

# HIV-AIDS POLICY AND HEALTH SYSTEM IN INDONESIA

## A DOCUMENT REVIEW



**HIV-AIDS POLICY AND HEALTH SYSTEM IN INDONESIA:  
A DOCUMENT REVIEW**

## **HIV-AIDS Policy and Health System in Indonesia: A Document Review**

By: **M. Suharni; Ignatius Praptoraharjo; Iko Safika; Satiti Retno P; Eviana Hapsari Dewi; Ignatius Hersumpana; Eunice Priscilla S; Sisilya Bolilanga**

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## **Foreword - DFAT**

The Australia 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.

The present study was conducted by Universitas Gadjah Mada to examine the integration HIV and AIDS into the National Health System. It examined how HIV and AIDS program, which is mostly centrally driven, funded by donors funding and delivered in parallel to the existing health system, can be integrated into the system for its sustainability.

The study assessed the level of integration of HIV and AIDS program into the health system at the national, provincial and district/municipality levels in eight provinces in Indonesia i.e. North Sumatra, DKI Jakarta, East Java, Bali, South Sulawesi, West Papua, Papua, and West Nusa Tenggara.

The study echoes the notion that integration is an 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 various contexts within which AIDS control and the health system operate. Political commitment from local leaders, the local economy, laws and regulations that are not always in favour of HIV and AIDS control and the interaction among stakeholders in the health system and HIV and AIDS control 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 highly expected that this study will assist the Government of Indonesia to further integrate HIV and AIDS programs into the health system and develop a sustainable strategy to support HIV and AIDS control.



**James Gilling**  
***Minister, Development Cooperation***  
***Australian Ambassador for HIV AND AIDS, Malaria and Tuberculosis***  
***Australian Embassy Jakarta***


## Foreword - KPAN

The development of policies and programs for effective HIV and AIDS control has been ongoing for about 30 years. In order to provide solid evidence and basis for policy development of HIV and AIDS in Indonesia, these policies and programs need to be thoroughly examined. Changes in the epidemic situation, in government systems, the global situation and initiatives, the involvement of civil society organisations, and groups affected by HIV and AIDS are various factors that influence the evolution of policy and programs on HIV and AIDS over the years.

In the National Strategy and Action Plan for AIDS Response in Indonesia 2015-2019, the National AIDS Commission or Komisi Penanggulangan AIDS Nasional (KPAN) has emphasized the important contribution of scientific research to the development of evidence-based policies and programs of HIV and AIDS in the future. The KPAN strongly supports the document review on HIV and AIDS policies and programs conducted by the Center for Health Policy and Management, Faculty of Medicine, University of Gadjah Mada (Pusat Kebijakan dan Manajemen Kesehatan, Fakultas Kedokteran, Universitas Gadjah Mada – PKMK UGM). The study was supported by the Australia-Indonesia Partnership for HIV (AIPH) Program and Australian Department of Foreign Affairs and Trade (DFAT). Our study is a policy study aims to provide an understanding of the context, process, and substance of the existing policies and at the same time to map the gaps in the implementation of the policies.

Therefore, KPAN looks forward to receiving the recommendations from this study for further analytical review and subsequent use by the governments, civil society organisations, program beneficiaries, and donor agencies or international development partner organisations in the development of HIV and AIDS programs within an underpinning and resilient health system. Furthermore, the results of this study may be used to promote improvement of the existing policies and programs while at the same time address various challenges and opportunities in the implementation of HIV and AIDS policies in Indonesia.

Jakarta, October 2015



Dr. Kemal N. Siregar

Secretary of KPA Nasional

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## List of Acronyms

ANC	Antenatal Care
AFAO	Australian Federation of AIDS Organisations Inc
AIDS	Acquired Immunodeficiency Syndrome
AIPH	Australia–Indonesia Partnership for HIV
AJI	Independent Journalist Alliance
APBN	State Budget
APBD	Local Budget
Apindo	Indonesian Employers’ Association
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASA	Stop AIDS Action
AusAID	Australia Agency for International Development
Bapas	Correctional Centers
Bappeda	Local Development Planning Agency
Bappenas	National Development Planning Agency
BCC	Behaviour Change Communication
BKKBN	National Family Planning Coordination Board
BLK	Medical Laboratory Center
BLU	General Services Board
BNN/P/K	National/ Provincial/ Municipality/District Bureau of Narcotics
BPJS	Social Security Executing Agency (government program for health and for employment)
BPOM	National Drug and Food Control Agency
BPPT	Agency for the Assessment and Application of Technology
BPS	Central Bureau of Statistics
BSS	Behavioural Survey Surveillance
CATS	Community Access to Treatment Services Study
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CFR	Case Fatality Rate
CSO	Civil Society Organisation
CSR	Corporate Social Responsibility

CST	Care, Support, and Treatment
DBK	Areas with Low Health Status
Depag	Ministry of Religious Affairs
Depbudpar	Ministry of Culture and Tourism
Depdagri	Ministry of Home Affairs
Depdiknas	Ministry of National Education
Dephan	Ministry of Defense
Dephukham	Ministry of Law and Human Rights
Depkes	Ministry of Health
Depkeu	Ministry of Finance
Depkominfo	Ministry of Communication and Information
Deplu	Ministry of Foreign Affairs
Dephub	Ministry of Transportation
Depperdag	Ministry of Trade
Deptan	Ministry of Agriculture
DFAT	Department of Foreign Affairs and Trade
DfID	Department for International Development
Dikcapil/KKB	Civil Registry Department/Demography
Dikbud	Provincial/District/Municipality Office of Education and Culture
Dinkes	Provincial/District/Municipality Local Office of Health
Dinpar	Provincial/District/Municipality Local Office of Tourism
Dinsos	Provincial/District/Municipality Local Office of Social Affairs
Dishub	Provincial/District/Municipality Local Office of Transportation
Disnaker	Provincial/District/Municipality Local Office of Manpower
Dispenda	Provincial/District/Municipality Local Office of Local Revenue
Dispora	Provincial/District/Municipality Local Office of Youth and Sports
Ditjen PP&PL	Directorate General of Disease Control and Environmental Sanitation
DIY	Special Region of Yogyakarta
DKAI	Indonesia AIDS Partnership Funds
DTPK	Disadvantaged Regions, Borders and Islands
FGD	Focused Group Discussion
FHI	Family Health International
FPI	Islamic Defenders Front
FSWs	Female Sex Workers
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRA	Group Risk Assessment
GWL-Ina	Indonesian Gay, Transgender and Lesbian
HAM	Human Rights
HAS	World's AIDS Day
HCPI	HIV Cooperation Program for Indonesia
HIV	Human Immunodeficiency Virus
IAKMI	Indonesian Public Health Experts Association
IBCA	Indonesian Business Coalition on AIDS
IDI	Indonesian Doctors Association
IDUs	Intravenous Drug Users
IEC	Information, Education, Communication
IMS	Sexually Transmitted Disease

IBBS	Integrated Biological and Behavioural Surveillance
IBRD	International Bank for Reconstruction and Development
IDHS	Indonesia Demographic and Health Survey
IHPCP	Indonesia HIV Prevention and Care Project
IKON	Addictive Drugs Victims Association
ILOM	Indigenous Leader Outreach Model
IO	Opportunistic Infection
IPF	Indonesia Partnership Fund
IPPI	Indonesia Positive Women Association
Iptek	Science and Technology
IRA	Individual Risk Assessment
Jangkar	Network of Agencies in Harm Reduction
Jamkesda	Local Health Insurance
Jamkesmas	Community Health Insurance
JKN	National Health Insurance
JOTHI	Network of People Affected by HIV and AIDS in Indonesia
KADIN	Indonesian Chamber of Commerce and Industry
KDS	Peer Support Group
Keppres	Presidential Decree
KIA	Mother and Child Health
KIE	Communication, Information, and Education
KLB	Outbreaks/ Epidemics
KPA	AIDS Commission
KPAN/P/K	National/ Provincial/ Municipality/District AIDS Commission
KSPI	Congress of Indonesian Workers Union
KSPSI	Confederation of Indonesian Workers Union
KTS	Voluntary Counseling and HIV Testing
Lapas	Penitentiary Facility
LASS	Sterile Syringe Service
LBH	Legal Aid Agency
LKB	Comprehensive and Continuity HIV and AIDS and STIs Service
LSM	Civil Society Organisation
MDG	Millenium Development Goals
Menakertrans	Minister of Manpower and Transmigration
Mendiknas	Minister of National Education
Menkes	Minister of Health
Menpora	Minister of Youth and Sports
Menristek	Minister of Research and Technology
Mensos	Minister of Social Affairs
MMT	Methadone Maintenance Treatment
MoU	Memorandum of Understanding
MPI	International Development Partners
MSM	Men who have Sex with Men
MSS	Minimum Service Standards
MTR-SRAN	Mid-Term Report-National Action Plan Strategy
Napza	Addictive Drugs
NGO	Non-Governmental Organisation

NSP	Needle Syringe Programme
NU	Nahdlatul Ulama - one of the largest independent Islamic organisations in Indonesia
OAT	Anti Tuberculosis Drugs
OBS	Social-based Organisation
OBM	Community-based Organisation
ODHA	People with HIV and AIDS
OHIDHA	People Living with HIV and AIDS
OI	Opportunistic Infection
OMS	Civil Society Organisation
OPSI	Indonesia Social Transformation Organisation
Ormas	Community Organisation
Pemda	Local Government
Penasun	People Who Inject Drugs (IDUs)
Perda	Local Government Regulation
Permendagri	Regulation of Minister of Home Affairs
Permenkes	Regulation of Minister of Health
Permenkokesra	Regulation of Coordinating Minister of People's Welfare
PICT	Provider Initiative Counseling and Testing
PKBI	Indonesia Family Planning Association
PKMK-UGM	Centre for Policy and Health Management of University of Gadjah Mada
PKNI	Indonesia Drug Victims Brotherhood
PMI	Indonesian Red Cross
PMKS	Problems of Social Welfare
PMTCT	Prevention from Mother to Child Transmission
PMTS	Prevention of HIV through Sexual Transmission
Pokdisus	Special Study Group
Pokja	Working Group
Polri	Police Force of Republic Indonesia
Posyansus	Special Service Post
PP	Government Regulation
PPB	Periodic Presumptive Treatment
PPH	HIV Research Center
PPIA	Prevention from Mother to Child Transmission
PPP	Post Exposure Prophylaxis
PR	Principle Recipient
PSA	Public Service Advertisement
PSK	Commercial Sex Worker
PTRM	Methadone Maintenance Treatment
Puskesmas	Community Health Center
PWID	People Who Inject Drugs
Renstra	Strategic Plan
Renstrakes	Strategic Health Plan
RKPD	Local Government Work Plan
RPJM	Mid-Term Development Plan
RPJMD	Local Government Mid-Term Development Plan

RPJPD	Local Government Long-Term Development Plan
RS	Hospital
RSCM	Cipto Mangunkusumo Hosital
RSKO	Drug Addiction Hospital
RSUP	Central Level Public Hospital
Rutan	Prison
SBSI	Indonesia Prosperous Workers Union
SDM	Human Resources
S&D	Stigma and Discrimination
Setkab	Cabinet Secretary
SIK	Health Information System
SKN	National Health System
SKPD	Local Government Component Working Unit
SOP	Standard Operational Procedure
SPM	Minimum Service Standards
SRAN	National Strategy and Action Plan
SSP	Behavioural Survey Surveillance
STBP	Biologic and Behavioural Integrated Surveillance
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
Stranas	National Strategy
SUM	Scale Up at Most Population Group
TB-HIV	Tuberculosis-Human Immunodeficiency Virus
TNI	Indonesia National Army
UN	United Nations
Uncen	University of Cendrawasih
Unicef	United Nations Children's Fund
UNAIDS	Joint United Nations Programme on HIV and AIDS
UPT	Technical Executing Unit
USAID	United States Agency for International Development
UU	Law/ Regulation
VCT	Voluntary Counseling and Testing
WPS	Women Sex Worker
WPSL	Direct Women Sex Worker
WPSTL	Indirect Women Sex Worker
WHO	World Health Organisation

## Executive Summary

In response to the growing epidemic of HIV and AIDS in Indonesia, a wide range of responses and countermeasures has been introduced by the Indonesian health systems. The current study aims to examine changes in the health system responses to curb the HIV epidemic over the last 3 decades. The study revealed that the health system responses to HIV and AIDS epidemic in Indonesia reflect complex contestations between various approaches, principles, and actors operating within a constantly changing sociological context.

First, there is discordance between the vertical and horizontal strategies to address the increasing number of HIV and AIDS cases. The vertical strategy relies on a rigid and highly centralized technical intervention. In contrast, the horizontal strategy emphasizes multi-sectoral and decentralized approaches. Secondly, in policy making processes, political and economical considerations often outweigh epidemiological evidence as the basis for decision making. For instance, evidence has shown that the use of condom in high risk population should be promoted; however political considerations have prevented widespread campaign on condom use. Furthermore, there is often a conflicting role between the central and local governments. With strong access over epidemiological data, there is a predominance of central government actors particularly in technical intervention. However, local government have stronger role given their politically strategic position and autonomy in program implementation. Finally, disagreement is often found between school of thoughts represented by different institutions working in HIV and AIDS, for example USAID and AusAID (now DFAT), GFATM, local and international NGOs, and government agencies.

These lacks of alignment and clarity of roles between different approaches, actors and principles characterized the evolution of HIV and AIDS policy in Indonesia. Two main issues substantially influenced changes in the development of HIV and AIDS policy in Indonesia. First is the transformation in the relationship between central and local governments (i.e. decentralisation). Prior to the decentralisation of the health sector in 1999 during which the health system was fully centralized, formulation and implementation of HIV and AIDS strategies were predominantly led by vertical approaches with the central government and funding of international development partners as the main actors. After health sector decentralisation was enacted by Law No. 32/2004 on Local Government and Government Regulation No. 38/2007 on Division of Government Affairs, autonomy was divided between the Central Government, Provincial Government, and the District/Municipality Government. As a consequence, the governance in health including HIV and AIDS also underwent substantial changes. The second issue influencing the evolution of HIV and AIDS policy is the growth of HIV and AIDS epidemic.

Two main challenges in the formulation of HIV and AIDS policy emerged from these circumstances. First, from the political and economic standpoint, it is important to align the HIV and AIDS policy and strategies with the government administration which has been undergone decentralization including the health sector. Second, it is crucial to find strategies for HIV and AIDS services integration into the existing health programs to ensure sustainable response given the limited resources and different capacity of local governments.

Decentralisation of policy making and authorities from the central to local government does not only present unique challenge but also opportunities to design effective HIV AND AIDS policies and programs. Decentralisation requires an enormous effort in order to synchronize the management of public services across government sectors, including the health sector. In the health sector, this process of synchronisation occurs both in the sphere of health policy and health services. This situation mandates the development of innovative approaches in health systems in order to improve the health status of the community.

