provincial level are financed from a variety of funding sources, including from IDPs, central government, local government, and other non-binding parties as mandated in the regulations on HIV and AIDS response. In all the study locations, the main source of funding for HIV and AIDS response was IDP. In some districts areas such as Denpasar and Badung, there was an increase in the amount of funding from the local government budget (Unud Research Team, 2014). However, in other areas such as Sidoarjo,
there was a fluctuation in the percentage of funding from the local government budget as well as from donors (Unair Research Team, 2014). The proportion of donor and local funding in Sidoarjo is shown in Figure 5.

Diagram 5. Proportion of HIV and AIDS Financing in Sidoarjo District

However, there has been little indication that these various sources of funds were well-managed and coordinated by the local AIDS committee or District/Provincial Health Office. There was no mechanism for resources pooling resources, in which the local government estimated the needs of HIV and AIDS funding in their districts and then generate funding from various sources to meet the program needs. The functions of local planning agency in ensuring the alignment and coordination in planning and budgeting have not been well implemented. These agencies only coordinated budgets from the local government budget, whereas funding from other sources such as IDPs was disbursed directly to the implementers such as NGOs or health service facilities. Each IDP has their planning and budgeting mechanism including their allocation.

... financing for routine HIV and AIDS programs in prevention and CST by NGOs, Municipality Health Office, Madising Puskesmas and the Andi Makkasau Hospital largely come from Global Fund. The APBD funds from the Parepare municipality that are allocated to the Municipality Health Office are generally used to pay for staff trainings, purchase of reagent and provision of STI STI medication (Unhas Research Team, 2014).

Coordination between various sources of funding including those from IDP was only observed in Jayapura. The local planning agency of Jayapura established a Partnership division that was assigned the role to coordinate funding. Even so, not all the funds were However, not all the funds could be pooled and coordinated. For example, funding from donors which were not significant in the amount, such as those from missionaries, were directly given to beneficiaries without coordination through the local planning agency.

Funding for HIV and AIDS response from various sources were managed separately from funding for other infectious disease control programs. There is no a mechanism in place to coordinate the various sources of funding in the districts, which consequently led to disintegration of between HIV and AIDS programs because the majority were implemented depending on the interests of the funding agency.
b. Funding Allocation

Funding for HIV and AIDS response had not been accommodated into the local government budget funding scheme in most of the study locations. The budget for HIV and AIDS response was limited to those allocated for the District Health Office. Budget proposals by government working units as members of the local AIDS committee were often not approved by the local planning agency because it was not considered suitable to the main tasks of these government working units.

*People in the Bappeda or DPRD are using the main tasks perspective. If they specifically mention HIV, relevant SKPDs such as the Social Office or the Education Office are often rejected. That is why in the KPA we always ask them to work around this by integrating HIV and AIDS programs into their main tasks. The problem is, there are still many SKPD that do not do that. We in the KPAD have informed them many times but many have not done it yet. It seems that many SKPD do not want the hassle or are not confident in dealing with Bappeda and DPRD (FGD, KPAD of Parepare Staff, in Unhas Research Team report, 2014)*

Meanwhile, in other districts like Surabaya, Sidoarjo and Jayapura, budget proposals for HIV and AIDS response were often not approved by the local parliament if is the programs were not directly associated with the political and economic interests of the local parliament.

*...the initial budget for HIV and AIDS response in Surabaya was around 10 billion rupiahs, but the realization of funds that was approved by the 2014 APBD was 3.9 billion rupiahs (Unair Research Team, 2014)*

*In the Strategic Plan of Jayapura for 2011-2015, the annual funding requirement is around Rp. 7 to 9 billion. If we compare that to the realization in the allocation of funds from the APBD in 2011 of only Rp. 1.7 billion, then we can say that the allocation of funds is very small compared to the planned budget (Uncen Research Team, 2014)*

Of the total budget allocated by the local government budget, there were budget posts for for PP, CST, and Impact Mitigation programs. The funding for prevention and medication is commonly allocated to the District Health Office. For example, in Parepare Municipality, the local government budget disbursed to the Municipality Health Office was generally allocated for prevention programs, treatment, staff trainings, purchase of reagent and procurement of STI drugs. Meanwhile, government working units other than the Health Office generally receive funding allocations for PP and Impact Mitigation programs. For example, in Surabaya, the HIV and AIDS budget post for the Education Office was allocated for Student Health Units. the Municipality Communications and Information Office received budget for producing brochures (Unair Research Team, 2014). In Denpasar, The Social Office, Labour Office, Education Office, Women’s Empowerment Office and the Tourism Office were allocated budgets for PP and Impact Mitigation.

However, not all non-health government working units were allocated funds for HIV and AIDS prevention. For example in Jayapura, although there was a program plan and budget allocation for government working units in the 2011-2015 Strategic Plan, in reality there was no specific funds allocated for HIV and AIDS programs in the government working units other than the Health Office and the Port Health Office (Uncen Research Team, 2014).

In addition, it seemed that the available funds were not allocated according to the needs. There was a disproportional allocation and also misallocation of budget. For example, of the total budget allocated for the Badung local AIDS committee, the proportion of operational budget was larger than that budget for programs. The communities and NGOs also perceived that funding for impact mitigation allocated by the Ministry of Social Work and the Social Office were
misallocated. Furthermore, the proposing mechanism and claim of funds from the government funding were slow (Unud Research Team report, 2014).

Funding from IDPs were allocated according to programs that had been planned by IDPs. If there is some funding allocated for the Health Office, local AIDS committee, and NGOs, it was still a part of the implementation of the programs determined by IDPs. Funding allocations for HIV and AIDS programs still occurred in disintegrated manner and not well coordinated. Consequently, there were gaps in program interventions because the allocated funds were not in proportion to the needs, so that access to certain HIV and AIDS services became limited.

c. Public Payment Mechanism for Services

In health service financing, PLWHA and key populations should have the same access to the national health insurance as the public. They are entitled to several payment schemes, such as BPJS (national security scheme), health insurance for the poor, or by security letter from the Social Office. It was reported community health insurance and maternity insurance were accessible for PLWHA and key populations in Manokwari. The total revenue for basic health services (consisting of Jamkesmas and Jampsals) in 2012 was around Rp. 2.904.895.000, which covered 245.640 patients.

The national health insurance has included treatment for opportunistic infections related to HIV and AIDS into their scheme. However, a number of services needed by PLWHA and key population are not included in the national health insurance scheme. For example, ARV treatment is not covered, because it is still covered by an existing program. There are also series of tests that needs to be taken before the initiation of ARC (pre-ARV), and treatment for IDUs with addiction problems. Those with no insurance memberships have to pay out-of-pocket for the services. This shows that the public payment mechanism for HIV and AIDS services remains different from the payment mechanism for general health services.

Although the JKN is often said as a positive thing for PLWHA, up to now only the OI component that has been covered in the JKN scheme. In the JKN, the scheme for HIV medication is still not covered because there is an argument that up to now, the ARV drugs are still supported by the government through the help of foreign agencies. Furthermore, in JKN, the funds for pre-ARV have not been covered so that those costs have to be paid by the client or the NGOs that receive support from foreign donors (Unud Research Team, 2014).

Access of beneficiaries to HIV and AIDS using national health insurance scheme were still limited because of these problem. Moreover, the administrative requirements for claim is also complicated. For example, people can only use the national health insurance at the health service facilities located in the same areas as the place residence status as written on the identity card. For key populations that have high mobility, it is difficult for them to access health services using the national health insurance.

3) Human Resources

Human resources refers to all aspects of availability and quality of human resources to ensure that the personnel involved in HIV and AIDS response are responsive, efficient, competent, fair, distributed equally according to the available resources and situation, and in sufficient number. The human resources components consists of: 1) policy and human resources management system that regulates the availability of work force hired by the Health Office as a staff member for HIV and AIDS programs; 2) a financing system that manages the financial resources for financing HIV and AIDS programs, either from the government and non-government sources; and 3) competency of resources, to ensure the availability of policy that regulates the
standardization of the competency of human resources working in HIV and AIDS and the availability of trained and certified human resources.

\subsection*{a. Human Resources Policy and Management System}

The human resources policy and management system function is to regulate the availability of human resources in the health sector or the non-health sector. The present study revealed a number of problems related to the human resources policy and management system. First, a human resource management system had been developed and disintegrated from the existing health system. There was no policy to regulate (recruit, train, remunerate) workers other than healthcare workers (referred to as HIV and AIDS workers in this report).

The two separated human resource management system developed because HIV and AIDS is a health problem that is closely related to social problems. The HIV and AIDS affected population are generally hidden and hard to reach, thus they are often marginalized from other population groups. Stigma and discrimination are one of the obstacles for the key population to access available services. Because of these characteristics, HIV and AIDS services require a tailored and different approach from the traditional health service. In the latter, healthcare providers tend to be passive and only treat patients who visit the healthcare facilities. Treatment is also limited to pharmacological treatment, while HIV and AIDS patients often need psychosocial support.

In health service facilities, healthcare workers have been trained to provide medical care in health service facilities, including counselling and HIV and AIDS services such as VCT/PITC, IMS, PMTCT, LASS, and others. However, to overcome the social obstacles such as stigma and discrimination, there is a need of service provision by specific HIV and AIDS workers. These workers provided various services which are as important as the medical treatment provided by healthcare workers. In particular, they work to ensure access to services for key populations and support for PLWHA. Functions that are typically performed by HIV and AIDS workers include peer support (buddies), case managers, and counsellors. So far, these functions of HIV and AIDS workers have been performed by NGOs supported with donor funding. Coordination of the NGO roles are frequently done by the local AIDS committee rather than the District Health Office. This condition resulted in the development of a human resource management system outside the health system.

In all study locations, there was no policy to regulate the management of HIV and AIDS workers. In the majority of study locations, the local governments referred to the policies from the central government such as Ministry of Health Regulation No.21/2013. This policy regulates the forms of cooperation that can be developed with other agencies in HIV and AIDS response such as NGOs, institutions of higher education, and other agencies in the health sector (Article 49). Nevertheless, separated human resources management systems that run parallel to the health system were still found in most areas. Recruitment and payroll mechanism in this system were supported by donor funding. However, in Surabaya, the local government budgeted salary for HIV and AIDS workers such as counsellors, case managers, and outreach workers by referring to the aforementioned regulation (Unair Research Team, Surabaya, 2014).

The lack of ability of the local government in managing two human resource management systems is due to differences in nomenclature between healthcare workers and HIV and AIDS workers, as seen in Table 5. The difference in nomenclature further underlines the absence of policy that regulates the needs for specific HIV and AIDS workers such as outreach workers, fieldworkers, case managers, ODHA peer support (buddies), including salary and technical competency standards.

The other problem related to human resource policy and management system was the high workload of healthcare workers and the shortage of workers. In several study locations i.e.
Surabaya, Jayapura, Makassar, Parepare, Medan, Deli Serdang, Merauke, Manokwari, the delivery of HIV and AIDS services by healthcare workers was commonly considered an additional workload and not part of their main task as with other infectious diseases. Healthcare workers who provided HIV and AIDS services were considered as performing double jobs.

Table 5. Nomenclature Differences between General Healthcare Workers and AIDS Workers

<table>
<thead>
<tr>
<th>Nomenclature of Healthcare Workers (Law No. 36/2014)</th>
<th>Nomenclature of AIDS Workers (SRAN 2010 - 2014)</th>
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| a. Medical workers including doctors, dentists, specialists and dental specialists. | A. Field worker  
Peer educator  
Outreach worker  
Fieldwork supervisor  
Field Program manager |
| b. Clinical psychology workers | | |
| c. Nurses | | |
| d. Mid-wives | B. Service Level  
Counsellors for various services (CST, VCT, IMS, PMTCT, LASS, PTRM)  
Specialist doctor (CST services)  
General doctor for various services (CST, VCT, IMS, PMTCT, LASS, PTRM)  
Laboratory worker for various services (CST, VCT, IMS, PMTCT)  
Nurses for various services (CST, VCT, IMS, PMTCT, LASS, PTRM)  
Administrative worker for recording and reporting, various service (CST, VCT, IMS, PMTCT, LASS, PTRM)  
Nutritionist  
Mid-wives  
Case managers |
| e. Pharmaceutical workers including pharmacists, pharmaceutical analysts, and assistant pharmacists. | | |
| f. Public health workers including epidemiologists, health promotion worker and behaviouralist, workplace health advisor, health administration and policy worker, biostatistician, and family and reproductive health worker. | | |
| g. Environmental health worker including environmental sanitation worker, health entomologists and health microbiologist. | | |
| h. Nutritionist. | C. Management at District level  
Program administrator  
Monitoring and evaluation, and surveillance  
Finance and administration  
Secretary or manager |
| i. Physical therapy worker including physiotherapists, occupational therapists, speech therapists and acupuncturists. | | |
| j. Medical technicians including medical records and health information, cardiovascular technicians, blood service technicians, refractionist opticians, dental and oral technicians, and audiologists. | | |
| k. Biomedical technicians including radiographer, electromed, laboratory technology expert, medical physicist, radiotherapist, orthotic prosthetics. | | |
| l. Traditional health workers including traditional herbs workers and traditional treatment worker. | | |
| m. Other health workers. | | |

The number of our human resources are still very minimum. Related to quality, we rarely conduct, even are often left behind in updating knowledge and trainings. So imagine the special health service post that became the first VCT clinic... the number of staff is the same with a clinic that just started – I said that it is like doremifasol. Meanwhile, we're still at 61 percent, which means that we are still lacking in the quantity of human resources (FGD, Special Service Post Adam Malik Hospital Medan, in USU Research Team report, 2014)

HIV and AIDS workers are all performing double roles, one person is responsible for a number of programs (Interview, Puskesmas Kotaraja, Jayapura, in Uncen Research Team report, 2014).

The shortage in healthcare workers with adequate capacity in HIV and AIDS services are more complicated by the transfer mechanism. In most study locations including Badung and
Denpasar, clinical health workers such as doctors, nurses, mid-wives, laboratory workers and RR (Report and Recording) workers who were trained and equipped with competency for HIV and AIDS were often transferred by the Local Employment Agency (Badan Kepegawaian Daerah - BKD) without considering the service requirements. The high turnover of HIV and AIDS worker had a significant impact on the continuity of services.

b. Financing of Human Resources

The source of funding for human resources and non-health workers for HIV and AIDS are mainly from the government and donor funding. Healthcare workers working in government health services were paid through the local government budget for the health sector. Those who performed additional tasks for HIV and AIDS programs typically received additional incentives from programs funded by donors, especially the Global Fund. Such finding was observed in all study locations with the exception of Merauke and Jayapura because the Global Fund had been withdrawn from Papua. Salaries for HIV and AIDS workers (non-health workers) largely came from donor funding, especially in areas that were part of Global Funds' area of work such as Denpasar, Badung, Medan, Deli Serdang, Makassar, Parepare, Surabaya, Sidoarjo and Manokwari.

When classified into the type of programs, funding for PP activities mostly came from IDP and not from the local government budgets. PP activities were commonly performed by non-health workers such as NGO staff therefore there was no funding available from the government. In Jayapura and Merauke, which were no longer part of Global Fund’s work area, PP activities were conducted by non-health agencies and the community with limited funding from various overseas donors.

NGOs play a very important role to reach PLHWA and key populations but so far there have not been any regulations or policy that control the financing of human resources for non-health AIDS workers (Unipa Research Team, 2014).

Meanwhile for personnel who are already trained (on prevention and CST) either by the government or the health office or from non-government such as HCPI for Puskesmas and local health office, ... one of the funding source for health workers in the Puskesmas comes from the BOK grant. For example, the honorarium for the condom task force. NGOs receive some support from the Surabaya Health Office and Global Fund including outreach for VCT and field workers (Unair Research Team, 2014).

Most of the financing for health workers in HIV programs in Denpasar are from APBD funds (especially for healthcare workers from the governmental sector) whereas human resources in NGOs still rely on funding from foreign donors. The government sector also receives help from foreign donors but also receives incentives based on performance (Udayana Research Team, Bali)

Meanwhile, programs related to care and treatment were mostly performed by government healthcare workers. Therefore, funding for human resources in care and treatment commonly came from allocations of the local government budget. This was observed in Jayapura, Merauke, Surabaya, and Sidoarjo. In these districts and municipalities, the healthcare workers also received incentives from the local government budget. In other districts, healthcare workers who provided care and treatment in hospitals or puskesmas received incentives from non-government budget, such as the Global Fund through a mechanism referred to as performance-based incentives. In some districts which were still within the Global Fund scheme, there was an increase in the amount of funding from the central and local government budget to compensate...
the decrease in donor funding. However, the dependency on donor funding was still strong in some aspects.

Currently, the available human resources are general human resources that are not just responsible for HIV and AIDS but also for other programs. The DOK 2 RSUD has workers on a contract basis who work in the ATM collaboration room, but these workers are also our interns/volunteers. The payroll source is from the Papua Province APBD fund (Uncen Research Team, Jayapura, 2014).

The Health Office of Surabaya states that funding for general doctors for CST, VCT, IMS, PMTCT, LASS, PTRM and case managers and program administrators come from the APBD I and APBD II 2011-2013. Within the financing for human resources, there are expenditures for human resources as a proportion of government spending. Based on the data from the Sidoarjo Health Office, the expenditure for human resources as a proportion of government expenditure in 2011 is 15 million. In 2012, it increased to 16 million and in 2013 it increased to 17 million (Unair Research Team, Surabaya, 2014).

It can be concluded that financing for non-medical workers working in prevention differed from the existing financing system for other healthcare workers. Meanwhile, financing for healthcare workers who provided care and treatment activities already followed the general financing system of human resources in healthcare.

c. Competency of Human Resources

All healthcare workers including those who work for HIV and AIDS services need to have a certain competency standard. For example, doctors, nurses, mid-wives, and laboratory workers have undergone education in medicine, nursing or health sciences to obtain a certain competency standard according to existing regulations. Competency standards can be obtained either from formal education or training by the Ministry of Health and other certified health agencies.

To be competent in HIV and AIDS care and treatment, healthcare workers must meet prerequisites of competency standards for infectious disease management including HIV and AIDS. In addition, in delivering services, there were guidelines of clinical practices for doctors in primary health facilities to manage specific diseases, including HIV and AIDS (Ministry of Health Regulation No.5/2014).

However, there was no certain competency standards for human resources performing PP and Impact Mitigation. These activities are there are not yet set competency standards. that is conducted by various people outside of formal healthcare workers, in all study locations, human resources involved in PP and Impact Mitigation typically consisted of volunteers, NGOs, and communities. This was observed in Badung, Denpasar, Merauke, Makassar, Parepare, Medan and Deli Serdang. Unlike healthcare workers in performing care and treatment, non-healthcare workers in these areas did not adhere to any competency standards when performing their tasks. HIV and AIDS workers such as outreach workers, peer support, counsellors, or case managers were not available in the existing healthcare worker nomenclature, thus the competency standards for these job titles were unavailable.

With the absence of competency standards as reference, training for non-healthcare workers in PP and Impact Mitigation services were not conducted in the framework of fulfilling competency standard. Training were conducted only to improve capacity in performing service delivery. The lack of competency standards also implies that anyone can conduct training for PP and Impact Mitigation, but people providing the training may not have the valid competency standards.

The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT
Training related to prevention or treatment for PLWHA was commonly provided by IDPs by involving NGOs and the Health Office or other government working units. We from the health (SKPD) sector have participated in many training sessions, since the mid-90s when AusAID was still present. In the 90s there was more focus on prevention. Together with NGO colleagues at the time, in a year it was very frequent that we participated in training in Makassar. Colleagues from other offices, such as the Social Office, also took part. However, as we in health sector and our NGO colleagues were dealing with HIV every day, maybe we have better competence. As I remember, around late 90s there were again many training sessions for CST because of the increasing number of PLWHA. So we can no longer only focus on prevention (FGD, South Sulawesi Provincial Health Office, in Unhas Research Team report, 2014).

Although NGO personnel were considered to have good technical ability in providing preventive programs, their competence are not acknowledged formally or regulated such as in healthcare workers. Similarly, for opportunities in capacity building, the District Health Office often only organized training for healthcare workers and not for HIV and AIDS workers from outside the healthcare sector.

4) Strategic Information Management

Strategic information is defined as the system of producing, analysing, disseminating and using trustworthy information on determinants of health, performance of the health system, and health status, which will be used as a basis for decision making. The dimensions of strategic information encompasses the following: 1) synchronization and coordination of information systems, consisting of infrastructure, type of data source, data collection, and mechanisms of data processing - all of which are part of the system that is used by the government in managing information from surveys, observations, and evaluation starting from input, process to output; and 2) dissemination and use of results of processed data from the HIV and AIDS information system currently being used for planning and developing HIV and AIDS programs at district level.

a. Synchronization of the Information System

Synchronization of the HIV and AIDS information system ensures the availability of useful data for the districts to develop planning and design of intervention programs based on the epidemiological situation and local needs districts. When districts are able to develop their own planning, they will have a stronger bargaining position when dealing with donors or other parties to establish collaboration in HIV and AIDS response. The ability of the district to collect, analyse, and organize HIV and AIDS information for the development of evidence-based HIV and AIDS response efforts becomes very important. Unfortunately, it was found in this study that the districts had numerous sources of data that were managed separately, which made it difficult for data synchronization and use.

There were a number of information systems existing in the districts. First, there were variations in the method of collection; most districts used computerized information system, but there were districts that still used manual records such as in Manokwari. Second, the types of online information system varied, depending on which stakeholder had interests on the data. For program data, the central government, the national AIDS committee KPAN and IDPs had their own information systems that were not synchronized to one another. At district level, the Local Health Information System (Sistem Informasi Kesehatan Daerah - SKIDA), Puskesmas Information System (SIMPUS), and other information systems were available. These information systems were developed to answer the information needs of a specific directorate or unit in the health sector, and thus were not mutually compatible.
HIV and AIDS program data collected by a number of IDPs were not synchronized such as HIV and AIDS Information System (SIHA), Recording and Reporting (R&R), and Inventory Order Management System (IOMS). SIHA was developed by the Ministry of Health with the support of Global Fund in order to obtain information related to the coverage of preventive services such as VCT, PITC, STI and condom distribution used in primary and secondary levels of health service. This system was developed to measure whether targets of coverage were adequately met. The application of each system also differed. For example, SIHA was used for VTC/PITC at Puskesmas level, while the drug information system in the hospitals used IOMS.

There were other information systems that belonged to certain agencies such as the Narcotics Information System (SINAPZA) of the Narcotics Bureau in South Sulawesi. Agencies that were the Principal Recipients (PR) of Global Fund also established their own information system, such as NU with the SINU (Nahdatul Ulama Information System) and PKBI with the PKBI Information System (SI-PKBI).

At PKBI, we collect information and make reports based on the format from Global Fund, who are financing our program. So, we collect data, such as the number of condoms, number of syringes, and number of KIE that has been distributed. Also the number of new IDUs in our work area. Therefore, the form is specific to the program that we do. (FGD, Program Manager PKBI South Sulawesi, 2 June 2014 – Unhas Team Report).

The disintegration and lack of synchronization between various information systems either for the local or program level led to a number of issues. First, data collection activities performed by health workers were not efficient. In Medan, for example, the study found that one patient has to be entered into three different information systems. Second, the various information systems demanded different competencies of users. In South Sulawesi, there was one information system that could not be used because there was no training conducted for the users. Third, there was a variety of data and information sources on HIV and AIDS programs outputs from different agencies. Consequently, data processing and analysis became difficult, let alone to be used as materials for formulating plans and policies in evidence-based HIV and AIDS response.

As a conclusion, the existing information system in most of the study location was still at the level of data collection and not at the level of analysis. The use of SIHA data was not optimal because there was no any data processing in the form of sheets that can be used for decision-making.

b. Dissemination and Use

With the lack of synchronization between information systems at district level, the data that were used for policy and planning of programs mainly came from the national level. This included sources such as the IBBS that was developed by a donor agency, the Rapid Behavioural Survey from the National AIDS Committee, the Indonesian Demography and Health System (SDKI) developed by the BKKBKBN, and the Basic Health Research developed by the BPS and other surveys conducted by IDPs.

However, data from these survey data were still presented in aggregates and it was difficult to interpret the results at the local level. Furthermore, the survey data owned by the central government were often difficult to be accessed by local stakeholders. Each agency conducted the survey using different indicators and definitions, which made comparison between survey results difficult. Survey results and quality of information widely varied and could not always be used as a basis for developing policies on HIV and AIDS, especially for districts at district level. Although some survey data had been used at the district, it was still limited to districts advocacy activities.
Another source of information was studies conducted by universities and NGOs. Findings from these studies were used as information for stakeholders, dialog with media, socialization of epidemiological situation and strategy for response, as well as data for advocacy of hospitals such as in Merauke (Uncen Team, 2014).

Because of fragmentation in the use and dissemination of information in HIV and AIDS response in the district, development of intervention programs were often not based on sufficient evidence. Rather, programs were developed using designs from the central government. The local needs and epidemiological situation were often not adequately represented in the programs. Moreover, the development of dissemination and educational campaign for HIV and AIDS became limited.