Institutional responses (e.g. establishment of entities and institutions) and enforcement of the regulations/policies are the two most widely adopted measures in HIV AND AIDS strategies. These measures are considered to ensure sustainability of the programs because they will enable the government to continue investments made by donors. The current study shows that the effective implementation of newly developed policies and regulations as well as institutional structures heavily relies on the existing health systems and governance. In other words, the development of HIV AND AIDS strategies often use too much assumption that the health sector and other sectors outside HIV AND AIDS area would have sufficient capacity to deliver comprehensive response. Through case studies in the study location, it was apparent that institutional responses and development of regulations were more of a normative basis against which performance in HIV AND AIDS response will be measured and therefore be made in place. However, institutional structures and regulations are ineffective due to inadequate implementation. For instance, almost all provinces have established the Local AIDS Commissions (*Komisi Penanggulangan AIDS Daerah/ KPAD*). However, for various reasons, the role of these institutions tends to be confined to merely fulfill their institutional mandates. The implementation of local government regulations (*Peraturan Daerah/ PERDA*) on HIV and AIDS was also ineffective due to the absence of adequate resources and punishment. In addition, overlapping or disagreement with other public regulations was not uncommon. In general, the weakness of local government's response to HIV/AIDS is in fact the overdependence on the "procurement" of policies (*PERDA* and *Peraturan Bupati/ PERBUP*) and institutions (*KPADs*), and the lack of attention to the capacity in implementation. This is a common problem in the health sector in general, and even have become a classic problem in the health sector across the world. For example, Lant Pritchett of Harvard Kennedy School in 2014 through a study on the proficiency of doctors in India concluded that the bottlenecks of development in most developing countries are mostly found in the implementation stage. "The problem (often) isn't either policy or capacity – it is

the organisational capability for implementation." Furthermore, Prichett's study showed a unique pattern in the response of developing countries in managing development programs. This pattern refers to a phenomenon called "Isomorphic Mimicry" technique – a technique used by a non-poisonous snake to deceive their predators by mimicking the appearance of other snake species that are poisonous (i.e. adopting mottled skin). By establishing new entities and institutions, enforcing policies, signing mutual commitments and so forth, policy makers will appear to have delivered a good response. The mottled skin of non-poisonous snake represented the institutions and policies issued by the government described above. Such an attempt is in fact ineffective because it was not followed by adequate implementation capacity within the municipality.

The other important issue was funding sources. At present, the majority of funding for HIV/AIDS is contributed by foreign donors. Government policies to encourage the local government to procure funding for HIV and AIDS response have been issued. A number of local governments have allocated funding from local budget (*Anggaran Pendapatan dan Belanja Daerah/APBD*), however, the allocated budget may only finance the administrative costs. Therefore, funding to sustain HIV and AIDS programs and services are still considered insufficient.

Lastly, the role of civil society represented by the key population has not been optimal. Although the identities of existing communities such as people living with HIV and AIDS (PLWHA) and Intravenous Drug Users (IDUs) are quite well accepted by the society, however, this is not the case for Female Sex Workers (FSWs), transgenders, Men who have Sex with Men (MSM), and homosexuals.

## **Recommendations**

Given the alarming situation of HIV/ AIDS epidemic in Indonesia, the contestations in HIV and AIDS response should be better addressed to prevent contradictions. It is necessary to develop a health system and policy roadmap that integrates HIV and AIDS programs into the existing health system at formulation and implementation stages. This roadmap will encompass not only the technical but also political economy aspects of HIV and AIDS program that will guide programs towards better implementation. An integration of vertical and horizontal approaches in HIV and AIDS policies is the key to improve effectiveness and strategies to scale up the coverage and quality of HIV and AIDS programs and at the end of the day strengthen the basic health services.

## INTRODUCTION

### 1.1. Rationale

The health system responses to HIV and AIDS epidemic in Indonesia have been ongoing for more than two decades. After the first AIDS case in Bali was officially reported in April 1987,<sup>1</sup> the Minister of Health (MoH) issued Ministerial Regulation No. 339/IV/1988 on the Establishment of HIV and AIDS Committee in Indonesia. However, the present study argued that the Presidential Decree No. 36/1994 on the establishment of National AIDS Commission (*Komisi Penanggulangan AIDS/KPA*) in 1994 laid the foundation of government's formal response to HIV and AIDS epidemic. This policy was succeeded by various international collaboration programs through bilateral (e.g. USAID, AusAID, and DfID) and multilateral collaborations (GFATM, UNAIDS, Indonesia Partnership Funds), and other non-governmental agencies. The total funds that have been disbursed by both international and government agencies since 1996 were at least USD 445 million, most of which came from foreign aid.<sup>2</sup>

Between 1988 and 2013, a wide range of policies in response to the HIV and AIDS epidemic have been imposed by the government at both central and local levels. Several regulations provide the foundations – such as the Presidential Decree No. 36/1994 on AIDS commission as well as several local regulations (Perda) on HIV and AIDS at the district level. A few regulations introduced cutting edge approaches – such as the Presidential Decree No. 75/2006 which aimed to revitalize the authority of National AIDS Commission (KPAN), Regulation of the Minister of Health No. 567/2006 and the Regulation of Minister of the People's Welfare No. 2/2007, both on the Distribution of Syringes.

However, responses from various parties to these policies seemed to be inadequate to support the Government of Indonesia (GoI) in achieving the national HIV and AIDS target. In 2014, as outlined in the 2010-2014 National Strategy and Action Plan (*Strategi dan Rencana Aksi Nasional/ SRAN*) for HIV and AIDS, the GoI aimed to achieve the goals of preventing 294,000 new infections, extending outreach services to 80% of key populations through

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<sup>1</sup> The first incidence of AIDS in Indonesia resulted to an intense debate in the mid to late 1980s. In October 1983, Tempo magazine released a report titled "AIDS, Welcome to Indonesia", which exposes a research of Dr. Zubairi Djoerban among transgender in Jakarta with indicative findings of AIDS – there was no HIV test at that time. In September 1985, the Minister had stated the discovery of 5 cases of AIDS in Bali, but two months after that the Minister said there was no AIDS in Indonesia. In April 1986, Tempo reported deaths of a 25 year old female AIDS patient through the article of "The Last Days of an AIDS Victim" – this case was also not recognized and reported officially by the government. On 10 April 1986, Kompas carried a report that "the existence of AIDS in Indonesia is still in debate". Only in 1987, the death of a 44 year old Dutch tourist in Bali was officially reported by the government as the first AIDS case in Indonesia – reported by Kompas, "A Dutch Tourist with AIDS Died in Bali", 11 April 1987. See also Zubairi Djoerban (1999). *Aiming AIDS: Endeavor in Understanding HIV and PLWHA*. Yogyakarta: Galang Press and Foundation of Advancement of Internal Medicine.

<sup>2</sup> Adapted from UNAIDS report, the National AIDS Spending Assessment (NASA) 2006-2010; NAC, "The Response to HIV and AIDS In Indonesia 2006-2011: Report on 5 Years Implementation of Presidential Regulation No. 75/2006 on the National AIDS Commission", October 2011, p. 72

comprehensive program, and achieving 60% of condom use during unsafe sexual intercourse. The 2011 Integrated Biological and Behavioural Surveillance (IBBS)<sup>3</sup> by the Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia (MoH) showed that HIV prevalence in key populations was as high as 42% in Injecting Drug Users (IDUs), 22% in transgender sex workers, 10% in direct Female Sex Workers (FSWs), and 3% in indirect FSWS and 3% in Men having Sex with Men (MSM).

Despite years of HIV and AIDS prevention programs, the potential for HIV transmission in Indonesia remains very high. The Ministry of Health reported that in 2012, a total of 8.7 million people were at risk of HIV. The 2011 IBBS data also revealed an alarming level of high risk behaviors. For example, only 32% of commercial sex workers use condom consistently. Amongst IDUs, around 13% shared used needles. In addition, the level of knowledge of HIV and AIDS has not been so encouraging. On average, only 22.7% of high-risk groups had a comprehensive knowledge of HIV and AIDS. The lowest percentage was found amongst the group of inmates (12%). In addition to the increasing rate of high risk population, the spread of HIV and AIDS transmission rate was evenly distributed across areas. During the period of 2007 to 2013, HIV and AIDS cases were widely spread in almost 80% of districts and municipalities across Indonesia. At least 7 of 10 districts and municipalities in Indonesia have now reported the cases of HIV and AIDS in their regions.

Previous studies indicated that this worrying situation was partly a result of the lack of integration of HIV and AIDS response into the existing health system – in other words, the HIV and AIDS response and the delivery of programs and services is still fragmented. There are several reasons that might explain this situation e.g. conflict of interests, different priorities in each program, and the lack of understanding on how the Indonesian health system is operationalized.<sup>4</sup> As the governance of health system is the platform within which HIV and AIDS programs is delivered, strengthening of the health system is required as a necessary and sufficient condition for the effectiveness of HIV and AIDS response in Indonesia. Therefore, an understanding on the health system becomes a basic requirement to improve the effectiveness and efficiency of HIV and AIDS interventions.

This study was conducted to bridge the gap of knowledge between the health system and HIV and AIDS control (intervention) programs. The goal of this review was to provide policy recommendations on the integration of HIV and AIDS into the health service system. This review employed the following methodology:

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<sup>3</sup> Also called Integrated Biological and Behavioural Survey (IBBS), is a survey aimed at measuring the prevalence of HIV within the highest risk population, the level of their knowledge about HIV AND AIDS, their risk behaviors for HIV transmission, as well as determining the extent of coverage of the intervention programs in reaching out the highest-risk and most vulnerable populations. The survey is updated every 2-3 years.

<sup>4</sup> For example, the US President's Emergency Plan for AIDS Relief (PEPFAR), "Indonesia Report FY 2011 Operational Plan"; WHO, "Indonesia Health Profile: Health Financing and Decentralisation"; Ignatius Prapto Raharjo et al., "Ethnographic Study of IDUs sexual networks in Indonesia". AIDS 2006 XVI International AIDS Conference: Abstract No. CDD0631; and UNODC, "NSP Review in Indonesia 2013".

- Documenting the genealogy and policies on HIV and AIDS response programs in Indonesia;
- Mapping of the existing policies, regulations, and programs regarding HIV and AIDS;
- Identifying the gaps between policy and program implementation. Policies that act as facilitators or barriers to effective HIV and AIDS control were identified.
- Formulating of policy recommendations on the integration HIV and AIDS response policies into the governance of health service system.

A number of key questions that guided this review include:

- **Genealogy and Policies**

Which important events or facts that triggered the emergence of policies on HIV and AIDS in Indonesia for the past 25 years? How were these policies developed? Who were the actors involved? What was the focus of the policies at that time and has the focus been changed?

- **Policy, epidemic situation, and policy implementation**

**Policy:** What policies, both at national and local level, are currently implemented in HIV and AIDS programs? What have been stipulated in these policies? (e.g. relationship between government, private sector, and civil society organisations; prostitution; access to government funding and health services; supply-side policies by health service providers (e.g. community health centers or *Pusat Kesehatan Masyarakat/ Puskesmas* and hospitals) such as screening, STI treatment, HIV testing, provision of sterile syringe, methadone, condoms, etc.).

**Epidemic situation:** What is the latest situation of HIV and AIDS epidemic, both at national and selected districts i.e. Jakarta, Medan, Denpasar, Surabaya, Makassar, and Manokwari?

**Policy implementation:** What are the HIV and AIDS response programs implemented in the region? Who is responsible for implementing and funding the programs? What is the role of local government and community in policy implementation? Is there any evidence demonstrating ongoing coordination and harmonisation of programs to support the continuum of care? What are the barriers and facilitators of integration of policies and services on HIV and AIDS into the existing health system?

## 1.2. Methods

Based on the study rationale, the nature of data, and the key questions, the present study exercised the following methods:

### 1.2.1. Document Review

An extensive review was undertaken on all published and unpublished literatures produced between 1987 and 2013 related to HIV and AIDS response in Indonesia. These included regulations and laws, scientific articles, reviews, reports, etc., produced by the government, institutions working in the field of HIV and AIDS as well as research institutions. Document collections related to AIDS policy and programming were done by manual searching either offline or online.

Hand search of literature was also done by submitting request proposal to relevant agencies for their archived documents.

Analysis of literature was conducted based on the key questions and categorized using the following classification:

1. Local, national and international key events between 1987 and 2013, which set up the context of emergence and change of policies on HIV and AIDS in Indonesia.
2. Type of policies and programs related to promotion and prevention, care, support and treatment, and mitigation of HIV and AIDS impact.
3. The role of health system in HIV and AIDS response, including governance, service delivery, financing, human resources (HR), strategic information, and provision of medical supplies for HIV and AIDS prevention and treatment.
4. Contextual factors: epidemiology, political commitment, social movement, global commitment, and program sustainability.

Epidemiological data of HIV and AIDS in Indonesia was obtained from HIV and AIDS behavioural and epidemiological surveys conducted by the Ministry of Health, KPA, or International Development Partners (*Mitra Pembangunan Internasional/ MPI*). Annex 1 contains the bibliography of documents reviewed in this study.

### 1.2.2. Field Visit: Interviews and Group Discussions

To gain a better understanding of the implementation of HIV and AIDS policies and program at provincial and district/municipality levels, several field visits were carried out in five provinces (North Sumatra, East Java, South Sulawesi, Bali, and West Papua) covering 10 districts/municipalities (Medan Municipality, Serdang Bedagai District, Surabaya Municipality, Malang Municipality, Denpasar Municipality, Gianyar District, Makassar Municipality, Manokwari District, Sorong Municipality, and Sorong District). In each field visit, a series of interviews and Focused Group Discussions (FGDs) were conducted using a standard semi-structured questions. These interviews and FGDs involved relevant

stakeholders as participants including representatives from health service providers, Provincial/District, Provincial and District/Municipality KPA Secretariats, and hospitals as well as those of program beneficiaries (i.e. transgender, FSW, MSM, drug users, and PLWHA). Interview and FGD guides are detailed in Annex 11. Triangulation was done by using interviewer notes, general data of the district/municipality, and results of the review to check the pattern, consistency, as well as variation in the data.

### **1.3. Study Period**

The current study was conducted from September 2013 to January 2014. The study was conducted by a team of studiesrs from Center for Health Policy and Management, Faculty of Medicine, University of Gadjah Mada (*Pusat Kebijakan dan Manajemen Kesehatan, Fakultas Kedokteran, Universitas Gadjah Mada/ PKMK UGM*). Field visits were carried out in November 2013 along with research team members from the University of North Sumatra, University of Airlangga, State University of Papua, and University of Hasanuddin.

### **1.4. Study Limitations**

The limitations of the present study are as follows:

1. The document review applied a historical perspective to describe the changes in policies and programs on HIV and AIDS in the past 25 years. There was a limited availability of literature related to policy and programs implemented in the early years of the HIV and AIDS epidemic in Indonesia. As a consequence, the description of the initial situation of the epidemic was limited. Although literature on the history of AIDS in Indonesia is widely available, the majority of these documents focused more on the description of the epidemic than on the important policy or events as the context of policy development.
2. HIV and AIDS is basically a multi-sector issue, consequently there is a myriad of policies and documents related to HIV and AIDS. This review was restricted to the context of Indonesian health system, and a description about HIV and AIDS response policy outside the health sectors is beyond the scope of this review. For example, literature related to political and economic aspects in the health sector which strongly influenced HIV and AIDS programs is not included in this study.
3. Policy and program issues in the implementation at local level described in this study are not sufficient to represent the overall national situation as data was only collected from 10 districts/municipalities in 5 provinces. Primary and secondary data from the field study were used to examine the extent to which the national policy is implemented at local level, as well as to identify whether the needs of the key populations are adequately met by the HIV and AIDS policies and programs at local and national levels.

## 1.5. Outline of the Report

Findings of the present study are presented in the following chapters:

- The epidemiological context of HIV AND AIDS in Indonesia is described in Chapter 2. This chapter describes the history of HIV and AIDS in Indonesia followed by responses from the government, communities, and international agencies. This chapter is divided into three periods: 1987-1996, 1997-2006, and 2007-present based on the availability of epidemiological data, changes in the contextual factors surrounding health system governance and contestations within HIV and AIDS programs. Epidemiological profile of HIV and AIDS in the study areas (North Sumatra, East Java, Bali, South Sulawesi, and Papua) will be treated as examples of the epidemiological situation in Indonesia.
- Formulation and enforcement of regulations are the most common health system response to address the challenges of HIV and AIDS epidemic. Chapter 3 explores the context of HIV and AIDS regulations in Indonesia and how these regulations evolve over time until today. This chapter describes the policy context and references used as the basis to formulate policies on HIV and AIDS in Indonesia. Lessons learned from the implementation of the HIV and AIDS responses, which influenced the evolution of policies were presented
- Chapter 4 elaborates in more detail the existing policies related to HIV and AIDS by identifying important elements in those policies such as (1) promotion and prevention; and (2) care, support and treatment; or by analysing governance aspect in those policies such as (1) governance of strategic information; (2) human resources and logistics; (3) rights-based policies; (4) multi-stakeholders cooperation; (5) funding; and (6) impact mitigation.
- Chapter 5 details the institutions and key factors in HIV and AIDS programs and their specific contributions to policy development.
- Chapter 6 elaborates the integration of HIV and AIDS policies and programs into the Indonesia's health system as the core topic of this review.
- As the concluding section, Chapter 7 presents conclusions and recommendations of the present study that are projected for the roadmap to advance the effectiveness of response to HIV and AIDS epidemic in Indonesia.

## **DYNAMICS OF HIV AND AIDS EPIDEMIOLOGY AND RESPONSE**

An accurate and thorough understanding of the epidemiological situation is an important prerequisite for an effective and context-specific policy formulation. HIV and AIDS epidemic has undergone through such dynamics in conjunction with the sociocultural, political, and economic changes in the society. The policy framework that shaped the HIV and AIDS response also underwent inevitable changes. This chapter describes the dynamics of HIV and AIDS epidemiology in Indonesia, the surrounding policy context, and approaches of previous HIV and AIDS control programs. This chapter also illustrated some case studies from the selected study sites.

Since it was first identified in 1987, the HIV and AIDS epidemic has been developing rapidly in line with the changes in the natural history of the epidemic, the health care system, as well as the political context and government system. The methods, prevalence estimation and key populations involved in the Integrated Biological and Behavioural Surveillance' (IBBS) also influence the response of government and development partners towards HIV and AIDS epidemic. The availability of antiretroviral (ARV) treatment has substantially reduced HIV and AIDS-related mortality rate and increased longevity. Consequently, HIV and AIDS professionals are presented with more challenge to provide long-term care.

### **2.1. HIV and AIDS epidemiology in Indonesia**

The first AIDS case in Indonesia was identified in Bali in 1987, during which was no HIV test available. Experts in this field immediately and repeatedly announced the potential spread of HIV and AIDS across the country. The potential of HIV and AIDS transmission in Indonesia was particularly high given the prevailing risk factors, such as the widespread availability of commercial sex industry, the high prevalence of Sexually Transmitted Infections (STIs), poverty, and the high rate of population mobility (Kaldor, 1999). Twelve years after the first case was identified, there was no significant increase in the number of cases despite the persistence of these risk factors. Interestingly, a number of risk factors that were perceived to accelerate increase in the number of cases have instead become prohibitive factors. For instance, poverty has in fact reduced the demand for commercial sex, although it might increase the number of commercial sex workers. However, increasing number of sex workers is not associated with increase in the turnover of customers.

The Ministry of Health reported that over the period of 1991 to 1995, approximately 40,000 females sex workers (FSWs) were annually tested for HIV. This number was nearly one-fifth of the total FSWs throughout the country. It was found that the annual HIV prevalence was always below 0.03%. It might be inferred that despite the the high rates of population mobility and STI prevalence, the spread of the virus would not take place if the HIV virus was not present in the population.

This situation changed dramatically in the late 1990s, during which the number of young

Injecting Drug Users (IDUs) rapidly increased especially in large cities. In 1997, there was no HIV case found among participants of rehabilitation program at the Drug Dependence Hospital (*Rumah Sakit Ketergantungan Obat/ RSKO*) in Jakarta. However, within four years, it was found that one in two IDUs in Jakarta was infected with HIV.<sup>5</sup> Within the next five years, IDUs became the major hub of HIV and AIDS spread in Indonesia. Thus, the main factor driving the spread of HIV and AIDS epidemic was not the size of sex industry or the high prevalence of STIs, but the influx of IDUs into the epidemic network (Family Health International/ FHI, 2002).

Nonetheless, the close relationship between IDUs and the commercial sex industry need to be considered because these two factors might work synergically and result in the rapid expansion of HIV and AIDS epidemic in Indonesia. The 2002 Behavioural Survey Surveillance (BSS) among IDUs in three major cities in Java showed a high number of IDUs practicing unprotected sex with non-IDUs. Approximately 20%-75% of IDUs reported unprotected sex with sex workers. Nearly one in ten IDUs also reported that they provided sex for money. This "synergy" has in fact accelerated the increase of HIV and AIDS prevalence among commercial sex workers. The 2004 BSS in Surabaya showed that the prevalence of HIV and AIDS among commercial sex workers brothel complex had tripled to 3.8% between 2001 and 2004. Among street-based sex workers, the prevalence of HIV and AIDS increased from 4.4% to 12.2% within a period of two years. In Jakarta, the HIV prevalence rose from 1.1% in 2000 to 6.4% within three years. Without the influx of IDUs into the sex industry, the prevalence rate would have been increasing at a slower pace.

Figure 1 shows that the the rate of HIV and AIDS prevalence among IDUs increases in parallel with the prevalence among sex workers. It is also apparent that the prevalence among sex workers increases as the IDUs population entered the sexual networks (i.e. IDUs as commercial sex consumers or workers). Previous studies (MoH, 2005; Riono and Jazan, 2004) identified factors that associated with the increase of HIV prevalence as follows:

1. Proportion of people who had been infected in a population;
2. Size of the population;
3. Level of high risk behaviour in a population (e.g., the use of condoms among sex workers, frequency of commercial sex transaction etc.);
4. Interaction between high risk populations (e.g., sexual contacts between IDUs and sex workers).

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<sup>5</sup> Based on data reported by RSKO and Yakita in 2002. See P. Riono and Jazant S. (2004). "The Current Situation of the HIV AND AIDS Epidemic in Indonesia." AIDS Education and Prevention 16 (Supplement A): 78-90.

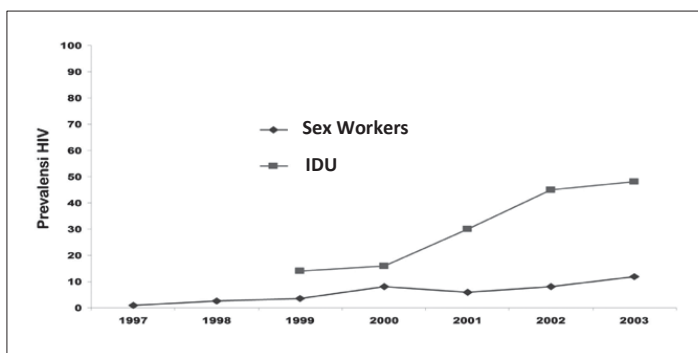


Figure 1 –Prevalence of HIV among Injecting Drug Users and Sex Workers, 1997-2003

(Source: The Central Bureau of Statistics & the Ministry of Health of Republic of Indonesia, 2004)

Despite the high prevalence of HIV and AIDS among IDUs, in 2006 KPAN estimated that the growth rate of new infections among IDUs seemed relatively stagnant. Although the HIV and AIDS prevalence in FSWs, transgender, and FSW clients are lower than in IDUs, these groups have a larger size of population which results in higher number of cases. KPAN estimated that within the following decade, new transmissions will be predominated by heterosexual contacts as it accounted for nearly 70% of new infections (KPAN 2007). Given such trend in HIV and AIDS epidemic, studies on high risk sexual behaviour have become increasingly important in order to gain a comprehensive understanding of the epidemic situation. It is particularly important to ensure effective response and control the impact on other sectors.

More attention was also addressed to interaction between transgender sex workers and their clients. The majority of clients of transgender sex workers identified themselves as heterosexuals. Many of them also had sex with female sex workers. With the high prevalence of HIV and AIDS in transgender sex workers – nearly 25% of transgender sex workers in most Indonesian municipalities are infected with HIV – their clients become the "bridge" of HIV transmission from transgender sex workers to FSWs and vice versa, and even to the general population (i.e. to their wives). In addition, the growing sex industries among men who have sex with men in several municipalities also need to be considered. Half of the male sex workers identified themselves as heterosexuals and also have sex with female sex partners (FHI, 2002). Sexual networks are closely interlinked and function as a highway for HIV to spread into the general population, as in Figure 2.

HIV and AIDS epidemic has been developing in Papua in a slightly different way. The number of IDUs in Papua is relatively lower than in other major municipalities in Indonesia. The main factor of the rapid spread of HIV and AIDS in Papua is sexual contacts especially heterosexual contacts. An anthropological study on Papuans sexuality described that the characteristics of sexual networks in Papua are very different compared to those in other areas. Premarital and intergenerational sex practices are very common (Butt et. al., 2002), which result in different patterns of HIV and AIDS transmissions and become the main

pathway of HIV and AIDS spread into the general population. The 2006 IBBS showed that the epidemic in Papua has reached the general population and developed into generalized epidemic), in which at least 2.4% of the adult population (15-49 years) are infected with HIV and AIDS.

Patterns of HIV transmission in Indonesia is mainly concentrated in the at risk populations such as injecting drug users, sex workers and men who have sex with men. However, since the populations are not isolated and they have social interaction with the broader population, the threat of transmitting the virus to the broader population is likely to happen.

The course of HIV and AIDS epidemic in Indonesia and its link to changes within the society reflect an epidemic situation which is concentrated on certain groups (e.g. IDUs and sex workers) and yet to find structural expanding transmission network condition to threaten the broader populations.

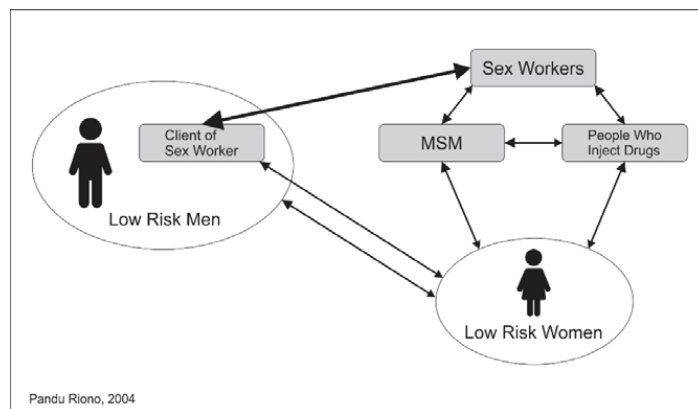


Figure 2 – Sequence of HIV Transmission (Riono, 2004)

A structural interaction between at risk population and broader population has thus evolved, resulting in an emergent pattern of HIV transmission which different from the previous pattern. For example, the majority of infected IDUs are sexually active groups. They become powerful bridge to spread the virus to other groups, i.e. their sexual partners such as sex workers or housewives through risky sexual behaviour.

In addition to individual characteristics, there are also other factors influencing the extent of HIV and AIDS transmission, such as supports of health services providers, poverty, and mobilization of people.

## 2.2. Epidemic Response

This section discusses how HIV and AIDS issues were identified and addressed by

government and non-governmental organisations in Indonesia from early 1990s to 2007. The development of HIV and AIDS epidemic in Indonesia was divided into three periods based on the predominant mode of transmission: 1) 1987-1996: HIV and AIDS was predominantly transmitted via sexual contacts; 2) 1997-2006: share of used needles became predominant as the mode of transmission; and 3) 2007-present: sexual contacts reemerged as the main mode of transmission.

### 2.2.1. Period of 1987 to 1996

Literature related to HIV and AIDS epidemic in the early years were reports on HIV and AIDS cases from the early years of this period until the end of 1996. The number of HIV-positive and AIDS were 381 and 154, respectively. These figures did not adequately reflect the magnitude of HIV and AIDS epidemic in Indonesia as there were no accurate data on the prevalence of high risk behaviours and estimates of key population estimates. Data used as reference were the profiles of people with HIV which 82.9% were in their productive age i.e. 15-49 years). Most of the key population were infected from unprotected sexual intercourse (95.7%), of which 62.6% were heterosexuals and 33.1% were male homosexuals/bisexuals contacts (National AIDS Strategy, 1994).

By December 1996 as reported by, Ministry of Health the cumulative number of HIV and AIDS cases was 232 and 107, respectively. The highest rate of HIV and AIDS cases was found in the age group of 20-29 years, especially amongst homo/bisexual populations. The mode of transmission and the number of HIV and AIDS cases as per December 1996 are shown in Tables 1 and 2.

**Table 1 – Cumulative Number of HIV and AIDS Cases based on the mode of transmission as per December 1996**

Risk Factors/Mode of Transmission	HIV	AIDS	Total
Homo-Bisexual	278	48	326
Heterosexual	34	51	85
IDUs	2	3	5
Blood Transfusion	0	2	2
Hemophilic	1	1	2
Perinatal Trans	1	0	1
Unknown	66	14	80

(Source: Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia)

A serological survey among FSWs in 19xx showed a prevalence of below 1%. HIV and AIDS epidemic was not considered significant and therefore the response was minimal and limited to socialization of HIV and AIDS, curative activities and regulations.

Table 2 – Annual number of people with HIV and AIDS PLWHA in Indonesia from 1987 to 1996

Year	Total Number of People with HIV	Total AIDS Case	Total
1987	4	2	6
1988	5	2	7
1989	4	3	7
1990	4	5	9
1991	6	12	18
1992	18	10	28
1993	96	17	113
1994	71	16	77
1995	69	20	89
1996	105	32	137

(Source: Directorate General of Disease Control and Environmental sanitation, Ministry of Health of Republic of Indonesia)

As mentioned before, AIDS cases had been found – although this was also a matter of debate – since the early 1980s. However, HIV and AIDS issue received a scant attention in Indonesia that only in 1986 had the Ministry of Health of the Republic of Indonesia established an AIDS Working Group chaired by the Ministry’s Head of Research and Development Agency. After the first discovery of AIDS case was published in 1987, the government established the National AIDS Committee chaired by the Director General of Communicable Disease Control and Environmental Sanitation. This response indicated that AIDS was perceived only as a health issue.

When the epidemic started to spread it was evident that HIV and AIDS did not only affect the health sector but also non-health sector. As a result, KPA was established by Presidential Decree No. 36/1994 as a coordinating institution for AIDS multi-sector responses. . The establishment of KPA was an initial institutional response and an acknowledgement that HIV and AIDS is a health and social problem which requires greater attention to mainstreaming HIV and AIDS issues in all government sectors.

Most of HIV and AIDS programs during this period focused on awareness raising of the existence of HIV and AIDS in Indonesia. These were delivered through educational programs with key messages that HIV and AIDS is a real threat and that HIV and AIDS is primarily transmitted through unprotected sex. As a result, civil society organisations working for the key populations started to flourish. These organisations commonly offered dissemination of information and STI clinics that provided services to key populations.

However, this period was also characterized by strong stigma and misconception about HIV and AIDS among the population.