5) Management of pharmaceutical supplies and medical equipment

The management of pharmaceutical supplies and medical equipment to examine medical products, ensure quality of the technology, security, efficacy, cost effectiveness and its use. The management of pharmaceutical supplies and medical equipment consists of the following components: 1) regulation of provision, storage and distribution of diagnostics; therapy that regulates the availability of ARV reagents, CD4 machines, and viral load, as part of the mechanisms allocated in the Health Office budget plan or supported by the National Health Insurance; and 2) resources that include funding source for provision, storage, and distribution of drugs and medical equipment for HIV and AIDS, as part of the mechanism allocated in the Health Office budget plan or supported by the National Health Insurance.

a. Regulation of provision, storage, and distribution of diagnostics, and therapy

There were several regulations at different levels and scope regarding the provision, storage, and distribution of drugs and medical equipment for HIV and AIDS. Most of the districts study locations referred to the regulations of drug provisions at the national level such as the Minister of Health’s Decree on HIV and AIDS treatment. In addition, there were Circular Letters from the PP and PL Directorate General on the composition of funding for HIV reagents, OI drugs, and IMS, as well as disposable medical equipment which were applied to all districts. A number of districts had produced local regulations related to logistics. For example, Sidoarjo issued a District Decree regarding working group on condom distribution in Benowo district and a Puskesmas Decree in Semeni on condom distribution. In Menur hospital in Surabaya, a standard operating procedure (SOP) on ARV service for PLWHA and mechanisms for drug exchange between institutions was produced.

In general, the regulation for provision, distribution and storage of medical equipment and pharmaceuticals were adapted to the existing general policies in the health sector. This was especially applicable for ARV and OI drugs that were financed by the national or local government budget under the coordination by the Health Office.

...for the regulations, we follow what is available from the national level. The management of HIV and AIDS drugs is the same as the provision process for other drugs. (Uncen Research Team, 2014)

In the past, it was all from the central government, but now since the circulation of a letter by the Minister of Health in 2013, there is a logistical division between central government and districts. For ARVs it is still 100 percent from the central government but the others are different. For condoms, HIV reagents and drugs for OI and IMS, 40 percent is from the central government and 60 percent from the districts (Unhas Research Team, 2014)
Similarly, the mechanism for storage and distribution of drugs followed the existing policies in the local health system. All the drugs were stored in the drug storage facilities owned by the Province, Municipality/District Health Office, hospitals and Puskesmas. The Provincial and Municipality/District Health Office regulated the mechanism of distribution from each drug storage facility. For instance, in Surabaya, the drugs in hospitals was stored based on a storage standard with a special SOP managed by competent staff (Unair Research Team, 2014).

In the management of drug logistics, the most commonly encountered problem was stock out i.e. when the planned drug supply run out. Most districts in this study had experienced a stock out on HIV reagents, OI drugs, and STI drugs. Several factors which might contribute to stock out were as follows: 1) The lack of ability districts to accurately plan the provision of drugs. For example, in Manokwari it was found that delays in the logistics of drugs and medical equipment were caused by the districts’ inability in logistic planning, particularly on a number of drugs that required cost sharing between the provincial and district government; 2) the expiry date of drugs were often very short; drugs might expire before they were distributed to consumers. The lack of quality control also contributed to the expired drug supplies, as found in Sidoarjo.

Problems in the provision, storage, and distribution of drugs and medical equipment were often solved by the Health Office. For example, to deal with stock out, a buffer system mechanism was designed to prevent out-of-supply of drugs in 3-6 months. The amount of the buffer system was around 10%-30%. Such a buffer system mechanism was applied in Denpasar, Badung and Surabaya. This mechanism was proven to overcome the problem of drug stock out. There were also efforts to improve the capacity of planning in drug provision according to the local needs projection based on the number of cases reported to the District Health Office.

Different policies for the supply of preventive tools such as condoms and sterile syringes were applied. The provision, distribution, and storage of these preventive tools were not conducted by the health sector but by the National AIDS Committee. In most study locations, condoms were distributed to districts by the National AIDS Committee through local AIDS committee and districts and not through the Health Office. In districts with Harm Reduction programs such as Medan, Makassar, Sidoarjo, and Surabaya, the policy for provision of LASS for HIV control in drug users commonly referred to donor’s regulations and policies. However, in Denpasar and Badung, the policy for the provision of syringes for the LASS program was regulated by the local government. Exceptions were also found in Manokwari, Merauke, and Jayapura city, in which the logistical policy had been integrated into the general health sector after the Global Fund support for Papua was terminated in the end of 2013. In these three districts, all mechanisms related to provision, storage, and distribution of drugs were regulated by local policies including financing using the local budget.

b. Resources

The resources for the provision, storage, and logistical distribution of drugs and medical equipment included funds disbursed by the central government, local government, IDPs and the community. Financing by the central government included program funding, special allocation funds (Dana Alokasi Khusus - DAK) from the national budget and grants from IDPs. Local government funding was earmarked from the local government budget. The community also contributed to funding, for example CSR programs by the private sector and solidarity support from the community.

The involvement of the local government in allocating funds for drugs had been regulated in the Letter No. HK.02.03/D/III.2/823/2013 from the Ministry of Health’s Directorate General of PP and PL regarding financing of drugs and medical equipment supplies in HIV/AIDS and STI STI programs using a cost-sharing strategy between the central and district government districts. The proportion of cost sharing was as follows: HIV reagents and CD4, 45% by the central
government and 55% by districts; OI and STI drugs, 40% by the central government and 60% by districts, Syphilis reagent (RPR), 50% by the central government and 50% by districts; GO drug and all consumables was fully supported by districts.

Central government funding for HIV and AIDS response was mainly allocated for ARV provisions. It was included in the programs funded by the state-budget and involving direct coordination between the Health Office and the central government. Funding for the methadone drug supplies was also fully supported by the central government through a national fund allocated to the Ministry of Health. This national fund was applicable in all districts and could be accessed through the referral hospitals assigned by the central government to provide ARV treatment.

Funding sources from IDPs for HIV and AIDS drug supplies included the provision of preventive material and medical equipment such as LASS, second line ARV drugs, condoms, lubricants, and CD4 tests (in a limited amount). However, IDP funding was typically temporary and given within a short time. In some districts that no longer received Global Fund support for the distribution of condoms such as Papua, community involvement in independent condom provision was successfully developed. Condoms were distributed using a mechanism of community pooling, as had been established in Merauke by a group of sex workers. The procurement of condoms in Deli Serdang district was not integrated into the local government budget, because condoms were directly supplied by the central government. Alternatively, condoms were supplied by the National AIDS Committee and distributed through three channels: through the local AIDS committee to be distributed to non-Global Fund NGOs; through PKBI and NU to be distributed to the recipients; and through the Health Office to be distributed to the Puskesmas by direct funding from donors.

Funding for syringes had not been available in most of study locations except in Denpasar and Badung, which had allocated local government funding for purchasing syringe. The procurement of syringes in Medan, Parepare, Surabaya, and Sidoarjo still depended on donor funding from donors because the local government has not taken over the responsibilities for funding the provisions.

6) Community Participation
Community participation is defined as the management of the delivery of health efforts by individuals, by community groups, or by the community with a planned, organized and sustainable community involvement. The objective is to enable the community to use various health services independently in order to achieve an optimum level of population health.

The dimension of community participation consists of two elements: 1) coordination meetings by stakeholders and community (for example, representatives of key populations), allocation of funding for HIV and AIDS response efforts by the community groups, and capacity building activities (such as training and technical assistance) that is strategically included as part of the process of planning, implementation, and evaluation; 2) access to services (both general health services or HIV and AIDS services) that represents the proportion of key population, and the proportion of key population who can access the National Health Insurance or Local Health Insurance.

a. Dimensions of Community Participation
Participation in the health sector is developed to encourage community involvement meaningfully in the process of planning, implementation, monitoring and evaluation of programs. The ability to mobilize community participation becomes an important part in building an accountability mechanism and a collective awareness in fighting the AIDS epidemic.
The types of community participation in HIV and AIDS response include: 1) active participation in the establishment of organizations at the community level, such as the establishment of Warga Peduli AIDS - WPA or AIDS Aware residents. WPA was established in almost all areas to represent the general community districts as a form of solidarity and interest to HIV and AIDS response; 2) strategic participation i.e. NGO representation, key population, community cadres as members of the local AIDS committee to enable active involvement in the decision making processes and planning of intervention programs. Other forms of participation was involvement in various routine meetings coordinated by the local AIDS committee, such as in Medan; 3) participation through independent activities carried out by the community to express their concern to HIV and AIDS. Public education on HIV and AIDS by cadres from the community was one of the examples.

In the 21 subdistricts, they all have it, though if we ask about whether they are active or not, well ... maybe half are active. That is why we try to put it into the Mayor’s Regulation that is currently being formulate. So in the Mayor’s Regulation, there will be HIV working groups at subdistrict level or even WPA, WPA will be established at the village level. (KPA Medan city, in USU Research Team Report, 2014).

In Balla’ta we try to empower our PLWHA friends and key populations. From the Drug Addict Rehabilitation Bureau we receive assistance namely a house that we can use for activities. This becomes a halfway house for friends from outside of Makassar that come to get treatment or to get support from fellow ODHA. From the Social Office, there is also a number of assistance for economic empowerment. We were recently given washing machines for a laundry business. We are grateful for this. But the problem in the implementation is that we are often asked to quickly finish the program, so the result is not as good as we expected. (FGD PKNM NGO Makassar city, 16 July 2014, in Unhas Research Team report, 2014)

These practices of community participation tend to be more meaningful than the model of community participation in the general health sector. Community participation in the health sector is usually aimed only at increasing service utilization by the community, instead of active involvement in the development of services. However, although community participation in HIV and AIDS response than in other programs, it was often suggested that community participation is still only symbolic or superficial. Community participation is often used as a form of legitimacy to fulfil the requirement of a project mechanism. Many projects, especially those funded by foreign donors, often that require the involvement of community especially the key populations as the main beneficiaries of the program (Udayana Research Team, 2014). As a result, the role of community was often limited to program implementation. Community involvement was still scarce at the strategic participation level including in decision making and program planning.

b. Access and Use of Services

Ensuring access and use of health services by the key population groups and marginalized community within the National Health Insurance scheme is one of the crucial methods to fulfill the rights to health. A few The study found that some PLWHA and key populations were able to use the National Health Insurance by paying the premiums. However, many of them had problems to routinely pay the premiums because of economic vulnerability, as experienced by some PLWHA in Bali, Makassar, and Parepare. The National Health Insurance did not cover all HIV and AIDS related services. For example, the cost of tests prior to ARV initiation was not covered. The costs for these tests is substantial. Furthermore, ARVs were not covered by the National Health Insurance because it was provided for free by a program.

Many PLWHA and members of key populations were not able to utilize health care using the National Health Insurance because most of them did not have any identity card, which was one
of the administrative requirements to use the insurance. In Denpasar and Badung, for example, some PLWHA chose to use Local Health Insurance, because the process was not as complicated as the National Health Insurance.

There are ODHA and key populations who use the National Health Insurance but it is still limited in coverage – it is only covering OI treatment; ARV is still provided by the central government, while CST and a number of pre-ARV components are not covered. Most PLWHA that access health services in RSUD Badung use the Local Health Insurance and only a few of PLWHA use the National Health Insurance (Udayana Research Team, 2014)

Yesterday, we assisted two PLWHA friends to deal with the BPJS. The administrative documents are very important to arrange BPJS. The city KPA helped us to deal with these administrative problems, by coordinating with the Community Welfare section. In the BPJS we did not state the B20 status, because it would automatically be rejected. We only put in the co-occurring infections to obtain the self-paid BPJS. We have communicated with colleagues in the Community Welfare, the Health Office, and the Andi Makkasau hospital about this issue. (FGD, LP2EM Staff in Parepare city, 3 June 2014)

The coverage of National Health Insurance scheme was also more focused on the curative aspects (CST), for example by providing coverage for OI drugs. Preventive treatments such as methadone was not in the coverage of the National Health Insurance; it was instead provided by the government through program funding. Costs for impact mitigation were also not covered. In Manokwari, Jayapura, and Merauke, impact mitigation programs were supported by the Special Autonomy. For example, food and transportation costs assistance were provided for PLWHA to access services, especially for those in remote districts or in places with no health service facilities in the vicinity.

7) Service Delivery
Service delivery refers to all health services or interventions at personal or community level that is effective, safe, and qualified, provided for those who need it at a certain place and time. The components of service delivery consists of three i: 1) Service for HIV and AIDS is available at primary and secondary care facilities in the study location; 2) Coordination and referrals in HIV and AIDS service coordinated by the Health Office through the local AIDS committee in the study location; 3) Quality assurance of service, i.e. supervision and evaluation mechanisms to ensure that the quality of HIV and AIDS services are comparable with the quality of other health services.

a. Availability of Services
Various types of HIV and AIDS services were available in the study locations provided by government or private health facilities, NGOs, and the community. These services can be grouped into preventive, CST, and impact mitigation services. In the majority of study locations, preventive programs showed the same pattern, except programs for IDUs that was not available in Merauke, Jayapura, and Manokwari.

Table 6. HIV and AIDS Services in the Study locations

<table>
<thead>
<tr>
<th>Location</th>
<th>Type of Service</th>
<th>Prevention</th>
<th>CST</th>
<th>Impact Mitigation</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medan</td>
<td></td>
<td>IEC VCT</td>
<td>PPIA PTR M</td>
<td>LASS ARV IMS</td>
<td>Capital assistance for Outreach by NGO;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OR 8 PKM, 5 PKM 2 RS 3 PKM 3 PKM 10 PKM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT 63
<table>
<thead>
<tr>
<th>Place</th>
<th>OR/PS, PKM</th>
<th>5 RS, 1 Clinic KKP</th>
<th>3 RS</th>
<th>3 LSM</th>
<th>5 RS</th>
<th>ODHA from Social Ministry, Management Training of ODHA from KPA</th>
<th>PKM FK UGM - DFAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deli Serdang</td>
<td>OR, PS</td>
<td>3</td>
<td>X</td>
<td>1</td>
<td>PKM</td>
<td>PS = Socialization by NGO, Health Office, RS, Puskesmas, KPA and SKPD Members of KPAD. X = No service PKM = Community Health Information Centre; KPP= Port Health Office</td>
<td></td>
</tr>
<tr>
<td>Surabaya</td>
<td>OR, PS, PKM</td>
<td>8</td>
<td>PKM 7 RS</td>
<td>5 PKM 3 RS</td>
<td>2 PKM 2 RS</td>
<td>6 PKM</td>
<td>7 RS RS</td>
</tr>
<tr>
<td>Sidoarjo</td>
<td>OR, PS, PKM</td>
<td>4</td>
<td>PKM 1 RS</td>
<td>1</td>
<td>X</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Denpasar</td>
<td>OR, PS, KSPA N</td>
<td>11</td>
<td>PKM 1 RS</td>
<td>11 PKM 1 RS</td>
<td>2</td>
<td>3</td>
<td>1 RSUD</td>
</tr>
<tr>
<td>Badung</td>
<td>OR, PS, KSPA N</td>
<td>11</td>
<td>PKM and RS</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1 RSUD</td>
</tr>
<tr>
<td>Makassar</td>
<td>OR, PS</td>
<td>13</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Parepare</td>
<td>OR, PS, PKR BKR</td>
<td>7</td>
<td>X</td>
<td>1</td>
<td>1</td>
<td>1 RSUD</td>
<td>1</td>
</tr>
<tr>
<td>Manokwari</td>
<td>OR, PS</td>
<td>9</td>
<td>2</td>
<td>X</td>
<td>X</td>
<td>1 RSUD</td>
<td>9</td>
</tr>
<tr>
<td>Jayapura</td>
<td>OR, PS</td>
<td>6 RS</td>
<td>X</td>
<td>X</td>
<td>2 RSUD</td>
<td>13</td>
<td>Health cards for workers in bars and massage parlours from Social Office</td>
</tr>
<tr>
<td>Merauke</td>
<td>OR, PS</td>
<td>18 PKM</td>
<td>X</td>
<td>X</td>
<td>1 RSUD</td>
<td>PKR</td>
<td>Reproductive health service at Community Health Centres</td>
</tr>
</tbody>
</table>

Source: University Research Team Report, 2014

The table shows that in most study locations, HIV and AIDS services were available in all primary and secondary health facilities which basically can be accessed by the key population, PLWHA, and the public. The services provided by these various parties created a continuum of care, starting from prevention, treatment to impact mitigation. Below is a description of each type of service category
Prevention is an organized effort to halt the HIV and AIDS transmission, which is the responsibility of the central government, local government, community, and private sector. Preventive programs in the study locations were conducted together with the general health promotion activities through the Communication, Information and Education (CIE). in Denpasar and Badung, these activities were performed by the Health Office, local AIDS committee, and relevant government working units such as the Education and Tourism Office. Preventive services included provision of equipment and test materials (VCT and PITC); provision of preventive tools such as condoms, lubricants, sterile syringes; and methadone therapy in the health service facilities such as hospitals, Puskesmas, and NGOs. The role of outreach workers in distributing preventive materials was very important because they can directly reach and support key population groups.

In HIV and AIDS prevention in Makassar city, the routine preventive activities are more commonly done by outreach workers from NGOs. In addition to outreach workers from NGOs, especially in the areas of LKB (Comprehensive Continual Care) Puskesmas there are community organizers that function as Community Health Information Centres (PIKM). The PIKM has trained cadres from the community and from key populations. The PIKM provides media for communication, information and education on HIV and AIDS that is distributed by the community cadres and the key population. (Unhas Research Team, 2014).

The delivery of CST services in the study locations were conducted using clinical, family, and/or community based approach by primary and secondary health facilities. In all the study locations, ARV treatment services were available in district hospitals or in ARV satellite Puskesmas. Interestingly, several NGO and private clinics were also involved in the delivery of treatment for key population. For example, in Denpasar, private clinics such as Bali Medical Centre provided treatment for MSM, while YKP provided services for FSWs in addition to pregnant women referred from Puskesmas. One of the Puskesmas in Denpasar city provided services for waria because of the proximity of Puskesmas to a waria area.

Related to the scope of CST, the study found that there was an increase in the coverage along with the increase in the number of service providers in Makassar, Parepare, Denpasar, Badung, Surabaya, and Sidoarjo. The coverage of VCT in Denpasar increased from 202 people in mid-2011 to 5042 people in mid-2013. Meanwhile, in Badung, the number of people accessing VCT increased from 48 people in July-September 2011 to 2539 people in mid-2013. The same increase was found in of the number of people accessing ARV treatment, which increased from 87.4% in 2012 to 90.9% in 2013 (Bali Provincial Health Office in Unud Research Report, 2014).

While clinical treatment for PLWHA was available at primary and secondary health facilities, community or family based treatment was organized by NGOs. For example, in Medan, home based care was provided by the Perempuan Peduli Pedila Medan NGO. A community based addiction recovery (PABM) was initiated by the Caritas PSE NGO and Medan Plus (USU Research Team, 2014).

Impact mitigation services are aimed at reducing the impact of HIV and AIDS especially in the social and economic lives of PLWHA. Impact mitigation services were more frequently conducted by non-health government working units that were members of local AIDS committee. Nevertheless, these programs were usually fragmented. Funding source for Impact Mitigation varied according to the districts. For example, programs in Bali was supported by the central government, i.e. the Ministry of Social Work and BNN (in Denpasar and Badung). The Ministry of Health provided capital assistance for PLWHA in Medan. In Surabaya, local budget through the Health Office was available to support food supplements for PLWHA. Impact mitigation services seemed to be conducted independently according to the planning of the funding agency and was not coordinated by the health sector. Furthermore, impact mitigation
programs were often conducted without thorough planning and needs assessments. Since the programs were only run within a short time, the sustainability was not warranted.

The service delivery for PP and CST was similar to the delivery of general health care, which enabled PLWHA to access services in the general health facilities. PLWHA were able to obtain health services in primary or secondary health facilities in their areas. Meanwhile, impact mitigation services were delivered on an incidental basis and generally dependent on funding and program availability from the central government.

b. Coordination and Referrals

Coordinated referral within the health system that will help PLWHA to obtain necessary services in primary and secondary health facilities. Coordinated referral also enables ODHA to access services across districts. However, coordinated referrals should also be applied for other services to prevent the HIV and AIDS services for PLWHA from being exclusive and separated from the general health service.

The present study found that coordination and referrals across the frontline services had been in place. For example, outreach workers from NGOs would refer a patient to Puskesmas. If further treatment was needed, then the patient would be referred to hospital. In Parepare and Makassar, there were routine coordination between outreach workers and healthcare workers in Puskesmas or hospital. In Deli Serdang and Medan, the Health Office coordinated referral system through three monthly meetings. Municipality/District AIDS committee would also facilitate the coordination meetings. The latter was observed in Surabaya, Sidoarjo, Badung, and Denpasar.

Coordination and referrals were also observed in the CST program. Collaboration and coordination between NGOs, Health Office, hospitals, Puskesmas, and local AIDS committee in CST programs were more intensive than those in prevention program. As an example is the community-based treatment for PLWHA conducted by YKPDS in Makassar city.

At the Wahidin Hospital, we really benefit from the help of our NGO colleagues. They connect us to the ODHA, for example for ARV compliance counselling. They also routinely support ODHA when they return home, and provide help so that their families can be more supportive to the ODHA. Our staff at the hospital working group is limited, so we cannot do it. (Interview, Wahidin Sudirohusodo Hospital Work Group staff Makassar, 25 July 2014 in Unhas Research Team Report, 2014).

Coordination and referrals should be stronger with the implementation of LKB (Comprehensive and Continual Care) strategy, which were being launched in the districts during this study. There were five Puskesmas in Surabaya with continuous comprehensive HIV and AIDS services including STI treatment (Unair Research Team, 2014). During the implementation, there were some obstacles found in referrals and coordination due to personal, procedural or funding reasons. To deal with these issues, coordination meetings among involved stakeholders were regularly carried out. Meanwhile, the USU Research Team (2014) reports that within the LKB framework, the Medan city local AIDS committee has formulated a MoU between the AIDS Concerned NGO forum, Health Office and the Pirngadi hospital. The system of coordination and referrals were always discussed in routine meetings of the Medan local AIDS committee in collaboration with the Municipality Health Office.

So it is like this, for planning of services we have coordination meeting with the Health Office, NGOs, that is every 3 months. There is a budget for these meetings in the KPA, so there we also decide what points of service that needs to be strengthened, which STI, what VCT, why this area etc. Medan is one of the examples for the LKB program, so we try to improve the ability of Puskesmas related to LKB, there are a number of
The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT 67

Puskesmas, and then the health service. That is why yesterday we had a kind of MoU among service providers, NGOs, KPA, Health Office, how to make the LKB network work best. (USU Research Team, 2014).

c. Service Quality Assurance

Quality assurance (QA) of HIV and AIDS services in the general health services is necessary to ensure comfort, safety, and privacy of PLWHA and key populations when accessing services. QA can be measured by examining the implementation of service SOP, compliance to guidelines, accreditations or client satisfaction surveys. A mechanism of monitoring and evaluations as well as the provision of technical assistance from the Health Office also significantly determines the quality of services.

The implementation of QA in HIV and AIDS service widely varied between services in the study location. In some areas, QA was implemented internally in the service, while in other areas, QA was implemented at the Health Office level. In Surabaya, QA in hospitals was conducted by a supervision to programs or reported cases. For instance, dr. Soetomo hospital conducts an internal supervision every three months by conducting a team meeting to discuss the program and case development. To discuss short-term developments, meetings and discussion were carried out every Tuesday. Such QA activities were also performed Dr. Soewandhi hospital. Three-monthly supervision was conducted on VCT services to discuss cases that need special attention.

To objectively measure quality of service, patient satisfaction towards services through a client satisfaction survey was also conducted in some hospitals. Such a survey had been conducted at Dr. Soetomo hospital in Surabaya. However, in other districts such as Makassar and Deli Serdang, measuring patient satisfaction for HIV and AIDS related services had not been commonly done.

In addition, technical assistance as well as monitoring and evaluation were typically conducted by the Health Office. In Surabaya, monitoring activities were performed in each program, for example the HR program, the "I am Proud I Know" (Aku Banga Aku Tahu - ABAT) program, the CST program, and the PMTS program. Monitoring and evaluation activities were conducted every three months or when deemed necessary. In Manokwari, Jayapura, and Merauke, the Health Office also conducted monitoring and evaluation activities to STI and VCT service facilities on a regular basis in the last two years. Meanwhile, in Medan and Deli Serdang, the Health Office together with the city KPA conducted monitoring of service quality in private facilities, government, and NGOs. A similar mechanism was also found in Badung and Denpasar, in which the Provincial and Municipality Health Office facilitated meetings to improve services. However, in Bali, the process of monitoring and evaluation were still conducted in a parallel manner to meet the requirements of the funding agency. It was suggested that monitoring and evaluation activities are conducted as a unified process that can provide a holistic picture of HIV and AIDS response.

It seemed that QA mechanism was more feasible to be performed on programs related to treatment and care and preventive services conducted by health services. However, for the delivery of preventive services and impact mitigation conducted by those entities outside of the health services such as NGOs or non-health government working units, QA activities often took place beyond the responsibilities of the Health Office. Monitoring and evaluation mechanism for prevention programs conducted by NGOs were typically conducted by each donor agency and separated from the health system.
C. Level of Integration Based on Dimension of Functions of the Health System

The level of integration of each dimension of health system function is described in Table 7. In all the study locations, a number of policy and regulations related to HIV and AIDS response had been issued at various levels of government such as local regulations, governor's decrees, mayor/regent regulations and decrees. These policies were developed through the prevailing policy formulation mechanism in the local government. Thus, it can be concluded that the dimension of regulation and policy formulation has been fully integrated with the health system.