### 2.2.2. Period of 1997–2007

This period was signified by the establishment of HIV and AIDS behavioural surveillance systems (BSS) in Indonesia that was conducted in 1996 and later became the principal reference in assessing the HIV and AIDS epidemic situation in Indonesia. When the data on HIV and AIDS prevalence among IDUs from Yakita Foundation, Bogor, Jakarta RSKO, and Stop AIDS Action Program of FHI were published, the public began to realize the significance of injection drug use as a mode of transmission, especially with the high rate of the sharing of used needles among IDUs (90%). Data from the Indonesia HIV Prevention and Care Project (IHPCP) /AusAID Program in 2004 (Suresh Narayanan, 2004) revealed that the illegal drug industry in Indonesia was growing rapidly, both in terms of supply and demand. IHPCP also reported an increase in illegal drug production globally. Illegal drug business has become the world's second largest business after gun trade (i.e. USD 500 billion/year). The types of drugs sold in the market also increased, in parallel with the increasing number of users.

Surveillance among inmates was started as a basis to improve the services in prison. In 2002, it was found that HIV prevalence among inmates in Jakarta was 5.2% (Ministry of Health, 2004). The availability of service providers in prison is limited, therefore implementing voluntary, counseling and testing services in prison is urgent.

MSM group was also established as one of the key affected populations during this period, following the findings of HIV and AIDS prevalence among this group. Since the early 2000s, the prevalence of HIV and AIDS among key populations had increased to more than 5%. With these figures, Indonesia was classified as a concentrated epidemic region.

In 2006, experts estimated that more than 110,000 people had been infected with HIV and AIDS (Ministry of Health of Republic of Indonesia, 2006). The National Surveillance Data on HIV and AIDS reported that transmissions continuously increased. Until the end of 2006, the highest prevalence among commercial sex workers was found in Sorong, which reached 22.8%. Meanwhile, transmission through unsterile needles was more than 50% in Jakarta RSKO and 68% among inmates in Bekasi Penitentiary Facility.

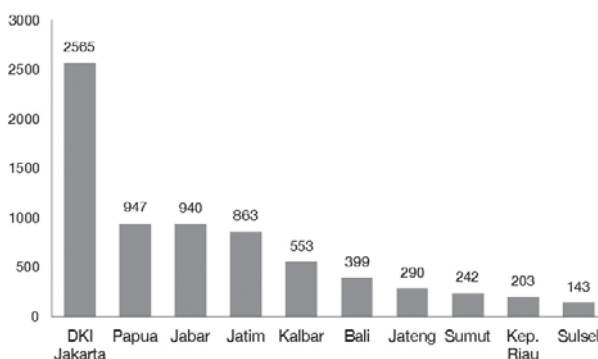
The IBBS survey in 2007 showed the following prevalence among key populations: direct FSWs 10.4%; indirect FSWs 4.6%; transgender 24.4%; FSWs customers 0.8%; MSM 5.2%; and IDUs 52.4%. Figure 3 shows the prevalence of HIV and AIDS in key risk populations in Jakarta, Indonesia.



**Figure 3 – Prevalence of HIV and AIDS in Key Populations in Jakarta, Indonesia, 2002 and 2004**

(Source: Ministry of Health of Republic of Indonesia, 2004)

The spread of HIV and AIDS epidemic to all regions of Indonesia occurred during this period. At the end of 2000, only 16 provinces reported AIDS cases, however, this number increased to 25 provinces by the end of 2003, and to 32 provinces and 186 municipalities/districts in 2006 (MoH and Central Bureau of Statistics/BPS, 2007). Provinces with the highest number of AIDS cases in descending order were DKI Jakarta, Papua, West Java, East Java, Bali, West Kalimantan, North Sumatra, Central Java, Riau Islands, and Riau. Figure 4 illustrates the 10 provinces with the highest number of HIV and AIDS cases.



**Figure 4 – Ten Provinces with the Highest Number of HIV and AIDS Cases (December 2006)**

(Source: Ministry of Health of Republic of Indonesia, 2004)

Meanwhile, the report on "Situation of HIV and AIDS in Indonesia in 1987-2006" from the

Center for Data and Information of the Ministry of Health in 2006 showed that the highest prevalence of HIV and AIDS cases per 100,000 population was found in Papua, followed by Jakarta (Figure 5).

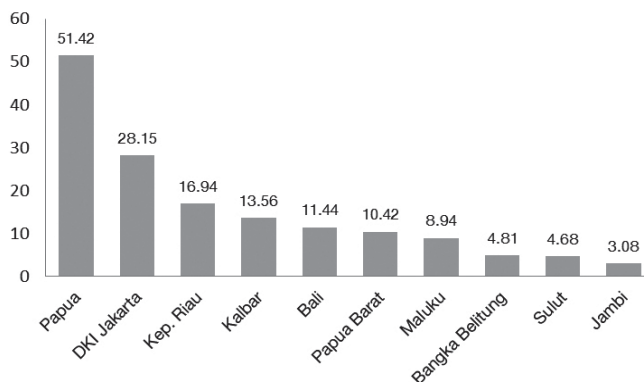


Figure 5 – Prevalence of HIV and AIDS Cases per 100.000 People by Province in Indonesia by 2006

(Source: Ministry of Health of Republic of Indonesia, 2006)

During the period of ten years (1996 and 2006), the cumulative number of PLWHA increased by nearly a hundred-fold. By December 2006, a total of 13,424 PLWHA had been reported, of which 3,492

In terms of the distribution of HIV and AIDS prevalence by age groups, those affected by HIV and AIDS were mostly between 20-29 years (54.76%), followed by the 30-39 years (27.17%); and 40-49 years (7.90%). Thus, almost 90% of HIV and AIDS cases occurred in the productive age group of 20-49 years (89.93%). In addition, HIV and AIDS also affected infants and children younger than 15 years through mother-child transmissions or a transfusion of bloods/blood components (e.g. on patients with hemophilia). A comprehensive health services for women with HIV and AIDS were not fully in place.

By the end of 2006, the most important mode of transmission was injecting drug use and followed by heterosexual intercourse. The other modes of transmission were homosexual intercourse, blood transfusion, perinatal transmission, and other unknown transmission.

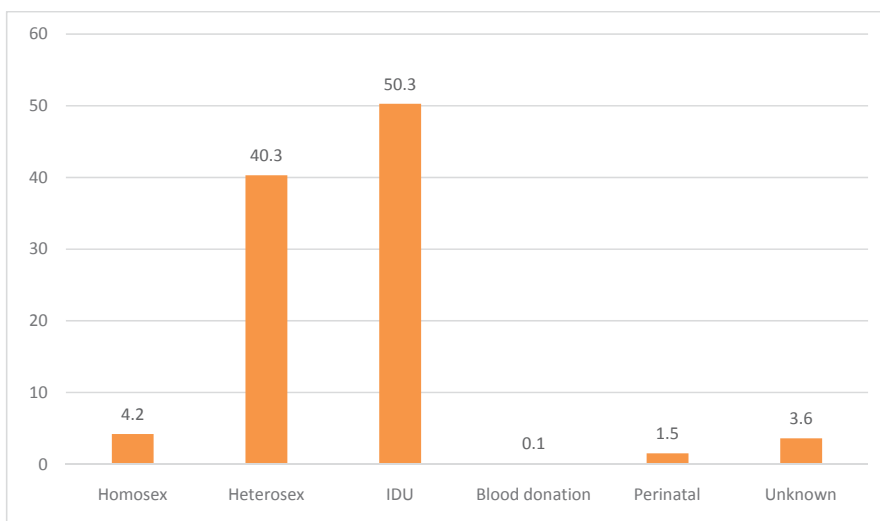


Figure 6 – Cumulative percentage of HIV and AIDS in Indonesia based on the mode of transmission by 31 December 2006

(Source: Ministry of Health of Republic of Indonesia, 2006)

Until the early 1990s, the HIV and AIDS transmission among IDUs was never a concern, although the data in other countries showed that the use of used needles and exchange of needles between users had increased the spread of HIV and AIDS. Three HIV and three AIDS cases among IDUs in Indonesia were first reported in 1997 (MoH, 1997). Since then, the prevalence of HIV and AIDS showed an increasing trend – the prevalence rose sharply during the period of 2003 to 2006.

During this period, the role of counseling and testing was increasingly considered important especially when the prevalence continued to increase. However, the provision of treatment was still low in coverage. From the institutional side, the coordination role of KPA was not fully functional. In 2004, the government and relevant stakeholders made a mutual political agreement through the Sentani Commitment which declared that efforts against HIV and AIDS response from national to local levels must be revitalised.

With the increasing importance of IDU transmission, three major HIV and AIDS programs for IDUs were observed during this period. The first program was pioneered by Yakita Bogor which used rehabilitation and education approaches. The second major program was IHPCP initiatives with twelve interventions<sup>6</sup> in Harm Reduction<sup>7</sup> focusing on the distribution of

<sup>6</sup> Twelve types of interventions among others are NSP, syringes disposal, peer educator, primary health, care and treatment for PLWHA, oral substitution, drug treatment, VCT, infection prevention, outreach, and Information, Education, and Communication. The applied models are outreach by NGOs, Mobile Unit by NGOs and Puskesmas, Shop Front by NGOs and Puskesmas, and Pharmacies.

<sup>7</sup> The main message of Harm Reduction is: "Stop using drugs. If you need to use, smoke, not inject. If you need to inject, use your own syringe. If you need to share syringes, clean them."

needles and syringes (Needle Syringe Program/ NSP) as well as methadone therapy. Third was the Indigenous Leader Outreach Model (ILOM) pioneered by FHI's Stop AIDS Action with the following characteristics:

- Combination of epidemiologic and ethnographic approaches;
- Outreach as a platform for services/ interventions;
- Involvement of target groups; and
- Focus on changes on behaviour and social norms related to at risk practices.

The purpose of this model was to identify and gain access to the IDUs groups, raise awareness of HIV and AIDS, promotion of risk reduction strategies, encourage the adoption of sustainable risk reduction, dissemination of information about the impact of HIV and AIDS, and advocacy. The followings are the illustration of the application of ILOM by Non-Governmental Organisations (NGOs):<sup>8</sup>

- Engage in the IDUs social environment.
- Provide information about HIV and AIDS and drugs, prevention and transmission (in discussions, or casually and entrust the media, if the group is in an "unconscious" state).
- Distribution of Information, Education and Communication (IEC) materials, alcohol swabs, sterilisation package, condoms (for sexually active).
- Perform Individual Risk Assessment (IRA) and Group Risk Assessment (GRA) for behavioural change and to provide alternatives.
- Continue support the behavioural change.
- Promote to take blood test (Voluntary Counseling and Testing/ VCT) for free at the kiosk, to determine the risk of assisted groups of HIV and AIDS.
- Promote activities organized by NGOs (medical examination and free medicines, peer support groups, and vocational training).
- Involve assisted groups and communities in HIV and AIDS prevention advocacy.

### **2.2.3. Period of 2007–2013**

According to the Global Report of AIDS Epidemic by UNAIDS in 2008, the AIDS epidemic in Indonesia was one of the most rapid growing epidemic in Asia. In 2009, the estimated number of people living with HIV and AIDS increased to 333,200 people, of whom 25% were women. This figure shows the feminisation of HIV and AIDS epidemic in Indonesia. Of 11,856 cases reported in 2009, 6,962 were in productive age (less than 30 years). A total of 55 infants under 1 year old were also affected.

Without scaling up prevention, treatment, care and support in the affected provinces, the

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<sup>8</sup> One of the programs that implements ILOM is the Integrated and Comprehensive IDUs Outreach Program across 27 villages in Jakarta. The program was organized by the Health Information Kiosk of PKPM Atma Jaya Catholic University in 2005, under the management of Field Coordinator Lamganda Sihombing.

number of PLWHA was projected to increase from 227,700 in 2008 to 501,400 in 2014.<sup>9</sup> During this period, HIV and AIDS had spread across all 33 Indonesian provinces and 348 districts/municipalities, or nearly 80% of the total districts/municipalities in Indonesia. Between 2007 and 2013, the cumulative number of HIV and AIDS cases reached 118,787 and 45,650, respectively. Provinces with the highest number of HIV positives were DKI Jakarta (27,207), East Java (15,233), West Java (9,267), and Bali (7,922). The highest number of AIDS cases was reported in Papua (7,795), followed by East Java (7,714), DKI Jakarta (6,299) West Java (1,699), and South Sulawesi (1,660).

The 2010-2014 National Strategic Action Plan for HIV and AIDS Response reported that HIV and AIDS cases have been documented in more than 200 districts/municipalities across all provinces in Indonesia. By 2009, HIV and AIDS epidemic in most provinces were still concentrated on key populations with a prevalence of more than 5%. However, the HIV and AIDS epidemic in Papua had spread into the general population with prevalence rate ranging from 1.36% to 2.41%.<sup>10</sup>

The 2011 IBBS indicated that the highest prevalence of HIV and AIDS was found in the IDUs (36%) followed by transgender, direct FSWs, MSM, prisoners, indirect FSWs and high-risk men. This finding was similar to the results of 2007 IBBS. Compared to the 2007 survey, there was no change in the prevalence rate among direct FSWs, indirect FSWs, high-risk men, and transgender. Nevertheless, an increase in the prevalence by 2-3 folds was observed among MSM group. The prevalence among IDU group declined by 10% in Jakarta and 20% in Medan.<sup>11</sup> The 2011 IBBS also measured the prevalence of STIs including syphilis, chlamydia, and gonorrhoea. Syphilis was most commonly found in transgender group (25%). Compared to the 2007 survey, the prevalence of syphilis among direct and indirect FSW groups decreased by 4-8 folds, transgender by 20%, and high-risk men by 3%. These declines were mainly observed in brothel complex areas receiving Periodic Presumptive Treatment (*Pengobatan Presumtif Berkala/* PPB) program. In contrast, the prevalence of syphilis in MSMs increased by 2-5 times compared to 2007.<sup>12</sup>

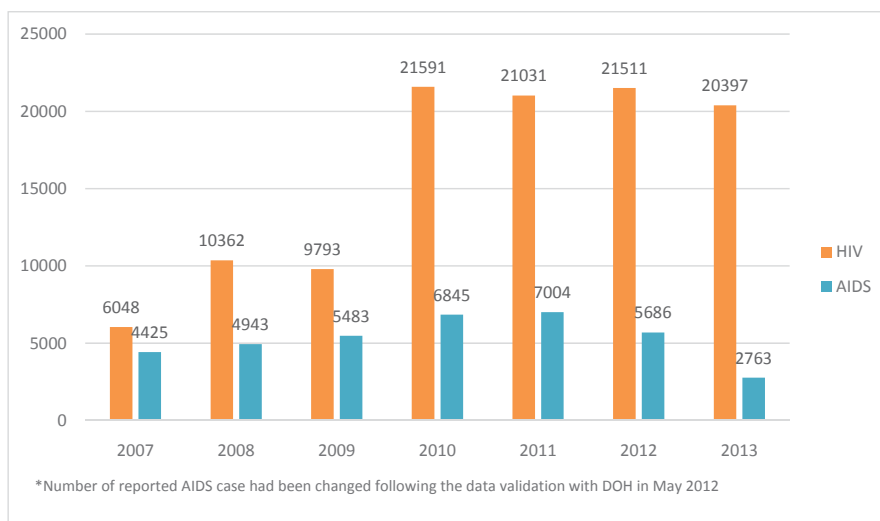
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<sup>9</sup> This has been revised in the 2012 Ministry of Health's estimates to 590,000 (MoH, 2012).

<sup>10</sup> BPS, Ministry of Health, KPAN (2006). "Risk behavior and prevalence of HIV-AIDS in Papua." Result of the 2006 Integrated Surveillance on HIV-AIDS and Behavior in Papua.