However, in terms of policy implementation, there were a number of obstacles including the lack of information to the public on how the policy is implemented. The public had limited participation in evaluating programs implemented in their areas. As a result, the accountability of these policies were very weak and were not responsive to the needs of the population. This is different from local government-funded activities in other sectors which achievements can be measured. Thus, the dimension of accountability and responsiveness of HIV and AIDS program is not yet integrated.

<table>
<thead>
<tr>
<th>Functions of the Health System</th>
<th>Dimensions</th>
<th>P</th>
<th>CST</th>
<th>MD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Management and Regulation</strong></td>
<td>1. Regulation</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>2. Policy formulation</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>3. Accountability and Responsiveness</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>2. Financing</strong></td>
<td>4. Management of Funding Source</td>
<td>+</td>
<td>+</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>5. Budgeting, Proportion, Distribution, and Expenditure</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>6. Mechanism for financing of services</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>3. Human Resource</strong></td>
<td>7. Policy and management system</td>
<td>+</td>
<td>+</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>8. Financing</td>
<td>+</td>
<td>++</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>9. Competency</td>
<td>+</td>
<td>+++</td>
<td>NA</td>
</tr>
<tr>
<td><strong>4. Provision of Drugs and Medical Equipment</strong></td>
<td>10. Regulation of provision, storage, diagnostics and therapy</td>
<td>+</td>
<td>+++</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td>11. Resources</td>
<td>+</td>
<td>+++</td>
<td>NA</td>
</tr>
<tr>
<td><strong>5. Information system</strong></td>
<td>12. Synchronization of information system</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>13. Dissemination and use</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td><strong>7. Service delivery</strong></td>
<td>15. Access and use of services</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>16. Availability of Services</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td>17. Coordination and referral</td>
<td>+++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>18. Ensuring quality of services</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
</tbody>
</table>

Key: +++ = Full integration; ++ = Partial integration; + = No integration
P = Prevention; CST = Care, Support, Treatment; MD = Impact Mitigation

Not all the dimensions in the financing sub-system were integrated. In the dimension of management of funding source, there was no coordination mechanism available. Funding from
the central government and IDPs were not well coordinated and funds from the central government could be directly allocated to NGOs, local AIDS committee or the Health Office. There was no pooling mechanism which included needs assessment conducted to HIV and AIDS programs and resource generation to meet these needs. This resulted in the high fluctuation in the budget that allocated only following its availability. Allocation of funding was not synchronized nor based on actual needs. In the dimension of health services financing, the financing mechanism of HIV and AIDS services was still disintegrated from the financing mechanism of the general health service. The National Health Insurance did not cover ARV treatment as because it was still supported by a program. Pre-ARV tests and treatment for IDUs were not supported either.

The human resource management of HIV and AIDS programs was not integrated because there was a system of human resource management for HIV and AIDS that run parallel to the existing human resource management for general health system. In all study locations, there was no existing policy which regulated the management of non-health HIV and AIDS workers, such as outreach workers, field workers, case managers, and PLWHA buddies. These personnel were mostly hired by NGOs. Related to human resources financing, health workers in government health service facilities who provided treatment were paid from the local government budget allocated for the health sector. However, in districts that were still funded by MPI, health workers typically earned incentives when they work for HIV and AIDS programs. Consequently, HIV and AIDS work were often seen as additional work for health care workers, therefore, it cannot be classified as being fully integrated. The technical competency standards was only applied for health care workers who perform medical treatment. For prevention and impact mitigation work performed by workers outside of the formal health sector, there was no standard of competency applied.

The function of pharmaceuticals and medical equipment procurement function in HIV and AIDS response especially CST had been integrated into the same function in the health system. The policy on procurement, distribution, and storage of medical equipment and drugs was already in line with the general practice in the health sector. However, the management of preventive materials supplies such as condoms and sterile syringes was not integrated into the health system, because most of the supply management was not taking place under the health sector. The financing of drugs and medical equipment procurement was also similar. in Provision of preventive materials were mainly supported by IDPs, whereas provision of ARV and OI drugs were funded by the state or local budget.

Information system was one of the health system functions that was the most difficult to be integrated, as there was no designated agency in the district responsible for regulating and managing various information systems. The existing health information systems in the district such as SIKDA and SIMPUS were not integrated into one comprehensive information system. In addition, the existing HIV and AIDS information systems such as SIHA, SINU, SIPKBI etc. were not integrated to one another. Data collection for HIV and AIDS indicators was not well coordinated. As a result, data and indicators widely varied and were difficult to use. Currently, to develop programs and policies, the policy makers at district level typically used population level surveys. However, the majority of data of these surveys were owned by the central level and not always accessible to districts.

The function of community participation was not integrated either. In the general health sector, community participation usually aimed to increase the health service utilization. However, in HIV and AIDS response, community participation aimed at the increased participation in planning responses and programs. Although the community participation activities in HIV and AIDS was more visible than in other sector, they were still limited to implementation level. Strategic participation in decision making and program planning had not been observed in any of the study locations. Access and use of services was not integrated in the existing social
security schemes. The National Health Insurance only provided coverage for OI treatment. Drugs and preventive materials that supported by available programs were not included in the coverage scheme of the National Health Insurance.

Finally, the available HIV and AIDS services had been quite comprehensive and fulfil the continuum of treatment including prevention programs, CST, and Impact Mitigation. These services had been available in primary and secondary health facilities. There had been coordination and referrals that worked well between health care workers and non-health care workers, for example between health care workers in the Puskesmas and outreach workers. Both service availability dimensions as well as coordination and referrals had been well integrated. For the dimension of service quality, the health sector took control of the quality assurance related to treatment and care and some of the preventive services in the health services. However, there was no such a control to preventive and impact mitigation services conducted by agencies outside the health service, such as NGOs. Therefore, this dimension seemed to be partly integrated.

**D. Level of Integration Based on Types of Interventions**

Based on the types of intervention, the level of integration of health system functions are shown in the table below:

<table>
<thead>
<tr>
<th>No.</th>
<th>Dimension</th>
<th>Prevention</th>
<th>Care, Support, Treatment</th>
<th>Impact Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regulation</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>2</td>
<td>Policy Formulation</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>3</td>
<td>Accountability</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Management of Funding Source</td>
<td>+</td>
<td>+</td>
<td>NA</td>
</tr>
<tr>
<td>5</td>
<td>Budgeting, proportion, distribution, and expenditure</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Financing Mechanism of Services</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>7</td>
<td>Availability of Services</td>
<td>+++</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>8</td>
<td>Coordination and Referral</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>9</td>
<td>Quality Assurance</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>10</td>
<td>Human Resource Policy and Management System</td>
<td>+</td>
<td>+</td>
<td>NA</td>
</tr>
<tr>
<td>11</td>
<td>Financing of Human Resources</td>
<td>+</td>
<td>++</td>
<td>NA</td>
</tr>
<tr>
<td>12</td>
<td>Competency of Human Resources</td>
<td>+</td>
<td>+++</td>
<td>NA</td>
</tr>
<tr>
<td>13</td>
<td>Regulation of provision, storage, diagnostics, and therapy</td>
<td>+</td>
<td>+++</td>
<td>NA</td>
</tr>
<tr>
<td>14</td>
<td>Resources</td>
<td>+</td>
<td>+++</td>
<td>NA</td>
</tr>
<tr>
<td>15</td>
<td>Synchronization of Information System</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>16</td>
<td>Dissemination and Use</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>17</td>
<td>Community Participation</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>18</td>
<td>Use of Services</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
</tbody>
</table>

Source: University Research Team Reports (2014)
Key: +++ = Full integration; ++ = Partial integration; + = No integration
1. Level of Integration of Prevention Programs

Table 8 shows that prevention programs were generally not integrated, in which only 4 of the 18 dimensions showed full integration between programs and the health system, 2 dimensions were partly integrated, and 12 of the other dimensions of the health system functions were not integrated.

The dimensions of regulation and policy formulation for preventive interventions were fully integrated, because regulations at the local level had regulated preventive interventions, and formulated according to the process of policy formulation in the region. The dimension of service availability was also fully integrated because prevention services were already a part of the general health system supported by the non-health sector such as NGOs, support groups, health cadres, and community leaders. Prevention programs provided in the health facilities such as VCT, PITC, LASS, PTRM, and PMTS had become part of primary health care services. This also applied to the dimension of coordination and referrals. These dimensions were fully integrated because coordination and referrals were crucial elements in the LKB approach that had been implemented in most of the study locations. This approach was introduced through a mechanism of routine coordination among stakeholders across sectors, including local AIDS committee, Health Office, hospitals, primary health facilities, NGOs, peer support groups, community leaders, and health cadres.

The partially integrated dimensions were the quality assurance of services and the use and access of services. In general, there had been a mechanism for quality assurance through certification and various training sessions for health care workers involved in prevention programs. For example, health care workers who provided counselling services received training and education from the Ministry of Health. There were also various guidelines aimed at ensuring the compliance of health workers to the established competency standards. However, most of the non-health workers who mainly performed the prevention programs were not certified. In general, non-health workers working in preventive interventions performed their tasks based on empirical experience and training provided by the Health Office and IDPs.

Since most prevention activities were budgeted through non-health sectors, the financing of preventive activities was not well-integrated into the health system. Funding for prevention programs were allocated based on the planning and priorities of the IDPs and not the health sector. The prevention programs financed by the IDPs were not covered by the National Health Insurance. The management of human resources for HIV and AIDS was not integrated, because for prevention programs, it involved many service providers outside the government health workers, such as NGOs, peer support groups, and community members. These non-health workers were not coordinated by the health sector, either in regulation, financing or competency standards.

The same practice applied to the function of provision, storage, diagnostics and treatment, both in the dimensions of regulation and resources. As the regulation for the prevention material supplies and the financing scheme is not available, the dimension of logistic management for preventive material supplies is not part of the health system. The financing for logistical provision related to prevention such as methadone, condoms, lubricants, and syringes still rely on IDP support.

2. Level of Integration of CST Programs

Compared to prevention programs, CST programs were more integrated into the health system because it has utilized the existing infrastructure and resources of the general health system. In addition, the traditional role of the health sector is in the curative aspect, thus interventions aiming at medical treatment were easier to integrate. Of the 18 dimensions, 7 dimensions were fully integrated, 3 were partly integrated, while the rest (8 dimensions) were not integrated.
Similar to prevention programs, the dimensions of regulation and policy formulation in CST were fully integrated, because these aspects had become part of the system of response to other infectious diseases. Beyond these management and regulation functions, all dimensions that were integrated were dimensions closely related to the core competency of the health sector, i.e. medical treatment. First, the function of CST service delivery was fully integrated, because it had been provided in secondary health facilities with a SOP that was also applied in other infectious diseases. Second, treatment was provided by health care workers whose standard competency was regulated by the health system. Three, the regulation and resources needed for procurement, distribution, and storage of drugs and medical equipment for CST services had utilized the existing mechanisms in the health system.

The three dimensions in CST that were partially integrated included quality assurance, financing of human resources, and access and use of services. The QA of CST services was relatively better integrated than QA in preventive interventions, because it involved only health care workers. Therefore, it was easy to be accommodated in the health system. The financing of human resources in CST interventions was also partly integrated, because although health care workers provided the services, most of them received additional incentives for CST services. As a result, there was a perception that HIV and AIDS services were “additional work”. The dimension of access and use of services were not fully integrated. Although ARV drugs were provided for free and the National Health Insurance covered OI, several components were not covered under the National Health Insurance, such as pre-ARV tests. This affected the use of services by PLWHA and key populations.

3. Level of Integration of Impact Mitigation Programs
For impact mitigation programs, there were only a few dimensions that were fully integrated, namely the dimensions of regulation and policy formulation and the dimension of service availability. From the regulation point of view, the impact mitigation program had been managed as such that it was integrated. The mechanism for policy formulation had followed the mechanism of policy formulation applied in the local government. The dimension of service availability was also integrated, because impact mitigation services were already available including activities for developing the skills of ODHA and key populations, provision of food supplements, support for productive economic development, and social security schemes.

Impact mitigation programs were mostly provided by agencies outside the health sector, particularly the Social Office. Some programs were conducted by other agencies such as the BNN (National Narcotics Body). There were also programs conducted by the community such as religious groups. The Health Office prioritized treatment and care, and therefore, few has been done by the health sector on impact mitigation. As a result, impact mitigation programs were likely to develop outside of the health system functions.

Many of the dimensions of the health system functions in impact mitigation were not integrated. The dimension of financing and the mechanism of financing of services, for example, were not integrated, because these programs were generally managed and financially supported by the Social Office. Similarly, the dimension of quality assurance was not integrated, because there was no monitoring of the quality of impact mitigation programs by the health system. In the information system aspect, most were not reported in the reporting mechanism of the health system.

E. Level of Integration Based on Study location
The level of integration were also examined based on the study location. The table below summarizes the description of level of integration for each study area.