<sup>11</sup> This decline is still in debate among experts in relation to the sampling method and estimation on the declining number of IDUs population. See Praptorahajo et al. (2013).

<sup>12</sup> 2011 IBBS. "Executive Summary Fact Sheet." This survey was conducted in cooperation with the Ministry of Health, Ministry of Law and Human Rights, Selected Provincial Offices of Health, KPAN, District/ Municipality KPA, GFATM, SUM (FHI and USAID), Word Bank, and CHAI.



**Figure 7 – Total number of reported HIV and AIDS cases up to September 2013**

(Source: Ministry of Health of Republic of Indonesia, 2013)

During this period, the main mode of transmission was heterosexual (60.9%), injection drug use (14.4%), perinatal (17.4%) and homosexual (2.8%) transmissions. The case fatality rate due to AIDS at 2007 was 7,46 % then decreased to 0,30% as of June 2013, indicating an increase in the number of PLWHA receiving ARV treatment (Ministry of Health, 2013).

There was no difference in the proportion of high risk groups in the same areas between 2007 and 2011 except in IDU population. Greater attention was paid to this increase in IDU population, as injection drug use can be an effective medium for HIV and AIDS transmission and double the risk of HIV and AIDS transmission to other high-risk groups. Unsafe behavior in injection drug use such as sharing of used needles was most frequently found in Jakarta (27%) and the least frequently in Medan (7%). Sharing of used needles behaviour is strongly influenced by the distribution system of needles and syringes as well as the level of integration with primary health services (Praptoraharjo et al., 2013). The proportion of IDUs who exchanged used needles showed a decline from 2004 to 2011.

HIV and AIDS response during this period focused on commercial sex workers and their clients due to the high number of population who are at risk of contracting HIV and AIDS via sexual transmission. Despite the higher prevalence rate of HIV and AIDS in IDUs, the number of population at risk due to unsafe sexual behavior was still higher. In addition, focus on commercial sex workers group also involved the awareness of close relationship between key populations. For example, the IDU transmissions are strongly associated with unprotected sex (e.g. practice of unprotected sex among IDUs, or commercial sex workers/clients who are also IDUs).

The importance of continuum of care was also recognized in this period as several policies related to integrated services of STIs, HIV tests, Needle Syringe Program (NSP), methadone, Antiretroviral Therapy (ART), as well as collaboration between NGOs and Puskesmas were developed. However, the practice of continuum of care varied between areas especially on NSP service, methadone and ARV, due to different interpretation of the regulations between areas.<sup>13</sup>

The availability of services also improved during this period. Until September 2013, there were 889 Voluntary Counseling and Testing (VCT) services available. A total of 330 Care, Support and Treatment (CST) consisting of 266 hospital referrals and 114 satellite services were established. A total of 85 Methadone Maintenance Treatment (MMT), 886 STIs clinical services and 144 Prevention of Mother to Child Transmission (PMTCT) services were available in several provinces. In addition, 9 penitentiary facilities and prisons provided HIV and AIDS programs through MMT services, while HIV and AIDS referral activities were implemented by 127 penitentiary facilities and prisons.

Until September 2013, the total number of PLWHA receiving ARV treatment was 36,483. The most frequently used regimen was ARV line 1 (96.42%) and ARV line 2 (3.19%). By September 2013, the cumulative percentage of PLWHA was 55.7% male, 29.2% female, and 15.1% unknown. The number of female PLWHA showed an increase every year.<sup>14</sup>

From the institutional side, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) initiatives which was founded in 2002 raised the awareness of the need to revitalize the role of KPAN. The Presidential Decree No. 75/2006 on KPAN was issued to amend the Presidential Decree No. 36/1994 in order to strengthen the institutional role of KPAN's. The policy reinforcement was followed by the preparation of the National Strategy for HIV and AIDS for 2007-2010, which clearly defined the comprehensive efforts on HIV and AIDS response based on the nature of the epidemics and adapted to the context of decentralisation.

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<sup>13</sup> Praptoraharjo et al. (2013). "Indonesia NSP Review". UNODC Indonesia.

<sup>14</sup> Directorate General of Disease Control and Environmental of Ministry of Health (2013). "HIV-AIDS Progress Report Third Quarter of 2013."

## 2.3. HIV and AIDS epidemic in Five Selected Provinces

### 2.3.1. North Sumatra

The first HIV positive in North Sumatra was discovered in an FSW in Pirngadi Hospital Medan in 1992. The first AIDS case was found in a seafarer in 1994. In 1997, the HIV and AIDS Team was established at Dr. Adam Malik General Hospital in Medan. However, this team was not functional.

*Since the first AIDS case was reported in 1987 at Sangla Hospital Bali, many provinces started to report AIDS cases. The first AIDS case in North Sumatra was found in Pirngadi Hospital Medan, in 1992.*

*In 1989, two cases of AIDS were found in Dr. Soetomo Hospital, Surabaya, EastJava. The first AIDS case in South Sulawesi was reported in 1996, while the one in Papua, i.e. in Merauke, was found in 1992.*

*The highest prevalence of AIDS cases in the study locations by 2013 was 375.03% in Papua, 102.42% in Bali, 23.28% in East Java, 21.20% in South Sulawesi, and 10.02% in North Sumatra. The national AIDS prevalence was 22.03%.*

*(Directorate General of Disease Control and Environmental Health of Ministry of Health, 2013)*

To ensure the continuation of AIDS Committee at the Adam Malik General Hospital Medan, the Decree on Establishment of Special Service Center (*Pusat Pelayanan Khusus/ Posyansus*) at RSUP Adam Malik General Hospital Medan was issued in April 2011. Based on the report from some NGOs, stigma and discrimination by health personnel were still prevalent at the time of the study.

Between January 2006 to December 2013, the number of HIV and AIDS cases in Medan Municipality reached 3,410 consist of 2,198 cases in heterosexuals, and 958 cases in IDUs (Medan Municipality Health Office, 2013). Currently, the total number of HIV and AIDS cases in North Sumatra has reached 6,340 i.e. 2,198 HIV and 4,241 AIDS cases (Ministry of Health, 2013).

### 2.3.2. East Java

The first cases of AIDS in East Java were reported in two patients of RS Dr. Soetomo Hospital Surabaya in 1989. In 1990 there were no additional reports, yet 1 case was reported in 1991. The AIDS patient was diagnosed because of advanced Opportunistic Infections (OIs). Dr. Soetomo Hospital was the first institution responded to this case. By 2013 the estimated number of PLWHA in East Java was 57,321 people, of which 19,017 were HIV positives and the rest were AIDS (33.2% of the estimated figure) (East Java Provincial AIDS Commission, 2013). East Java has been declared as a concentrated epidemic area, as it hosts the second highest number of AIDS cases after Papua as of June 2013.

Based on East Java Provincial AIDS Commission data (2013), the main mode of transmission in East Java is heterosexual transmissions (72.68%) and followed by IDUs (18.44%) with one of three PLWHAs is female (35.46%). Interestingly, report from the East Java Provincial KPA

showed that as many as 1,268 AIDS cases occurred amongst housewives. This number is substantially higher than the number of cases in FSWs which totaled 568 cases (6.8%).<sup>15</sup> Of the 627 pregnant women with HIV positive, 442 had access to ART. A total of 454 babies were born from HIV-positive mothers. Of the 65 babies born from HIV-positive mothers, 32 babies were declared positive of HIV (East Java Provincial AIDS Commission, 2013). Figure 8 shows the annual number of HIV, AIDS and mortality cases in East Java.

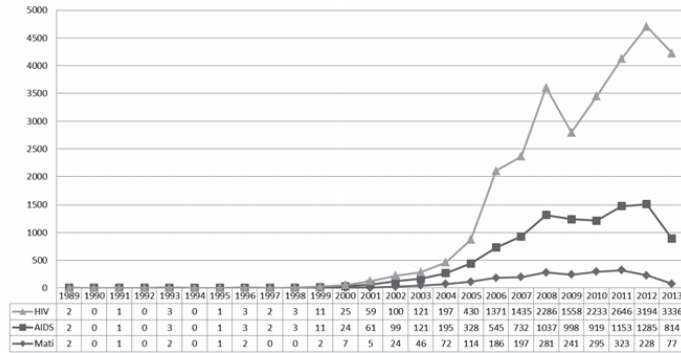


Figure 8 – Total of HIV and AIDS, and Deaths by HIV AND AIDS in East Java (xxxx – xxxx)

(Source: East Java Provincial AIDS Commission, 2013)

### 2.3.3. Bali

The first AIDS case in Indonesia was discovered in Sanglah Hospital in Denpasar, Bali in 1987. The case was detected in a homosexual Dutch man who lived in Candi Dasa.

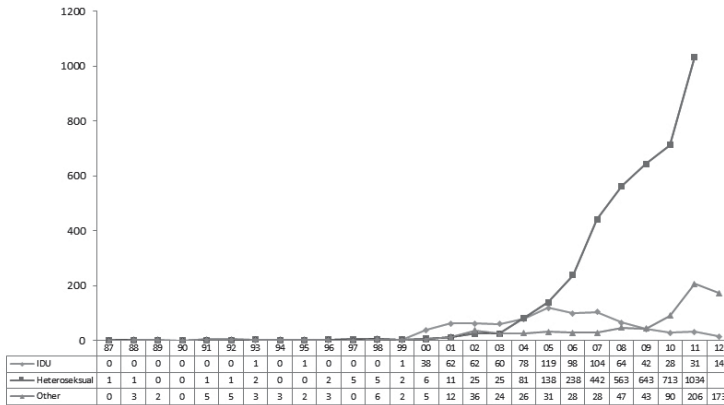


Figure 9 – Trend of Cumulative Total of HIV and AIDS Reported to Bali Provincial Health Office based on Transmission Risk Factors Year 1987–2012

(Source: Bali Provincial AIDS Commission, 2013)

<sup>15</sup> With no data due to the possibility of FSWs reported themselves as housewives as it is uneasy to write down FSW as a status in their registration form.

The HIV and AIDS epidemic in Bali displayed a changing pattern over time. Although the first case was found amongst homosexual, but in 2000 the HIV and AIDS epidemic had expanded towards the group of IDUs. Currently, an increasing trend among heterosexuals group has been observed. HIV and AIDS cases had also been found in women and pregnant women.

Until July 2013, the total number of HIV and AIDS cases in Bali was 8,003, i.e. 4,230 were HIV positives and 3,773 were AIDS cases. HIV and AIDS positives were also found in housewives, infants, and children. Data on HIV and AIDS epidemic in Bali was obtained from medical records and serological surveys conducted among high-risk groups. To describe the epidemiology among general population, a group of pregnant women was also sampled (KPA Bali Province, 2013).

The HIV and AIDS cases in Bali were not evenly distributed. Districts with the highest number of PLWHA were Denpasar, Buleleng, Badung, Gianyar, and Tabanan. The distance between districts within the province is not that far. For example, it will take approximately 45 minutes by car or motorcycle from Denpasar Municipality to Badung District or from Denpasar to Gianyar District. Such an easy access enables high mobility of people or clients from one area to another. Other factors that ease the transmission were concentration of population distribution, distribution of high-risk populations, and distribution of entertainment centers (Bali Provincial KPA, 2013).

#### **2.3.4. South Sulawesi**

The first HIV cases in South Sulawesi were documented in 1996. Three bride and groom were reported by the media to be HIV positives. All of the three brides had been former FSWs who were detained under the community/social problem operation by the Municipal Police in South Sulawesi. These three brides were sent to a social welfare rehabilitation of *Penyandang Masalah Kesejahteraan Sosial* (PMKS) in South Sulawesi Province.

The South Sulawesi Provincial KPA had been established in 1994, however, there was no significant response towards HIV and AIDS after the first cases were reported. Around 1991 and 1992 there was a group of volunteers who started providing outreach services to FSWs and transgender population in South Sulawesi. The volunteer group was initiated from a discussion between students from several universities on the HIV and AIDS situation in South Sulawesi and became the forerunner of *KRA-AIDS* and *Yayasan Gaya Celebes*, the two prominent civil society organisations working in HIV and AIDS in South Sulawesi.

Since 1996, an annual increase in the number of HIV and AIDS cases in South Sulawesi has been observed. Since 2005 until September 2013, the South Sulawesi Provincial Health Office documented a total of 7,147 HIV and AIDS cases. In 2011, a very sharp increase in the new cases of HIV and AIDS compared to previous years was observed. Unfortunately, there was no information that could explain the phenomenon. There seemed to be a lack of adequate response from South Sulawesi Provincial KPA and the Provincial Health Office to

anticipate the development of the epidemic in the coming years.

The course of HIV and AIDS in South Sulawesi has undergone changing transmission patterns. During the period of 1996 to 2004 after the discovery of first HIV cases, the HIV and AIDS transmission was predominated by sexual transmission. HIV and AIDS cases were mostly found among FSWs and transgender populations. During the period of 2005 to 2009, the HIV and AIDS were mainly transmitted via sharing of used needles among IDUs population. From 2010 until now, the rate of transmission in IDUs population has been declining and replaced by transmission in FSW and transgender populations.

Until 2005, there had been no standardized system for recording new cases of HIV and AIDS, resulting in differences in the number of HIV and AIDS cases in each district/municipality in South Sulawesi. Therefore, the South Sulawesi Provincial Government created a standard reporting system which required all new HIV and AIDS cases from all health service facilities in the district/municipality/municipalities be collected at the provincial level through the Provincial Health Office. The South Sulawesi Provincial Health Office is responsible to develop a summary and publish reports on HIV and AIDS cases. The reporting of HIV and AIDS is performed through the Provincial Health Office.

### 2.3.5. Papua

HIV and AIDS cases in Papua were first reported in Merauke District in 1992. However, the documentation of HIV and AIDS cases only began in 1995. The number of cases in Papua increased every year. Figure 10 shows the increase in the number of cases of HIV and AIDS in Papua during the period of 1995-2000.

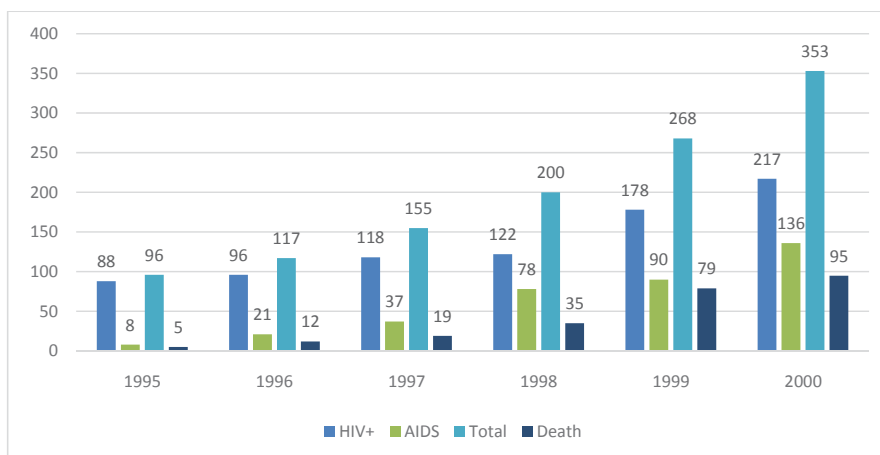


Figure 10 – Cumulative Number of HIV and AIDS Cases in Irian Jaya (Papua), 1995–2000

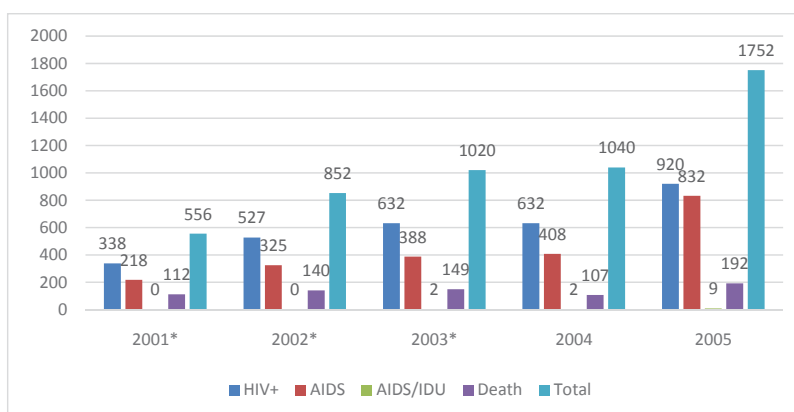
(Source: Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic Indonesia, 2000)

In Papua and West Papua Province, the main route of HIV transmission was unprotected heterosexual sex, either commercial or non-commercial sex. Papua is the only region in Indonesia with "generalized epidemic" as the prevalence among the general population has reached 2.4% among the 15-49 years age group and 3% among the 15-24 years age group (IBBS, 2006). The prevalence in males (2.9%) was higher than in females (1.9%). The highest prevalence was found in remote coastal areas (3.2%), followed by 2.9% in mountain areas and 1.8% in accessible coastal/ lowland areas. These data indicated that in Papua, HIV and AIDS has penetrated far into rural areas and is in parallel of the level of access to basic services (Ref)

According to a study by the Ministry of Health in five provinces, there was an increase in comprehensive knowledge about HIV and AIDS amongst youth (age 15-24 years) in the general population, from 11.4 per cent in 2010 to 20.6 per cent in 2011, with similar proportions for men and women. In Tanah Papua, only 20.2 percent of young people in school and 15 per cent of out of-school young people had accepting attitudes towards people living with HIV (UNICEF, 2012).

High-risk sexual behaviours were also common among young people. A survey by UNICEF in 2011 showed that 18% of young people reportedly had more than one sexual partner, but only 10% of them perceived that they were at risk. The situation in young people who were out of school was even worse. More than half (51%) of children who were out of school in Papua and 44% in West Papua reported having sex with multi-partner sex but only 18% perceived that they were at risk. Sexual violence that frequently occurred in these two provinces had worsened the situation. The majority of young people knew the effectiveness of condom to prevent pregnancy (70%), however 80% reported that they did not know the price of condoms (meaning that they had never bought them) and were not sure if they would use them. In addition, only 7% of schoolchildren in Papua and 5% in West Papua were certain that they were able reject peer's invitation to have sex. Access to VCT services has been constrained by the limited availability of VCT services. .

Compared to other provinces, HIV and AIDS epidemic in Papua shows remarkable differences. The total population of Papua only accounted for 1% of the total population of Indonesia, however, by December 2004 the number of people with HIV, AIDS and AIDS-related deaths reached a total of 632, 408, and 107, respectively (Directorate General of Disease Control and Environmental Sanitation, Ministry of Health, 2005) (see Figure 11). The total number of HIV and AIDS cases reported in Papua accounted for 19.1% of all new infections in Indonesia within the same year, i.e. 1,844 new PLWHA (Directorate General of Disease Control and Environmental Sanitation, Ministry of Health, 2004). Figure 11 also shows that the annual number of HIV and AIDS cases showed an increase every year.



**Figure 11 – Total Number of HIV AND AIDS Cases in Papua and West Papua Province**

(Source: Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia, 2005)

\* In 2003, the data of HIV and AIDS for Papua Region were a unified data for the whole region, despite the development of the new Province of West Irian Jaya. Papua initial data were then apportioned in 2004 into data of Province of Papua and Province of West Irian Jaya (which were subsequently changed to Province of West Papua with Manokwari as the provincial capital).

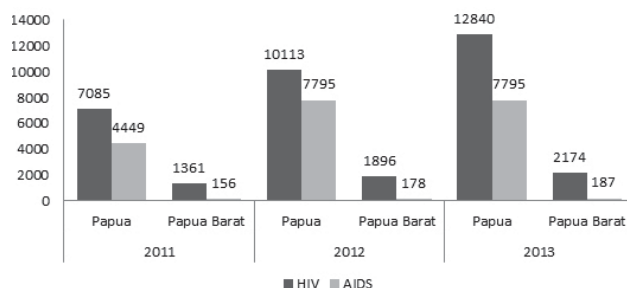
Table 3 shows the number of HIV and AIDS cases among the group of IDUs in Papua and West Papua in 2001-2005. It implies that the increase in HIV and AIDS cases among IDUs was not the major contributor to the increasing number of cases. The prevalence rate among FSWs was 22%, while the prevalence rate among general population was 2.4% (KPAN, 2007).

**Table 3 – Cumulative Number of HIV and AIDS Cases for the Provinces of Papua and West Papua**

Year	Province	AIDS	AIDS/IDU	Death
2004	Papua	399	2	107
	West Papua	0	0	0
	Unknown	9	0	0
2005	Papua	772	9	192
	West Papua	51	0	0
2006	Papua	947	4	221
	West Papua	58	5	0
2007	Papua	1339	4	238
	West Papua	58	5	0

<b>2008</b>	Papua	2382	1	1351
	West Papua	58	5	19
<b>2009</b>	Papua	2808	2	371
	West Papua	58	5	19
<b>2010</b>	Papua	3665	3	580
	West Papua	38	5	19

(Source: Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia, 2010)



**Figure 12 – Cumulative Number of HIV and AIDS cases in Papua and West Papua Province, 2011–2013**

(Source: Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia, 2013)

In 2011, Papua contributed 15% of all new HIV cases in Indonesia. The number of HIV cases reached 7,085 while the number of AIDS cases was 4,449. In West Papua Province, the number of HIV and AIDS cases was 1,361 and 156, respectively. On average, the number of cases in Papua was 15 times higher than the national mean. Unlike other regions in Indonesia, The IBBS 2006 results showed that prevalence among Tanah Papua population was 2,4 percent among age group 15 -49 old which was higher compare to other parts of the country (BPS and MoH, 2006). The prevalence of HIV and AIDS in Papua indigenous population was 2.8%. Among non-indigenous population, the prevalence of HIV and AIDS was 1.5% – 2.9% in male and 1.9% in female (UNICEF Indonesia, 2012).

Almost all major HIV and AIDS response programs in Papua were initiated by donors. A small number of programs was conducted by church. As in other districts, the Provincial and District/Municipality KPAs were established; however most of these entities showed the "isomorphic mimicry" phenomenon. For example, in 2010, a local regulation on HIV and AIDS was issued, but the impact of this policy was yet to be seen. Another example of isomorphic mimicry in HIV and AIDS responses included the integration of HIV and AIDS response into the local development (*Rencana Pembangunan Jangka Menengah*

*Daerah/ RPJMD* 2012-2016), the establishment of Papua Working Group in the KPAN, the issue of Governor Regulation on HIV and AIDS in Education Sector, the collaboration with churches (Badan Kerjasama Antar Gereja/BKAG), the establishment of HIV and AIDS Working Group at the University of Cendrawasih. These mechanisms seemed to be an effective weapon to combat HIV and AIDS, however, they were not that influential. Studies on the capacity of education sector in Papua to respond to HIV and AIDS supported by UNICEF (2011) suggested that the problem is on the capability to implement the established policies and commitments.

## EVOLUTION OF HIV AND AIDS RESPONSE POLICIES IN INDONESIA

### 3.1. Policy Context

Two main issues substantially influenced changes in the development of policy response to HIV and AIDS epidemic in Indonesia were the transformation of the relationship between central and local governments (i.e. decentralisation) and the development of epidemic. Prior to the decentralization of the health sector in 1999 during which the health system was fully centralized, formulation and implementation of HIV AND AIDS strategies were predominantly led by the central government with vertical approaches and funding of international development partners as the main actors<sup>16</sup>. When decentralisation in health sector was implemented, all management in health affairs, including HIV and AIDS response underwent substantial changes accordingly. The shift of autonomy to district, including budget management, has contributed to the changes in health system delivery. In the era of decentralisation, horizontal approaches seemed more relevant.

The growth of the HIV epidemic played a crucial role in the development of the health system response. The success of awareness raising programs have created demands for better services and increased the number of PLWHA receiving ART services. These have resulted in the shifting of program orientation from awareness campaign to provision of health services. Consequently the health service provision requires more adequate adjustments in terms of standards, mapping priorities, policies, and resource requirements by service providers to ensure the effectiveness of management process; also adjustment of the operational system to ensure high quality services in line with the program development.

The two issues mentioned above lead to two challenges in the formulation of effective public policy against the threats of HIV and AIDS. First, is to align the political economy of HIV and AIDS policies with the good governance within the context of partial decentralisation. Second, is to technically integrate HIV and AIDS services into the existing health programs to ensure the long-term response in a setting with limited resources and capacity of local governments.

Integration of HIV and AIDS programs into the health system is not an easy process as it

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<sup>16</sup> The debate about the vertical and horizontal approaches to health policy, including the issue of HIV and AIDS epidemic, is still ongoing (Atun et al., 2008). Vertical approach has to be sectoral to be able to respond quickly to a health situation through provision of adequate resources in order to deliver the necessary interventions. Meanwhile, horizontal approach presumes the integration of cross-sector or cross-program would be able to comprehensively respond to problems. Each of these two approaches has its own strengths and weaknesses within the context of a certain disease. At the beginning of the emergence of health problems, a vertical approach is considered very appropriate as it is able to respond quickly to problems, but in the course of time, the intervention to the health problems needs to be integrated with intervention of other programs or sectors as the vertical approach would not be able to respond to the problems sustainably.

requires the involvement of a wide range of stakeholders and interests, infrastructure, policies, and resources. It requires an effort to improve the effectiveness and accessibility of HIV and AIDS services to maximise the available resources and infrastructure (Dudley and Garner, 2011).

Effort to integrate the vertical and horizontal approaches is inherently carrying some risks, as the results achieved through vertical approaches may not be evident and may even disappear.<sup>17</sup> Moreover, the majority of health systems at district level are still weak, and therefore policy makers are often encouraged to continue vertical approaches (Godwin and Dickinson, 2012).

In the light of different policy context between districts, the fundamental issue is not about whether one approach is favorable than another, or the integration of the two approaches. Instead, it is more important to realize that these different approaches can complement each other and simultaneously be integrated, each with appropriate degree of share. Every decision should be made by taking into account the complexity of providing integrated and sustainable health service as well as effective planning, coordination, and management (Dudley and Garner, 2011, Atun et al., 2008). Achieving a synergistic integration of vertical and horizontal approaches is a major challenge and requires a very careful consideration.

*The change of government system from a centralized system to a decentralized system (local autonomy) and the epidemic had carried influences towards the HIV and AIDS response policies in Indonesia. The fundamental weakness of the district's response to HIV and AIDS was that it relied on policy and institutional action, however the capacity of policy implementation is weak. The integration of HIV and AIDS programs into the health system is not simple as it will involve many interests, infrastructure, policies, and resources.*

The present review aims to provide a historical perspective towards issues in the integration of vertical and comprehensive approaches in addressing the development of HIV and AIDS epidemic. From the historical point of view, policy is a form of sense making of the executors during policy formulation that attempts to interpret situations and circumstances that undergo changes over time based on their interests and to decide policies that are considered beneficial (Weick, Sutcliffe and Obstfeld 2005). It is expected that by understanding the evolution of policy over certain period of time, the effort to set the agenda of policy reform will become more contextually appropriate with the dynamics of social and political systems of the Indonesian society.

In the New Order era, the policy response to HIV and AIDS epidemic at national level was

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<sup>17</sup> Related to this is the national surveillance system, experience shows that in terms of quality standards, the centralized governance surveillance system has some advantages but it may be politically much of a challenge.

initiated by the Presidential Decree No. 36/1994 on KPA. KPA was established as a coordinating agency of HIV and AIDS control. The Decree was issued as to provide answer to global HIV and AIDS situation, prevention and control, as well as to respond to international commitment. In the United Nations meeting in October 1987, the global strategy of AIDS prevention and control proposed by the WHO in 1985/1986 was launched.<sup>18</sup> In a way, the commitment of the government to HIV and AIDS response was influenced more by campaigns at global level rather than by local epidemic or pressure from the civil society.<sup>19</sup> The growth of civil society organisations dealing with HIV and AIDS was also driven by available funding opportunities from international agencies.<sup>20</sup>

In mid-June 2001, Indonesia was one of the 189 countries that signed the Declaration of Commitment on HIV and AIDS at the UN General Assembly Special Session (UNGASS). The signing was followed by the Special Session on HIV/AIDS of the Cabinet meeting in March 2002 with the aim of: 1) Improving national-level leadership's commitment on HIV and AIDS response; and 2) Improving and establishing strategic policy in addressing the danger of HIV and AIDS. Subsequently, a momentum which was a big leap in HIV and AIDS response in Indonesia was the accomplishment of Sentani Commitment on 19 January 2004, which was signed by six provinces with the highest level of epidemic at the time, six Ministers, one Head of Agency, and the Head of Commission VII of the House of Representatives. Through this agreement, the provinces and various sectors committed to further improve HIV and AIDS response within their respective work areas.

In 2001, Indonesia started the implementation of local autonomy (decentralisation, followed by the implementation of new policies on development funding at central, provincial, and district levels. Consequently, the decentralisation in health sector followed, as a result of political decentralisation as stipulated in Law No. 22/1999.<sup>21</sup> Local government or the district/municipality government was provided with the authority to determine development priorities in their areas. However, in some districts, health problems have not received sufficient attention and consequently funding. Many districts have not allocated any funds in their budget to create a surveillance system, which is the basis to develop

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<sup>18</sup> See Presidential Decree No. 36/1994 on National AIDS Commission.

<sup>19</sup> An example of international "pressure" includes the Paris Summit Agreement 1994 which focuses on equal and fair treatment of PLWHA; the United Nations Millennium Summit in September 2000 in which the Indonesian Government signed the Millennium Declaration as the government's commitment to work towards the the UN Millennium Development Goals (MDGs) where HIV and AIDS are included in the sixth goal. Furthermore, in 2001 the Indonesian government signed an 11-points agreement of the Declaration of Commitment of the UN General Assembly Special Session on HIV and AIDS (UNGASS). Also in the same year Indonesia signed on the Commitment of Asia Pacific Ministers on HIV and AIDS 2001, the Declaration of Commitment of ASEAN Heads of State on HIV and AIDS 2001, the Declaration of the Inter-Parliamentary Union on HIV and AIDS 2001.

<sup>20</sup> See Pisani (2008), *The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS*. New York: W. W. Norton. The composition of funding for HIV is still dominated by foreign sources (UNDP 2011), especially funding for civil society organisations for HIV and AIDS, that nearly all depend on donors.