Table 9. Level of Integration According to Study location

<table>
<thead>
<tr>
<th>District/City</th>
<th>P</th>
<th>CST</th>
<th>MD</th>
</tr>
</thead>
</table>
The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT

<table>
<thead>
<tr>
<th>Deli Serdang</th>
<th>+</th>
<th>++</th>
<th>+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medan</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Surabaya</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Sidoarjo</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Denpasar</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Badung</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Makassar</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Pare-pare</td>
<td>+</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Manokwari</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Jayapura</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Merauke</td>
<td>++</td>
<td>++</td>
<td>+</td>
</tr>
</tbody>
</table>

Note: ++ = Partial integration; + = No integration

Table 9 shows the patterns of integration based on districts. Three districts were more integrated than the other 8 districts, i.e. Jayapura, Merauke, and Manokwari. These three districts were partially integrated for preventive interventions and CST, with the number of integrated dimensions of around 6-10 dimensions for both type of interventions. Compared to other districts, these three districts had more integrated dimensions because since the Global Fund as one of the most dominant IDPs was withdrawn, the local government has played more roles in HIV and AIDS response.

Eight districts outside Papua that were less integrated included Medan, Deli Serdang, Surabaya, Sidoarjo, Denpasar, Badung, Makassar, and Parepare. In these districts, the prevention programs were not integrated, as mostly were depended on the support of Global Fund, such as the LASS program and the provision of condoms and lubricants. On the other hand, CST programs were relatively more integrated because all the districts had utilized funding sources from the state budget for the provision of ARV drugs. Implementation of CST programs has utilized the existing health sector infrastructure, including the use of human resources with valid competency standards.

Meanwhile, in all study locations, the impact mitigation intervention has not been well integrated. It was reported that impact mitigation programs were mostly provided by the Social Office. Skills training, provision of supplementary food, and support for entrepreneurship and social security programs were perceived as not part of the health sector tasks. However, several local governments (Papua and West Papua provinces through the Special Autonomy fund) had budgeted the financing for referrals, especially transportation and living costs for community members who lived in remote areas to enable their access to ARV treatment in referral hospitals and Puskesmas.

The level of integration at the local level for CST further highlights that CST has more potential to be integrated into the health system in the districts than the other two types of interventions. It also underscores that promotion and prevention in HIV and AIDS response were still perceived as ‘additional work’ to the traditional roles of the health sector in curative efforts. The promotion and prevention effort remains debatable issue, therefore in the RPJMN 2015-2019, it is emphasized that the health sector needs to prioritize promotion and prevention efforts at the level of basic health services.

F. Factors that Influence Integration in the Region

HIV and AIDS response was not well integrated into the local health system. The level of integration of a program into the health system is influenced by many factors. According to Atun et al. (2010), the factors that influence include political, economic, social and cultural contexts.
as well as the characteristics of the health system itself. The interaction between these factors can create obstacles or opportunities. It might be examined from the relationship between strategic stakeholders in the districts relate with one another. These stakeholders include political leaders, actors in the health system, and actors in HIV and AIDS response. Following this framework, the factors that potentially influence the integration of HIV and AIDS response into the health system are as follows:

1. The strength of the health system at the local level will influence the integration of HIV and AIDS response efforts into the health system. In the analysis of integration levels, it was identified that a number of functions in the local health system has not been implemented optimally, for example in the function of health financing, human resources, and strategic information management. This is in line with the results of the observation on the health sector conducted in 2014 (AIPHSS, 2014). When the functions of the health system in HIV and AIDS response are integrated into a weak health system the results might be worse. Therefore, the choice to integrate will depend on the readiness of the health system itself. If the local health system is not functioning well, it might significantly affect the level of integration of HIV and AIDS programs. Based on the observation of the AIPHSS (2014), the Indonesian health system is not well functioning well.

2. The acceptance of HIV and AIDS response as a local program also depends on the commitment of the local government. The majority of the local government in this study tend to build normative political commitment in the form of regulation or policy. However, as also observed in other developing countries, the problem of development lies not in the capacity to formulate policy, but in the capacity to implement policy (Pritchett, 2014). The obstacles in the implementation of policies at the local level become a recurrent issue. With this situation, it becomes difficult to expect a high operational commitment in order to integrate HIV and AIDS response efforts into the health system at the local level. This situation is indicated by the low capacity of the local AIDS committee to advocate for stronger implementation of these political commitments because of its position as a non-government working unit and its ad hoc nature. Meanwhile, the main players in planning and budgeting in the districts (i.e. local parliament and planning agency) do not provide more attention to the HIV and AIDS response in their districts.

3. The regulations or laws outside the health sector that limits the access of key populations to health services such as Perda on Pekat, Anti-Prostitution or Public Order remain a point of debate between policy makers at the local level. On one hand, there is an argumentation that these Perda may provide protection for the public, but on the other hand, there is the need to control the disease transmission. The more popular regulations were more widely accepted than the Perda on HIV and AIDS response. If HIV and AIDS response is accommodated in the regulations, it has to be synchronized with the limitations set by the Perda on Public Order.

4. The functions and role of stakeholders highly influence the integration of HIV and AIDS response into the health system. A formal political commitment of the key stakeholders without an operational commitment implies that it is difficult for HIV and AIDS response to become a priority for the district. In addition, the dominant administrative and technical role of the central government also becomes an obstacle in integrating the HIV and AIDS response with local health systems. The position of the central government as the planner and controller of financing becomes an obstacle in the acceptance and level of commitment of local governments to HIV and AIDS response. As a result, the HIV and AIDS response efforts are implemented vertically in nature, where local governments only take the role as the implementers.

5. In the mapping of strategic stakeholders in the districts, IDPs were identified as actors that have high interest and high resources in HIV and AIDS response. Although they significantly contribute to the implementation of programs. However, their programs were mostly vertically implemented, especially on the administrative aspects. This can hinder the effort of integrating HIV and AIDS response into the health system at the local level. There is
limited control on the planning and budgeting of MPIs by the Health Office or the local AIDS committee. The study documented that the withdrawal of an IDP in a region (Papua and West Papua) led to an opportunity for the local government to be more committed and responsible for HIV and AIDS response. Available resources in districts were utilized to maintain HIV and AIDS response, even though the scale of the programs were not as large as programs by IDPs.

6. CST interventions tend to be more integrated than preventive and impact mitigation interventions. This situation shows that full integration is possible for curative interventions, because it is more in line with the characteristics of the current health system. The CST activities are characterized by the relations between health workers and patients on medical issues, in which various guidelines or SOPs on treatment and care are already available. Meanwhile, preventive interventions involve social and behavioural aspects that are more complicated and should involve a cross-sectoral approach. The acceptance of the complexities of interventions in HIV and AIDS response by actors in the health sector also influence the level of integration (cf. the conclusion of Atun et al., 2010).

G. The Relation between Integration and Effectiveness of HIV and AIDS Programs

In the previous section, we have discussed the interaction between the characteristics of HIV and AIDS problems, the actors, contexts, and the implementation of health system functions. These factors determine the level of integration of health service delivery, either in prevention, CST, and impact mitigation. Integration is not an aim, but a means to achieve effectiveness in health service delivery. To evaluate whether an integration is effective or not, a measurement of the performance of health services is required.

To explain how the level of integration influences the effectiveness of HIV and AIDS programs, an analysis was conducted as follows:

1. Using a table of the analysis of the level of HIV and AIDS integration into the health system, in which the Service delivery sub-system is fully integrated for Prevention and CST.
2. Using a conceptual framework and results of the integration analysis, a proxy to measure the effectiveness will be contexts, role of stakeholders and level of integration.
3. The performance of Service Delivery that is being measured for effectiveness is 1) output, i.e. coverage and 2) outcome, i.e. change of behaviour.
4. Data for coverage was obtained from the Ministry of Health Three Month Report III 2014, while data for behavioural change in the key population at the study locations was taken from the STBP 2011.
5. To examine whether integration can predict effectiveness, an analysis is conducted on the performance of programs in areas where many of its sub-systems are integrated.

There are two items being measured regarding the effectiveness of the performance of health services. First, from the perspective of coverage, whether targeted groups are using available services in order to meet the needs of the beneficiaries. The percentage of coverage of prevention is compared with the national target of up to 80% to evaluate if the activities being conducted have met the expected targets. Second, from the perspective of behavioural change, which is whether existing services can make the key populations change their behaviour that makes them vulnerable to HIV and AIDS infection, such as consistently using condoms every time they engage in sexual intercourse. Other than that, the CST aspect being measured is how far has existing health services can increase the number of ODHA that are on treatment for ARV.

The data from the STBP 2011 are used with the consideration that it most comprehensively describes the conditions of each city/district, although not all of the city/districts in the research are included in it. The most complete data is for the population of WPSL and WPSTL, whereas in some districts the data for MSM and high-risk men are not available. Because of this,
the research uses the data for WPS as the key population, by taking the average coverage between WPSL and WPSTL. In addition, there are a number of different indicators of coverage in the STBP for the measurement of coverage so that to accommodate the process of analysis, these indicators are made into averages and will be referred to as the program exposure coverage. Based on the data from STBP 2011, the percentage of WPS outreach is 72.9% in Bali, 55.5% in Papua, 48.5% in West Papua, 43.1% in East Java, 33.9% in North Sumatera, and 18.5% in South Sulawesi. This data shows that the coverage of WPS outreach has not met the national target, only Bali comes close to the target, with 72.9% from the 80% that the national target demands.

Based on the evaluation of the level of integration of each dimension, it was found that in Deli Serdang, Medan, Surabaya, and Denpasar, there have been 5 dimensions out of 18 dimensions of the health sub-system that are fully integrated from the 18, whereas Jayapura has 7 dimensions that are fully integrated for prevention programs. For the coverage of programs, the results show that Jayapura, with a 7 on the level of integration, has a coverage level that is higher than other districts that have 5 on the integration level. However, in districts with 5 on the integration level, there is considerable variation in the results of their coverage, between 28% to 67.1%. Hence, while there is a tendency of an increase in effectiveness according to the level of integration, the relation between these two variables is not yet robust.

Whereas for behavioural change, the results show that there is no linear pattern between the increase in effectiveness and the increase in the level of integrated dimensions. In Medan, at 5 on the level of integration, the behavioural change is 51.5%, which is higher than Jayapura which as a behavioural change of 48.8%, even though it has 7 on the level of integration. Diagram 6 combines the comparison between level of integration and the prevention program coverage (exposure of program on WPS) and the level of behavioural change.

Diagram 6. Relation between Integration and Effectiveness:
Program Exposure Coverage and Behavioural Change compared to Level of Integration

7 The indicators include data on attendance of meetings/discussions, visits to the clinic for IMS check up in the past month, frequency of contact with fieldworkers, etc. From these different indicators, one will be chosen with the highest results that will be used as an indicator of the program exposure which will be compared with the outreach of each key population.
To measure the influence of integration to CST services, this research views how far the level of integration influences the effectiveness of CST specifically on the number of ODHA that are on ART treatment. The Ministry of Health (2014) does not detail the number of ODHA that are on treatment based on city/district, so that the data being used here is at the provincial level. Diagram 7 shows the analysis result of the number of ODHA on treatment compared to the level of integration.

Diagram 7. Relation between Level of Integration and Number of ODHA on ARV Treatment

Diagram 7 shows that the percentage of ODHA on ART treatment is not correlated to the level of integration. The variation between level of integration with the number of ODHA on treatment is very large and does not show any pattern that indicates that integration levels at most of the study locations correlates and contributes to the effectiveness of the program.

The inconsistency in the relationship between the level of integration and coverage as well as behavioural change in the form of number of ODHA that are on treatment is also influenced by the performance of the health system at the local level. The low level of integration occurs because of the various factors that have been explained in previous sections, such as the lack of support in operational policy and the weak role of key stakeholders in pushing the local government to prioritize the HIV and AIDS response efforts. In this condition, it is difficult for HIV and AIDS programs to achieve their set targets. For example, the lack of operational support to meet the human resources needs of non-health HIV and AIDS such as outreach workers becomes one of the challenges in improving the coverage for key populations. Similarly, the lack of operational policy on financing makes it is difficult to improve the performance of HIV and AIDS in the region.

Integration is assumed to contribute to the effectiveness of programs if the program is well-integrated into an effective health system. However, there is an indication that the health system has not fully supported the integration of HIV and AIDS response into the health system. As a result, the current status of integration into the health system is not sufficient to explain sufficiently whether integration has contributed in improving the effectiveness of HIV and AIDS programs.
V. Conclusions and Recommendations

a. Conclusion

1. STI  The development of HIV and AIDS policies and programs in the districts is influenced by the local political context, external support, and epidemiological situation. The local political context influence whether the HIV and AIDS issue will be prioritized or not because it is not a populist issue. All the districts have development policies and conducted efforts in HIV and AIDS response, but the implementation is not yet optimal. The regulations still do not have accountability and responsiveness, proven by the lack of operational policy for the implementation of existing regulations so that the financing and provision of HIV and AIDS human resource by the local government is still at a minimal level.