<sup>21</sup> See Laksono Trisnantoro (2009). *Implementation of Health Decentralisation in Indonesia 2000-2007: Examining Experiences and Future Scenarios*. Yogyakarta: BPFE.

strategies for disease prevention.<sup>22</sup>

Furthermore, the revitalisation of KPA was conducted in 2006 based on Presidential Decree No. 75/2006 on KPAN, which confirms stronger government's commitment on HIV and AIDS. According to this regulation, members of KPAN should consist of twelve Ministers, Cabinet Secretary, Indonesian National Army Commander, National Police Chief, three Heads of Agency, Chairman of the Board of the Indonesian Doctors Association (*Ikatan Dokter Indonesia/ IDI*), Chairman of the Association of Public Health of Indonesia, Chairman of the Indonesian Red Cross (*Palang Merah Indonesia/ PMI*), Chairman of the Chamber of Commerce and Industry (*Kamar Dagang Indonesia/ KADIN*), and Chairman of the National Organisation of PLWHA. The Minister of Health holds the position of chairman with the Minister of Home Affairs as the deputy chairman. The change in the KPAN structures has implications for involvement and policies issued by the Ministries and Agencies that are members of the KPAN.

To determine the direction, strategy and national action plan, the Coordinating Ministry for People's Welfare issued the Regulation of Minister of People's Welfare No. 07/2007 on National Strategy and Action Plan for HIV and AIDS Response 2007-2010. This has been updated with the Regulation of Minister of People's Welfare No. 08/PER/MENKO/KESRA/I/2010 on National Strategy and Action Plan for HIV and AIDS Response 2010-2014. The NATIONAL STRATEGIC ACTION PLAN currently focuses on efforts to prevent and reduce the risk of transmission, improve the living standards of PLWHA, and mitigate social and economic impacts for individuals, families, and society as a whole. These policies aim at the creation of universal access to services related to HIV and AIDS through prevention, treatment, care and support, as well as to create conditions which allow accomplishment of the objectives.

To respond to changes in the patterns of HIV and AIDS transmission in Indonesia, there have been two ministerial-level policies issued at the beginning of 2007. The Coordinating Minister of People's Welfare issued the Regulation of Minister of People's Welfare No. 2/2007 on National Policy on HIV and AIDS Response through Intravenous Addictive Drugs Harm Reduction. The formulation of this policy was led by the Coordinating Ministry of People's Welfare as the Chairman of KPAN with the involvement of the Head of BNN/ State Police, Minister of Health, and Minister of Law and Human Rights as members of the KPAN.

The enactment of Regulation of Minister of Home Affairs No. 20/2007 on General Manual of the Establishment of Local Level AIDS Commission, General Manual of Establishment of AIDS Commission and Community Empowerment for HIV AND AIDS Response at the Local Level was one form of the Ministry's commitment to address HIV and AIDS issues through local leadership. The latter regulation governs the organisation, duties and responsibilities of provincial/ district/municipality KPA, as well as sources of funding for HIV and AIDS response

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<sup>22</sup> WHO (2008). "WHO Country Cooperation Strategy 2007-2011 Indonesia."

in the regions. Responding to the local level funding needs, the KPAN through the Minister of Home Affairs endorsed the Regulations of the Minister of Home Affairs No. 16/2006 and No. 59/2007 on Local Financial Management as a basis for planning and budgeting management. The review sessions to discuss the implementation of the budget have been initiated in 2007. As a result, the contribution of funding from government sources increased from 22.37% in 2004 to 39.03% in 2008 (KPAN, 2011).

Provincial and local governments' response to this policy varied from one district to another. During the field visits, description on the responses of provincial and district governments towards HIV and AIDS issues<sup>23</sup> was obtained. KPADs have been established in all the five visited provinces as well as at the district/municipality level. Regulations and decisions of the governor are available as an institutional policy response in all provinces.

### **3.2. Research as a Basis for Policy: Study on HIV and AIDS in the Initial Phase of Epidemey**

Studies on the epidemiology of HIV and AIDS have been evolving along the development of its control program. This shows an awareness of the importance of data in the formulation of program policy and public policy. In the period of 1997-2003, there have been at least 65 studies on HIV and AIDS across 12 provinces. The main topics of the research included aspects of knowledge, attitude and practice among FSWs population (14 studies), FSWs clients (10 studies), transgender prostitutes (4 studies), and IDUs (7 studies) were associated with the risk of STIs and HIV (MoH, 2005). In addition, there have also been studies on custom, culture or rituals associated with the risk of STIs including HIV (9 studies). In addition, a number of BSS on a routine basis have also been conducted by the Ministry of Health and the Statistics Indonesia (BPS) in 13 provinces. As a surveillance survey, BSS aims to determine not only the level of risk of a population, but also to collect information related to socio-economic condition and institutional situation in STIs and HIV and AIDS control.

Basuki et al. (2002) examined the various reasons of not using condoms among FSWs in brothel complexes. Most FSWs assumed that sexual partners seemed healthy and would not transmit any STIs. Another reason is that they had done preventive efforts such as taking antibiotics. This study also found that procurers (pimps) were not supportive on the use of condoms. Three years earlier, Ivan Wolffers et al. (1999) found that the characteristics of FSWs in Indonesia in terms of income, ways to attract customers, reasons for joining the sex work, and career development significantly influenced sexual behaviour. Wolffers's research sought to describe the relationship between FSWs and clients as well as their male couples in Surabaya and Jakarta. Different perceptions of relationships (boyfriend and clients) were associated with different ways in cleaning themselves (body), perception of risk, preventive behaviour and the use of condoms. The concept of their identities was diverse, as well as

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<sup>23</sup> Visited regions are: Provinces of North Sumatra, East Java, Bali, South Sulawesi and West Papua.

their expectations of particular roles and behaviours of their partner's. This research suggested that intervention programs should pay attention to the complexity of double identities and social relationships, as well as recognize sex workers as a whole person, not just limited to their sexual transactions.

An in-depth study of the contemporary cultural concept on HIV and AIDS in Indonesia has been done by Crisovan (2006), who examines cultural ideas about HIV and AIDS, particularly the perception of risk. The two-year field study using survey techniques (n = 413) and in-depth interviews (n = 60) as well as participatory anthropological observation can be used as a basis for building a thorough understanding of the impact and effectiveness of the existing HIV and AIDS education programs. This study suggested that the notion of "risk" of the West was used to define, build, and fund HIV and AIDS education programs throughout Indonesia. It turned out that such a construction often fails to consider the idea of Indonesian culture in association with HIV and AIDS. The study aimed to explore the use of "high risk groups" and "high-risk behaviour" concepts in Indonesian setting. Anthropological understanding of cultural perceptions, its association with HIV and AIDS as well as the risk is very helpful to explain how the Western conception of "risk" does not always correspond to the reality in Indonesia.

Crisovan suggested that HIV and AIDS education programs in Indonesia would be more effective if they are able to identify: (a) the diverse identity of program targets; (b) the importance of cultural categories and how they are applied in different religious ideologies and complex situations; and (c) that the cultural and programmatic definition of "risk" is often inconsistent. Understanding the cultural conception makes it possible to understand more deeply the effective ways to develop the appropriate and culturally sensitive policies and programs in various places in Indonesia.

In general, the above studies can be classified into two groups. The first group is studies that link the high risk population with individual characteristics (perception, conception, and knowledge). Studies employing ethical approaches that attempted to examine the subjective meaning of risk behaviour from the high-risk respondent's point of view are often caught up in this classical explanation model, which associated risk behaviour with the lack of knowledge and values attached to the behavior. The second group is studies that examine structural influence (i.e. social structure of the targeted population) against the behaviour of the group member. Studies under this group suggested that risk behaviour was a product of structural situation. It is evident that the principles of these two study groups opposed each other. The first group put the emphasis on the role of individuals in controlling risk behaviour, while the second group identified risk behaviour as structural product.

A study by Nugroho (2008) explained that there are two main paradigms in the reviews of HIV and AIDS, those with psychobiological and socio-cultural natures. Psychobiological approach tries to link the psychological aspect (knowledge, attitude, and practice) and

biological (the prevalence of infection) with the level of their risk of being transmitted the HIV virus. When the epidemic begins to escalate in a region, it is due to lack of knowledge and attitude on safe behaviour of the population groups. This view adopts a psychological reductionism philosophy which posits that HIV transmission logic follows the logic of individuals' behaviour. Sexual behaviour, as one of the main transmission lines, is placed in a very private sphere that psychological factors are considered more appropriate to describe the action. They tried to identify a motive or pressure experienced by the individual and to develop a theory of how the experienced pressure has been the motive for those practicing risky sexual behaviour. In contrast, sociocultural explanation stated the opposite: the spread of HIV epidemic has its own logic, which is different from the logic of knowledge, attitude and practice of the individuals. In other words, they believe that the mechanism, structure, and collective means outside individuals – tools used by humans to transform themselves – are more appropriate objects of study to explain the difference of one group against another.

The two viewpoints above reflect the core of the debate on agency and structure, which is the question of "whether men are free to choose how to think and act, or whether in fact there are forces beyond themselves that drive their ways of thinking and acting?" Policy implications of each approach will be different. If human beings are free to choose, then the way to ease HIV risk behaviour would be through provision of adequate knowledge and skills for the key populations for them to be able to make their best decisions. The second approach would focus on the variables outside individuals, who are perceived to be able to influence the actions of individuals.

Analysis of the 2004 BSS data by FHI showed an interesting fact: that the power of social capacity also played an important role in reducing HIV risk behaviour. Data shows that knowledge, program intensity, and perception of risk are not in line with the expected safe sexual behaviour. The question that should be asked is not only on the factors underlying this phenomenon, but also what intervention should be addressed to some of the groups who retain the wrong knowledge. Groups who had extensive knowledge experienced intense exposure to the programs, as well as perceived their risks, did not necessary demonstrate such safe behaviours. Despite provision of accurate information, awareness raising and intensive assistance, it seems that the results would be similar. Therefore, breakthrough in the analysis is necessary, i.e. approaches which examine positive behavioural changes and the role of social forces in the process. From sociological perspectives, it can be translated into a question on how to change human behaviour through intervention and addressing factors beyond individuals.

Figure 13 shows the relationship between visits to health facilities and risky behaviour. Higher frequency of visits to clinics for STIs examination (screening) is associated with more reduction in behavior (such as self-treatment by consumption of unprescribed antibiotics). In the fourth visit, respondents quitted their self-treatment for STIs.

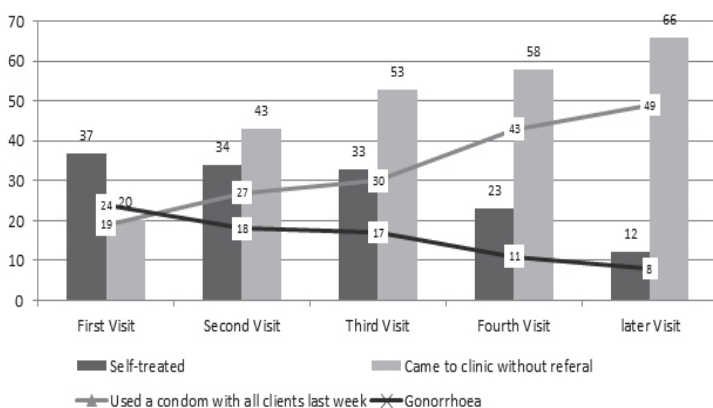
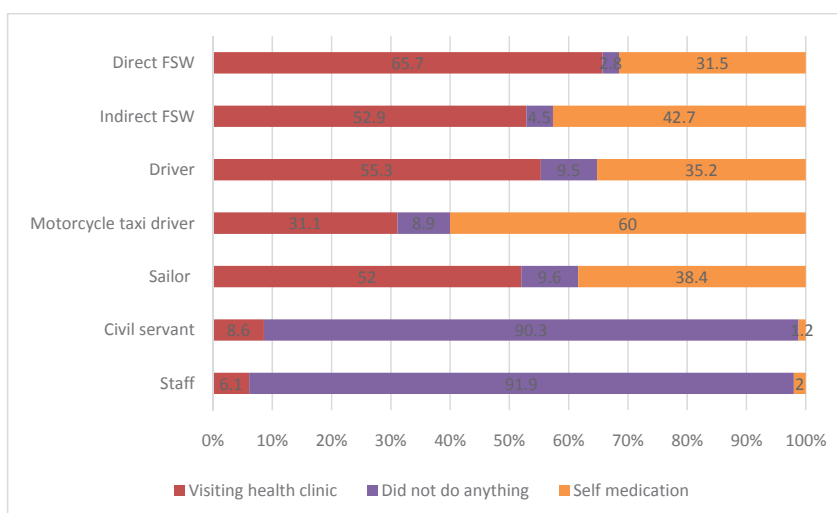


Figure 11 – Frequency of Clinical Visit and Risk Behavioural Change

(Source: Klinik Program FHI/ASA Program Clinic 2004)

Likewise, it only took four visits to double the level of condom use from 19% to 43%, but it took two years with counseling approach to increase the level of condom use by 2% (BSS, 2002 and 2004). The awareness to come to the clinic also significantly improved from only 20% in the first visit to almost three-folds by the fourth visit (58%). One of the risk behaviours associated with the availability of clinics is treatment seeking behaviour. Without proper treatment, STIs are difficult to be cured and people with STIs are at greater risk for catching HIV.

In the BSS, respondents are asked whether they experience any symptoms of STIs. If the answer is yes, respondents are asked whether they visit doctors or health clinics or pursue self medication. The following figure shows the pattern of treatment seeking behaviour among respondents with STI symptoms.



**Figure 12 – Treatment Seeking Pattern of People Experiencing STIs Symptoms**

(Source: Behavioural Survey Surveillance 2004)

It can be implied that health behaviour is closely linked to the availability and accessibility of clinics. However, this raises the questions whether provision of health services should precede intervention to address health seeking behavior, i.e. shall we first increase knowledge and awareness related to health behavior, or shall we provide health facilities first? In sociological language, is the behaviour changed as a result of ideas (knowledge and attitude) or material (the availability of health facilities)? The availability of clinics might increase knowledge and awareness. It is also common to find that the availability of health facilities do not support any behavioural change because they fail to merge into the cultural system of the target groups. The same argument can also be drawn from the correlation between the supply of condoms and the level of condom use. The rate of condom use tends to be higher when education materials and condoms – both are often referred to as prevention materials – are available, in comparison with the respondents who do not have both or only have either one of them available.

### 3.3. Lessons Learned from the HIV and AIDS Program Implementation

In general, there are two main challenges facing health programs in Indonesia. First is the internal challenge within the health sector: the lack of coherence between policy, planning, budgeting, and implementation. Second is the challenge related to other sectors: the weak synergy in the formulation of cross-program activities.

In the context of decentralized governance system, these two challenges are related with challenges faced by the local government. As mandated by the Presidential Decree No.

72/2012 Article 1 paragraph (2), the national health system emphasised that health care is to be implemented by all components of the nation in an integrated and mutually supportive manner in order to ensure the achievement of the best health outcomes. The health system process is taking place on a stratified basis central to the districts by taking into account the local autonomy and functional autonomy in the health sector. The implementation of a decentralized government system is also a particular challenge for districts in providing support to the national health system. The delegation of government affairs from the central to the regions is not simple. Overlaps or absence of delegation of assignment is common, which results in some bottlenecks in health system management. Therefore, to improve the health status of the population, development of innovative approaches in health system is a prerequisite.

Since the implementation of a decentralized government system, a number of provinces have developed some innovative programs in health system. East Kalimantan, Yogyakarta Municipality, and NTT, are the three provinces that have attempted to develop health systems in accordance with local specific characteristics, for example innovation in government regulation; innovation in government financing; Local Health Insurance (*Jaminan Kesehatan Daerah/ Jamkesda*) and the implementation of *contracting out* system; as well as innovation in hospital services through the autonomy of government hospitals as Public Service Agency (*Badan Layanan Umum/ BLU*).<sup>24</sup>

Nonetheless, the challenges of national health system development remain obvious in the context of decentralisation, which is manifested in various cases, for example inconsistent use of indicators. As previously reported,<sup>25</sup> there are symptoms of misaligned planning between central and local governments. Within the scope of planning process, it was realized that it is difficult to shift the mindset of "project oriented" or "budget oriented" to "performance-based budgeting". Another factor is the limited capacity of human resources to support health planning, lack of regular reporting and development of activities aimed at improving the quality of health planning.