The formulation of policy and initiation of HIV and AIDS programs are conducted by the central government with the support of MPIs so that the programs are vertical in nature. The epidemic situation in districts that are economic centres with good medical facilities available attract the attention of MPIs in conducting HIV and AIDS programs. However, the local government has not taken advantage the opportunities of these MPI initiatives to integrate HIV and AIDS response efforts into the health system.

2. Stakeholders with high power and interest (Health Office, MPIs, and Local Leaders) influence the awareness of the HIV and AIDS problem at the local level. The Local Leaders that are also leaders of the KPAD often determines whether HIV and AIDS response becomes a local priority or not. The role of Local Leaders in the study locations consist of formulating policies on HIV and AIDS as the legal foundation of intervention programs. However, local leaders have not paid attention to the implementation of HIV and AIDS policies in the districts because the operational support is not yet optimal, such as the availability of funding and HIV and AIDS human resources. The Health Office as the agency in charge of the health sector has full authority conduct any effort on HIV and AIDS response. This authority will be optimal if it has support from Local Leaders who are consistent in implementing regulation related to HIV and AIDS. However, the current resources and financing of HIV and AIDS at the Health Office is still dependent on MPIs. As a result, the role of MPIs is still dominant in HIV and AIDS response efforts. The dominant role of MPIs and the central government, starting from planning until implementation results in HIV and AIDS programs not being integrated into the local health system.

3. The HIV and AIDS response efforts tend to be not yet integrated because they are centralized, resulting in the minimal role of the districts:

   a. Although there are a number of different regulations at the local level, their implementation is not yet optimal. Regulation as one of the dimensions in the health sub-system becomes the formal foundation to push for integration if implemented consistently. However, the implementation of HIV and AIDS regulations in the districts is not yet consistent, as shown by the small amount of funding and resources provided by the government for HIV and AIDS programs. Other than that, the implementation of regulation depends on the will of the local leader regarding AIDS response efforts.

   b. Financing is still largely dependent on the central government with minimal management authority for the districts. HIV and AIDS programs that are vertical in nature with the funding support of the central government and MPIs are responded by local government with the perception that the issue of HIV and AIDS belong to the central government and MPIs. Because there is funding from the central government, the local government does not allocate any funds. This is related to the limitations on administrative authority in resources and funding management given by the central government to the local government. This means that the authority
for planning, management, and allocation of funding and determining program targets are still held by the central government and the MPIs.

c. Dualism in the management of AIDS workers versus health program workers is still dominant in CST interventions and even more so in prevention programs. There is not yet any policy to ensure the availability of non-medical HIV and AIDS human resources in service delivery and one that can be used to regulate the mechanisms for recruitment, competency standards, and financing. As a result, the fulfilment of non-medical HIV and AIDS human resources runs separately and is not integrated with the mechanism of recruitment of health workers.

d. The strategic information system for AIDS has not become a part of the monitoring and evaluation system of local health programs so that it is not yet optimally used for the planning of HIV and AIDS response in the region. Many parties develop the HIV and AIDS strategic information system according to their program needs. The Health Office has not played its role as the highest authority in the health sector in the districts to synchronize all the HIV and AIDS information into one local health strategic system. The donors conduct the monitoring and evaluation of HIV and AIDS programs and the results are not coordinated with the Health Office so that only the program owners use the results.

e. The policy and pattern of the management of the logistics of pharmaceuticals and medical equipment in CST has been conducted according to the policies of the health system, but the policy for prevention runs parallel to the system. The management of the logistics of pharmaceuticals and medical equipment in CST that follows the logistical system of the general health system helps to ensure the legal certainty for both the national and local governments to allocate funding to fulfil local needs. The high number of parties and uncertainty in regulation for the logistics of pharmaceuticals and medical equipment becomes an obstacle for government adoption of its provision and distribution.

f. Community participation as a manifestation of program accountability is still overlooked. The community is only involved at the level of implementation; there is not yet any planning, so that the programs responsiveness is not yet robust. The involvement of ODHA and key populations in the HIV and AIDS response efforts are still limited to implementers of programs that are designed and financed by the central government or MPIs. Other forms of participation are in the form of representation of ODHA and key populations in the KPAD. However, there is not yet a clear mechanism of how they can access funding sources from APBD to implement the programs that they plan based on their own needs.

4. Institutions of higher education as a centre of knowledge development and resources have not optimally played their role. A number of research result from higher education institutions regarding HIV and AIDS are documented in the form of scientific works such as thesis, dissertations, research reports, and articles in scientific journals. The biggest challenge for institutions of higher education is how these academic works can be accessed and used by key stakeholders in the formulation of policy and implementation of HIV and AIDS development programs. Institutions of higher education also functions and is responsible for producing quality HIV and AIDS workers that meet existing standards.

5. The level of integration in the region is also influenced by the strength of the health system in the region, the characteristics of AIDS interventions, the political and legal context, and the presence of MPIs.

6. The effectiveness of HIV and AIDS programs in the study locations, viewed from a number of key indicators (coverage, behavioural change and compliance to ART treatment) cannot yet be explained in a satisfactory manner by the level of integration of HIV and AIDS response into the health system. The low degree of local involvement, domination by MPIs and the central government in AIDS response, the segregation in the management of human
resources and the dynamics of program funding becomes probable reasons that need to be studied further with better data.

b. Recommendations
Integration as an ideal objective to ensure the effectiveness and sustainability of HIV and AIDS programs can be achieved is there is also a concurrent effort to strengthen the health system itself through:

1. The presence of synergy of the strategic stakeholders (Bappeda, Local Leaders, DPRD and SKPD) in HIV and AIDS issues to prioritize it as a local health issue. The strategic stakeholders in HIV and AIDS response that have the authority to formulate and decide policies such as the Bappeda, Local Leaders, DPRD, and SKPD need to be synergized to push for the implementation of existing regulation so that HIV and AIDS efforts becomes a health sector priority in the region.

2. The regulatory function needs to be strengthened through the development of an operational policy at the local level regarding local and national regulations. The existing regulations, such as Perda, need to have an operational policy so they can be implemented, such as the operational policy for HIV and AIDS budgets in cities/districts in each SKPD member of the KPAD. The strengthening of regulation needs to be accompanied by the formation of mechanisms for the monitoring and evaluation of policies and programs that are integrated with the mechanism of monitoring and evaluation in the general health sector.

3. More authority for the districts to manage the program and epidemiological data as a foundation of the development of administrative authority (planning and budgeting) to strengthen service delivery in prevention, CST, and impact mitigation in the districts. The surveillance of diseases in the districts that is already under the authority of the local government needs to be activated and surveillance of diseases needs to involve a HIV and AIDS component. The synchronization of planning between the central government and the local government needs to be conducted so that each party has the same rights on the ownership and use of data for local health planning.

4. The central government and MPIs need to be willing to give most of their administrative authority (including resources) in HIV and AIDS response to the districts according to local capacity. The transfer of authority starts from the planning of programs and financing so that there is a shared ownership between the central government and the local government. The basis of this planning is the needs of the region based on local epidemiological evidence.

5. Commitment of the local government to take a larger role in prevention through funding of communities that have been funded by MPIs. The commitment of the government, for example, can begin from making operational policy in the Perda that states that there is community participation in HIV and AIDS response.

6. Replications of successes in HIV and AIDS policies at the local level (city/district or village) at the provincial or national level. There needs to be an identification of success in the integration of HIV and AIDS response into the health system that is applicable in various districts to then be developed in other districts. Examples of successes that can be seen from the results of this research is the development of the financing of HIV and AIDS workers by allocating local funds such as in Jayapura and Merauke. Also, the success in innovation and initiative of the local government in conducting HIV and AIDS programs in Bali until the village level, by allocating village funds.

7. Higher education institutions in the province should be involved in providing evidence as a basis for the development of local policy. According to three main obligations of higher education, which is education, research, and service, the provision of evidence by institutions of higher education as information for policy development must start at the local level. In this case, the role of the KPAD, as the multi-sectoral coordinator, needs to coordinate with local institutions of higher education starting from program planning.
until monitoring and evaluation of programs. From the side of higher education, there needs to be concrete steps in disseminating the results of research to stakeholders in HIV and AIDS response in the districts, which can technically become an agenda between the KPAD and institutions of higher education.
Bibliography


Australian Indonesia Partnership for Health System Strengthening. 2014. Indonesia Health System Review.


The Integration of HIV/AIDS Response into the Health System: PKMK FK UGM - DFAT
Appendix 1. Research Instrument: Primary Data Collection

The primary data research instrument consists of questions that represent every sub-system in the HIV and AIDS response (e.g. prevention, CST, and impact mitigation). Each component and sub-system require in depth investigation to obtain the strategic issues in each sub-system and their relations to other sub-systems. Below is the instrument that will be used based on the seven (7) health sub-system.

1. Sub-system of Management, Information, and Health Regulation on HIV and AIDS response

The sub-system of management, information, and health regulation is The management which brings together various efforts of health policy, health administration, health law regulation, data management and health information to ensure that there is a strategic policy framework combined with supervision, partnership development, accountability, regulation, incentives and suitability with the existing health system design.

a) Under the existing regulations (laws, government regulations, Ministry regulations, Perda), are the roles and responsibilities of SKPD and CSO in AIDS response clearly defined? In general, are the resources available to carry out those roles and responsibilities sufficient?

b) Is there a strategic plan for AIDS response? If Yes, does the strategic plan reflect the strategic plan in the health sector? Is there a periodic review of this strategic plan? Is this strategic plan used to make decisions, to determine allocation of human resources and to stipulate the epidemic situation in the region?

c) Are there any impacts of the decentralization policy on AIDS policy in this region? If Yes, what are the impacts on AIDS response in this region?

d) Are there any plans from the local governments to achieve MDGs for AIDS response?

e) Has there been any assessment of the epidemic situation in the district?

f) How is the development of planning for activities and services in order to develop AIDS response in this area? To what extent is this policy based on evidence of epidemiological trend or evaluations of activities in the past?

g) How can people find out about HIV and AIDS programs implemented in this region so as to make them easy to access?

2. Sub-system of Health Financing

The financing sub-system is the management of various efforts on fund-raising, allocation, and expenditure of health funds to support the development of health sector to achieve the likely highest health level. The elements of health financing consist of funds, resources, and management of health funds.

a) Has any assessment ever been done on AIDS response financing in this region? If Yes, how often is the assessment conducted?

b) Are there any plans to increase the amount of local government budget (APBD) in the region for AIDS response? How is the plan prepared?

c) Where is the source of AIDS funding in this district from?

d) Are there any funding sources from other parties used to help the AIDS response? If Yes, are there any difficulties in managing these various financing sources?

e) Are there any government health insurance (JKN or Jamkesda) for HIV and AIDS-affected groups?

f) Do the HIV and AIDS-affected groups need to pay for this either formally or informally for AIDS- related health services they receive? If Yes, how much do they have to pay? Does it create a problem for the patients to access the services?

3. Sub-system of Health Human Resources
This sub-system is used to ensure that the human resources involved in HIV and AIDS response are responsive, efficient, competent, fair, and evenly distributed in accordance with the available resources and the existing situation and sufficient in number.

a) How are HR policies for the AIDS response structured? What about the capacity building for doctors, nurses, midwives, other health workers and field officers who work for key populations or cadres? Are there any sustainable capacity buildings for them?

b) Are the human resources that the service providers (government and non-government) have sufficient to carry out daily work and responsibilities, including meeting the needs of key population?

c) Are there any policies governing non-government personnel (from private or CSO) contracted or hired to carry out the AIDS response? If Yes, please specify!

d) If the number of HR need in the district is insufficient, what steps has been taken to meet the need?

e) What support mechanism is used to maintain human resources working for AIDS response (career development, supervision, security, mobility, welfare)? Is the rotation and mutation for HR in AIDS response an important issue in the program implementation?

f) Are there any policies governing the competency standardization for AIDS response? If Yes, please specify!

4. Sub-system of Strategic Information
The sub-system functions to ensure that the production, analysis, dissemination and use of reliable and timely information about the health determinants, health system performance and health status, are used as a basis for decision-making.

a) Has a research or assessment on HIV and AIDS response (e.g. research/behavioural survey, the evaluation, mapping of key populations, Integrated Bio-Behavioural Surveillance (IBBS) ever been conducted in your region?

b) Are there any information systems related to HIV and AIDS response used to help to make decisions?

c) How are the results of the information systems disseminated and utilized?

d) Are there any data about key population and targets for HIV and AIDS response programs? What are they?

e) Is HIV and AIDS information system the same as the one used by other health systems?

5. Sub-system of Provision of pharmaceuticals, medical equipment, and supplementary food
This sub-system is used to see medical products, technologies that are guaranteed in terms of quality, safety, efficacy, cost-effectiveness and its use.

a) Are there any specific issues related to the supply, distribution and quality of drugs, reagents, or prevention equipment? (Issues to dig further: provision, regulations, quality assurance, access, medical technology, storage, and supplementary food)

b) Where is the source of drugs, reagents, preventive equipment, consumable medical devices, consumable medical material, diagnostic tools, and supplement food?

c) What are the regulations for drugs, reagents, preventive equipment, consumable medical devices (AMHP), consumable medical material (BMHP), diagnostic tools, and the supplementary food?

d) How is the quality assurance for drugs, reagents, preventive equipment, consumable medical devices, consumable medical material, diagnostic tools, and supplementary food?

e) What is the procedure to access drugs, reagents, preventive equipment, consumable medical devices, consumable medical material, diagnostic tools, and supplementary food?

f) Are there any obstacles for the access process? If so, what are the obstacles and its solutions?
g) Is there an existing logistics management information system? How is it implemented and who is responsible?

h) Are there any specific rules about drugs (e.g. paediatrics ARVs, TB - HIV, Hepatitis, pregnant women)?

i) Are there any Standard Operating Procedures (SOP) to release, distribute, and give to the health service unit at the provincial or district/city levels?

j) Are there any SOPs to lend drugs to other service units at the provincial/district/city levels?

6. Sub-system of Service Delivery

This sub-system covers interventions for personal and public health, which are effective, safe and of good quality provided for people in need at a particular location and time.

a) How is the healthcare delivery system for HIV and AIDS response in the region organized?

b) Explain briefly the responsibilities of the health units. Are their capacities suitable with the current responsibilities? (Check list Ministry of Health no: 296)

c) Does the type of healthcare provided include services such as prevention, medication, palliative and rehabilitative, health promotion, and impact mitigation? (check the list of service types).

d) Are there any services to support medication compliance?

e) Are there any legal advocacy and social welfare support services for the poor and the excluded living with HIV?

f) Are the services for prevention, diagnostic and medication available for anyone (e.g. distance, stigma and discrimination, information services, cost)?

g) Have all HIV and AIDS services provided nutritional support? What are the obstacles?

h) Have all services tried to defuse stigma and discrimination (S & D) for PLWHA? What are the efforts to defuse stigma and discrimination?

i) Are there facilities and medical equipment available for the application of standard precautions?

j) How is quality assurance system for care units in the private sector, government and NGOs? Is supervision provided for all programs or do the existing programs have different supervisory systems? (Are there any external supervisions?)

k) Is the assessment of beneficiary satisfaction done regularly? How are these results used?

l) How can the private sectors and NGOs jointly get involved in building a network of healthcare services in this region?

m) What are the plans to provide services in remote districts (e.g. DTPK - Disadvantaged Borders and Islands, DBK - Region with Health Problems)? How is the model to reach the communities in those districts? (if any)

7. Sub-system of Community Empowerment

The sub-system covers the active role of the community towards the efforts for HIV and AIDS response by the government through building a cooperation with communities such as NGOs, universities, health profession organizations, key population community and business world. The definition of community empowerment based on Presidential Decree No: 72 of 2012 on SKN is as follows "Sub-system for community empowerment is organizing the management of various health efforts, either individual, group, or community in a planned, integrated, and sustainable way to achieve the highest degree of public health".

a) What is the partnership type between the local government and community (e.g NGOs, key population community, health profession organizations, universities, etc.)?

b) What kind of involvements are there in AIDS response?
c) Are there any regulations issued by local governments concerning the community participation in AIDS response?

d) Does the local government allocate funds for programs involving the community’s active participation? For example: training to health workers from the community

e) Are there any efforts from the local government to promote the community’s capacity in AIDS response in this partnership?

f) What are the obstacles you mostly feel when establishing partnership with the government?

g) What are the roles of private enterprises in HIV and AIDS response (e.g. Corporate Social Responsibility).

h) Are there any community-based forms of care in this region?

i) Are the key population and community involved in the planning, implementation and evaluation of HIV and AIDS response?

j) Does communication take place between policy makers and implementers in the field? Are there any periodic consultation meetings?

k) Especially for mitigation, how is the usage of cash transfers from the Social Department?

l) Are the community involved in defusing the impacts of stigma and discrimination against ODHA and their families, as well as the key population community?

m) To what extent are the universities as parts of civil society organizations involved in the planning and implementation of policies and programs in the region? What kinds of involvement?
## Appendix 2. Sub-system, Dimensions, and Questions that Lead to Measurement of Integration

<table>
<thead>
<tr>
<th>Sub-system</th>
<th>Dimension</th>
<th>Key Words</th>
<th>Leading Questions</th>
<th>Reference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Management and Regulations</td>
<td>1. Regulations</td>
<td>• Local Health System&lt;br&gt;• Perda AIDS&lt;br&gt;• Health Strategic Plan&lt;br&gt;• SRAD&lt;br&gt;• APBD&lt;br&gt;• Regent Regulations</td>
<td>Is the management of HIV and AIDS program in the region regulated through local government regulations (Perda HIV, Strategic Plan/SRAD, Local Health System, Regent Regulation, etc.)? Does the process of policy development (planning, budgeting, allocation of funds and accountability) for the HIV and AIDS program use the mechanism of policy formulation that is valid for the local government?  (\Rightarrow) similar to other health efforts – Family Health, Environment, Infectious Disease Eradication, etc. Does the public have access to know about the HIV and AIDS program that is being conducted in this region and are they involved in decision-making? (\Rightarrow) does the management of the HIV and AIDS program use good principles of public service&lt;br&gt;Does the local government coordinate and manage the source of funding of AIDS response that come from various sources?&lt;br&gt;Is there a budget allocation for HIV and AIDS programs in the APBD? (in the form of budgets in SKPD or Social Assistance)</td>
<td>- See FGD questions No. 2, 3, 4 from this sub-system.&lt;br&gt;- See FGD questions No. 5 and 6 from this sub-system.&lt;br&gt;- See FGD question No. 7 from this sub-system.&lt;br&gt;- See FGD question No. 9 &amp; 10 from the Sub-system of Community Empowerment&lt;br&gt;- See FGD questions No. 1 &amp; 3 from this sub-system.</td>
</tr>
<tr>
<td>2. Policy Formulation</td>
<td></td>
<td>• Source of data on epidemic (prevalence of HIV)&lt;br&gt;• Use of epidemic data in local planning</td>
<td></td>
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<tr>
<td>3. Accountability and Responsiveness</td>
<td></td>
<td>• Public access to information of HIV and AIDS programs in the region.</td>
<td></td>
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<tr>
<td>2. Financing</td>
<td>4. Management of Funding Sources</td>
<td>• Funding sources of HIV and AIDS programs&lt;br&gt;• Proportion of funds between government and foreign donors&lt;br&gt;• Financing of HIV and AIDS entered into the APBD</td>
<td></td>
<td></td>
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<tr>
<td>5. Budgeting, Proportions, distribution and expenditure?</td>
<td></td>
<td>• Amount and composition of budget in the APBD for each program&lt;br&gt;• Report on use of APBD budget for every program</td>
<td>Is there a budget allocation for HIV and AIDS programs in the APBD? (in the form of budgets in SKPD or Social Assistance)</td>
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<tr>
<td>6. Mechanism of service financing</td>
<td>• Responsible parties for financing of services</td>
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<tr>
<td><strong>Reference:</strong></td>
<td>Can the public make use of the JKN or local health insurance to access treatment and care of HIV?</td>
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<tr>
<td><strong>Reference:</strong></td>
<td>- See FGD questions No. 4 &amp; 5 of this sub-system.</td>
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<tr>
<th>3. Service delivery</th>
<th>7. Availability of services</th>
<th>• HIV services present in basic health services</th>
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<tbody>
<tr>
<td><strong>Reference:</strong></td>
<td><strong>Reference:</strong></td>
<td>Are HIV and AIDS services available in primary and secondary health care facilities in this region?</td>
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<tr>
<td></td>
<td></td>
<td>- See FGD questions No. 1, 2, 3 from this sub-system.</td>
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<tr>
<th>8. Coordination and referral</th>
<th>• Coordination meeting between stakeholders</th>
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<tr>
<td><strong>Reference:</strong></td>
<td>Are the HIV and AIDS services in the region coordinated by the Health Office through the KPAD as the agency responsible for the development of health including HIV and AIDS response in the region.</td>
</tr>
<tr>
<td><strong>Reference:</strong></td>
<td>- See FGD question No. 1 from this sub-system.</td>
</tr>
<tr>
<td><strong>Reference:</strong></td>
<td>- See FGD questions No. 1, 2, 3 from Community Empowerment sub-system.</td>
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<tr>
<th>9. Service quality assurance</th>
<th>• Mechanism for regular monitoring and evaluation</th>
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<tr>
<td><strong>Reference:</strong></td>
<td>Is there a supervision and evaluation mechanism to ensure the service quality of HIV and AIDS response just as in mechanisms of other health services? (implementation of service SOP, compliance to implementation guidelines, accreditation, client satisfaction survey, etc.)</td>
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<tr>
<td><strong>Reference:</strong></td>
<td>- See FGD questions No. 10 &amp; 11 from this sub-system.</td>
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<tr>
<th>4. Human Resources</th>
<th>10. Policy and management system</th>
<th>• Presence of policy that manages workers from outside of the health services that is contracted by the Health Office to conduct AIDS programs</th>
</tr>
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<tbody>
<tr>
<td><strong>Reference:</strong></td>
<td><strong>Reference:</strong></td>
<td>Are there regulations that organize Human Resources that is used in HIV and AIDS response in this region? (competence, capacity development, placement/transfers, working relations with non-government)</td>
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<tr>
<td></td>
<td></td>
<td>- See FGD questions No. 1, 3, and 5 from this sub-system.</td>
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<tr>
<td>11. Financing</td>
<td>Funding source for health and non-health AIDS workers</td>
<td>Is the funding of HIV and AIDS human resources using funding in the health sector (government)?</td>
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<tr>
<td><strong>Reference:</strong></td>
<td>- See secondary data for Human Resources sub-system: expenditure for human resources as a proportion of government expenditure.</td>
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<tr>
<td>12. Competence</td>
<td>Trained and certified health workers</td>
<td>Does the competency standard for workers in HIV and AIDS programs refer to existing regulations on health workers?</td>
</tr>
<tr>
<td><strong>Reference:</strong></td>
<td>- See FGD questions No. 1 and 6 from this sub-system.</td>
<td></td>
</tr>
<tr>
<td>5. Provision of Drugs and Medical Equipment</td>
<td>Process of provision, storage, and distribution of drugs and medical equipment</td>
<td>Is the regulation of provision, storage, diagnostics, and therapy related to HIV and AIDS similar to other health problems in the region or provided by JKN? (reagent, ARV, condoms, syringes, CD4 and VL machines)</td>
</tr>
<tr>
<td><strong>Reference:</strong></td>
<td>- See FGD questions No. 1, 5, 8, from this sub-system.</td>
<td></td>
</tr>
<tr>
<td>2. Resources</td>
<td>Funding sources for provision of the above materials</td>
<td>Is the funding for the provision, storage, and distribution of drugs and medical equipment for HIV and AIDS part of the Health Office budget or supported by JKN?</td>
</tr>
<tr>
<td><strong>Reference:</strong></td>
<td>- See FGD questions No. 2, 4, and 6 from this sub-system.</td>
<td></td>
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<tr>
<td>6. Information system</td>
<td>Infrastructure</td>
<td>Does the HIV and AIDS program make use of the information system that is used by the Health Office? (surveillance, survey, monitoring and evaluation based on input, process, output)</td>
</tr>
<tr>
<td>3. Synchronization of information systems</td>
<td>Type of data sources</td>
<td><strong>Reference:</strong></td>
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<tr>
<td></td>
<td>Data collection</td>
<td>- See FGD questions No. 1, 2, 5 from this sub-system.</td>
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<td></td>
<td>Mechanism of data processing</td>
<td></td>
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<tr>
<td>4. Dissemination and use</td>
<td>Type and frequency of reports per program</td>
<td>Are the existing results of the data processing of the information system of HIV and AIDS programs currently being used for planning and development of the HIV program in the region?</td>
</tr>
<tr>
<td></td>
<td>Dissemination and use of data</td>
<td><strong>Reference:</strong></td>
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<tr>
<td>5. Community Empowerment</td>
<td>Coordination meetings by stakeholders and the community (e.g. representatives of key</td>
<td>Are there any forms of partnerships between the government and civil society or the private sector in the process of planning until evaluation of HIV and AIDS program in the</td>
</tr>
</tbody>
</table>
| 6. **Access and use of services** | Proportion of key populations that can access government HIV and AIDS services  
Proportion of key populations that can access JKN or Jamkesda | Are there efforts from the HIV and AIDS program to encourage the public, especially key populations, to use JKN or social assistance in accessing HIV and AIDS services that are available in the region?  
**Reference:**  
See FGD questions No. 8, 12, 13, from this sub-system. |
The Integration of HIV and AIDS Response into the Health System
Landscapping from nine provinces in Indonesia