In HIV and AIDS control, the fundamental weakness of local governments is overreliance on policy and institutional actions as well as dependence on vertical approaches from the central government. The establishment of KPAD, for example, is the mandate of national policies of the Regulations of Minister of People's Welfare and of Minister of Home Affairs.

Nevertheless, the process of establishment, role and performance of the KPAD vary by districts. The establishment of East Java KPA underwent various processes; however, it essentially followed the central government policy. These included: the establishment of the

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<sup>24</sup> See Laksono Trisnantoro et al. (2009). "Local Health System Innovation, Transformation of Provincial/District, as well as the Role of Consultants and Donors." In Trisnantoro, ed. (2009). Implementation of Health Decentralisation in Indonesia 2000-2007: Examining Experiences and Discussing the Future Scenarios. Yogyakarta: BFFE.

<sup>25</sup> Trisnantoro, ed. Ibid.

Rehabilitation Agency of Juvenile Delinquency (*Badan Penanggulangan Kenakalan Remaja/ Bapenkar*) in 1994; the establishment of the Rehabilitation Agency for Addictive Drugs Abuse and HIV AND AIDS (*Badan Penanggulangan Penyalahgunaan Narkotika, Alkohol, Psikotropika dan Zat Adiktif (Napza) dan HIV AND AIDS / BPNA*) in 2000, which was a partner of the East Java Provincial Bureau of People's Welfare; and finally in 2008, the East Java Provincial KPA was established based on the Regulation of Minister of Home Affairs No. 20/2007 and Presidential Decree No. 75/2006 on National AIDS Commission and Establishment of Provincial and District/Municipality AIDS Commission.

From the institutional point of view, the establishment of KPAD was not followed by the capacity building to implement policies. According to Pritchett et al. (2014), the main problems of development in developing countries are at the implementation stage. "*The problem (often) is not either policy or capacity – it is the organisational capability for implementation.*" Furthermore, Prichett's study showed a unique pattern in the response of developing countries in managing development programs. This pattern refers to a phenomenon called "Isomorphic Mimicry" technique – a technique used by a non-poisonous snake to deceive their predators by mimicking the appearance of other snake species that are poisonous. (i.e. adopting mottled skin). By establishing new entities and institutions, enforcing policies, signing mutual commitments and so forth, policy makers will appear to have delivered a good response towards health problems. These institutions and policies issued by the government are like the mottled skin of a non-poisonous snake described above. Nevertheless, such an attempt is in fact ineffective because it is not followed by adequate institutional capacity in the implementation.<sup>26</sup>

Vertical approaches in HIV and AIDS response created particular challenges for the districts, because there is a huge gap of experience between districts. In East Java, for example, the provincial strategic plan on HIV and AIDS Prevention had been included in the 2009-2014 Local Government Medium Term Development Plan (*Rencana Pembangunan Jangka Menengah Daerah/ RPJMD*). It was also obvious how the response of East Java district/municipality government replicated the national approaches. Similar to the Sentani Agreement developed at the national level, there are several agreements that have been signed at the local level, e.g. the Agreement of Provincial and District/Municipality Governments across East Java on HIV and AIDS response in East Java, signed on 29 June 2004.

In addition to enacting specific local regulations regarding HIV and AIDS, the East Java Provincial Health Office also included issues of HIV and AIDS services and response into the 2009-2014 East Java Provincial Health Strategic Plan (*Rencana Strategis Kesehatan/ Renstrakes*). The strategic plan outlined that in order to improve access and quality of health

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<sup>26</sup> See Pritchett et al. (2012). "Looking Like a State: Techniques of Persistent Failure in State Capability for Implementation." CID Working Paper No. 239, June 2012. Downloaded from [http://www.hks.harvard.edu/var/ezp\\_site/storage/fckeditor/file/239\\_PritchettWoolcockAndrews\\_Looking\\_like\\_a\\_state\\_final.pdf](http://www.hks.harvard.edu/var/ezp_site/storage/fckeditor/file/239_PritchettWoolcockAndrews_Looking_like_a_state_final.pdf)

services for mothers, infants, children, adolescents, and the elderly, as well as reproductive health, several target indicators must be achieved. For example, the provincial target set that at least 25% of districts/ municipalities have delivered MMT/HIV counseling for pregnant women within Antenatal Care (ANC) services. Furthermore, in order to achieve the goal of "Preventing, reducing and controlling communicable and non-communicable diseases and other health problems", the following objectives were set: to reduce the morbidity and mortality of communicable, non-communicable, and other diseases that could be prevented by immunisation and disease surveillance in the context of early warning systems and prevention of outbreaks (*Kejadian Luar Biasa/ KLB*), epidemics and disasters. It was targeted that at least 70% of districts/ municipalities have comprehensive HIV and AIDS services.

Local policies, most of which are supported by the central policy have not been optimally implemented. The impact of these policies has not significantly influenced the intended target groups. The case in South Sulawesi can be an example. The 2010 local Regulation on HIV was still considered ineffective. There was skepticism among the civil society, that with or without the regulation, there would be no significant change in HIV and AIDS response in South Sulawesi. Before the regulation was issued, HIV and AIDS response program had been running and almost met the expectations of civil society. The issue of the regulation only added incremental benefit for the civil society. Instead, the local regulation on HIV cannot be a legal basis for the allocation of special funds for HIV and AIDS response from the Local Budget (*Anggaran Pendapatan dan Belanja Daerah/ APBD*). Provincial KPA was still dependent on block grants, which amount was decided by the Governor. However, according to the Provincial KPA, this regulation could drive the development of HIV and AIDS response and prevention programs at the respective Local Government Component Working Units (*Satuan Kerja Pemerintah Daerah/ SKPD*).

In Bali, the Provincial Health Office as one of the SKPD played a significant role as the leading sector on HIV and AIDS response programs. Table 4 shows that HIV and AIDS prevention programs in Bali Provincial Health Office involved a number of institutions and donors. For example, the Sterile Syringe Service (*Layanan Alat Suntik Steril/ LASS*) program was led by hospital or clinic. However, not all hospitals and Puskesmas provided the service due to limited funding, human resources and materials. Even if the service was available, the IDUs did not necessarily have access to the service due to considerations on convenience and safety. This confirms that cultural factors and social conditions of the beneficiaries should be considered in service provision. Programs and services that are planned using solely top-down approaches are at risk of implementation failure.

Interestingly, the majority of HIV and AIDS programs were initiated by donors. In most of the five areas visited, HIV and AIDS service provision were originally initiated and funded by donors including human resources and capacity building such as training for paramedics. Shortage of funds and lack of trained personnel, high turn over of well-trained personnel

were the major obstacles to a continuing HIV and AIDS service in Puskesmas.

Table 4 – HIV and AIDS Response Programs in Bali Province

<b>Name of Program</b>	<b>Focus of Population</b>	<b>Source of Funding</b>	<b>Unit in Charge/Executing Agency</b>
<b>Sero-survey</b>	<ul style="list-style-type: none"> <li>• High Risk Population</li> </ul>	<ul style="list-style-type: none"> <li>• MoH</li> <li>• Bali Provincial APBD</li> <li>• District/Municipality APBD</li> </ul>	<ul style="list-style-type: none"> <li>• Bali Provincial Health Office</li> <li>• District/Municipality Health Office</li> <li>• Bali Medical Laboratory Center</li> </ul>
<b>Blood Donor Screening</b>	<ul style="list-style-type: none"> <li>• General Public</li> </ul>	<ul style="list-style-type: none"> <li>• APBN</li> <li>• Patients</li> </ul>	<ul style="list-style-type: none"> <li>• District/Municipality Red Cross</li> </ul>
<b>STI Service</b>	<ul style="list-style-type: none"> <li>• FSWs</li> </ul>	<ul style="list-style-type: none"> <li>• Provincial APBD</li> <li>• District APBD</li> <li>• Global Funds</li> </ul>	<ul style="list-style-type: none"> <li>• Puskesmas</li> <li>• Hospital</li> </ul>
<b>VCT Service</b>	<ul style="list-style-type: none"> <li>• Risk Population</li> <li>• General Public</li> </ul>	<ul style="list-style-type: none"> <li>• APBN</li> <li>• APBD</li> <li>• Global Funds</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital</li> <li>• Puskesmas</li> </ul>
<b>CST</b>	<ul style="list-style-type: none"> <li>• PLWHA</li> </ul>	<ul style="list-style-type: none"> <li>• APBN</li> <li>• APBD</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital</li> </ul>
<b>PMTCT</b>	<ul style="list-style-type: none"> <li>• Pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Global Funds</li> <li>• APBD</li> <li>• APBN</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital</li> </ul>
<b>Sterile Syringe Service</b>	<ul style="list-style-type: none"> <li>• IDUs</li> </ul>	<ul style="list-style-type: none"> <li>• Global Funds</li> <li>• APBN</li> <li>• APBD</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital</li> <li>• Puskesmas</li> </ul>
<b>MMT</b>	<ul style="list-style-type: none"> <li>• IDUs</li> </ul>	<ul style="list-style-type: none"> <li>• APBN</li> <li>• APBD</li> <li>• Global Funds</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital</li> <li>• Puskesmas</li> </ul>

Name of Program	Focus of Population	Source of Funding	Unit in Charge/Executing Agency
		<ul style="list-style-type: none"> <li>• HCPI</li> </ul>	
<b>TB-HIV</b>	<ul style="list-style-type: none"> <li>• TB Patients</li> </ul>	<ul style="list-style-type: none"> <li>• APBN</li> <li>• APBD</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital</li> <li>• Puskesmas</li> </ul>
<b>Laboratory development</b>	<ul style="list-style-type: none"> <li>• All population</li> </ul>	<ul style="list-style-type: none"> <li>• APBN</li> <li>• APBD</li> </ul>	<ul style="list-style-type: none"> <li>• Bali Medical Laboratory Center</li> </ul>
<b>Capacity building for health personnel</b>	<ul style="list-style-type: none"> <li>• Health personnel of Puskesmas, hospitals, and laboratories</li> </ul>	<ul style="list-style-type: none"> <li>• Global Funds</li> <li>• APBN</li> <li>• APBD</li> </ul>	<ul style="list-style-type: none"> <li>• MoH</li> <li>• Bali Provincial Health Office</li> <li>• Bali Medical Training Center</li> <li>• Bali Medical Laboratory Center</li> </ul>

(Source: Bali Provincial AIDS Commission, 2013)

The case in Manokwari District can be an example. Puskesmas in Maripi subdistrict is located within a short distance to the brothel complex 55 Maroni. It started to provide STIs examination in 1992. Documentation of data was done manually. Door-to-door outreach services for STI high risk population were conducted. In 2005, an integrated STI examination training was conducted for Maripi Puskesmas funded by GFATM. With GFATM funds, an STI clinic was built within the 55 Maruni brothel complex with the aim of facilitating access to health services especially STI examination for sex workers. Started in 2006, the clinic also supported the "100% condom" program by providing and distributing condoms to sex workers, thus ensuring the availability of condoms in this area. In 2007, GFATM supported Maripi Puskesmas to establish a VCT service in Puskesmas. Five Puskesmas staffs were trained as the VCT Team. VCT service was also made available at the STI clinic at 55 Maruni brothel complex. In 2011, GFATM also supported training program for counselors. One Puskesmas staff was trained as a counselor, however soon after the completion of training, these staffs were relocated. As a result, the VCT service both at Puskesmas and Clinic has been inactive until present.

Another factor that significantly affected HIV and AIDS services is the change in the administrative status of hospitals. One of the consequences of decentralisation in health sector was changes in the status of hospitals into BLUs (*Badan Layanan Umum*/General Service Unit), which amended the hospital management system such as the practice of

procurement services on a contract basis. This new situation did not only affect the provision of general health services but also HIV and AIDS services. Some hospitals were directly assigned by the Minister of Health's decree as referral hospitals for PLWHA and ART services.

In contrast to the other provinces, the Province of South Sulawesi has established Drug and HIV and AIDS Rehabilitation Bureau since 2008. The local health insurance (Jamkesda) in South Sulawesi has officially included services for PLWHA since 1 December 2012. In addition, the Makassar City KPA has been running programs which were developed based on the KPAN strategic direction. The existence of Drugs and HIV AND AIDS Rehabilitation Bureau in South Sulawesi, which became a special institution in the Province, should have made a positive contribution towards control of HIV and AIDS. However, in some domains, the role of this institution might overlap with other programs initiated by the Makassar City KPA. Without coherence and coordination, such overlaps can be counterproductive to HIV and AIDS response programs.

This chapter emphasizes that the integration of HIV and AIDS response into the health system is indispensable at all levels and so is the integration of inter-agency coordination. Horizontal collaboration within or inter- institution needs to be further strengthened. This collaboration should be accomplished with the affirmation of roles and adherence to regulations.

## POLICIES AND PROGRAMS ON HIV AND AIDS RESPONSE

POLICY is a series of decisions made by bearers of responsibilities on particular fields. Policy on HIV and AIDS includes series of decisions and actions that affect the institutions, organisations, the roles of relevant stakeholders, health service systems, and funding related to HIV and AIDS.

This chapter maps the existing policies related to HIV and AIDS response program during the early phase of the response until 2013. The policy map is divided into the main components of HIV and AIDS program as follows: promotion and prevention; care, support and treatment; management of strategic information; human resources, access and logistics; human rights; funding; and impact mitigation.

*The policies on HIV and AIDS response from the early phase of HIV and AIDS epidemic in Indonesia until 2013 ranged from those related to Promotion and Prevention; care, support and treatment; management of resources, access and logistics, rights-based policies; multi-sector governance to funding and impact mitigation. A number of policies developed at the outset were based on the assumption that the establishment of institutions and policies will ensure program sustainability. However, these efforts were mostly initiated by the central government and donor driven. It was also assumed that non-AIDS sectors and the health sector were able to provide comprehensive response. In practice, these assumptions were not entirely true, causing bottlenecks in policy implementation and ultimately leading to gaps in the policy and implementation.*

### 4.1. Policies on Promotion and Prevention

The course of HIV and AIDS epidemic in Indonesia put a demand on the government to issue a policy of prevention as the legal basis and direction for program development. In the beginning, these policies focused on prevention of infection through sexual transmission. The changes in the pattern of HIV and AIDS transmission from sexual transmission to IDU transmission required a contextual, comprehensive, and sustainable policy response.

Comprehensive and continuity HIV and AIDS and STIs services are not a new concept. This concept of service has been initiated by the Ministry of Health since 2004. Based on the lessons learnt during the implementation, a comprehensive and continuity of HIV and AIDS and STIs services was re-launched with a strengthened network, referrals, components of community, with the comprehensive service was centralised at district/municipality level. The development of manual and concept of Comprehensive and continuity of HIV and AIDS and STIs services was supported by the WHO, as well as other partners such as KPAN, NU, IPPA, SUM, and so on. Discussions on the development of guidelines, modules, selection of district/municipality, and division of tasks and functions of each partner were intensified.

This section presents the results of review on policies related to promotion and prevention. In IEC activities, prevention strategies are often referred to as the strategy of Abstinence, Be faithful, Condom, Drug and its Equipment (ABCD). Promotion and prevention policies included communication strategy, prevention through sexual transmission; harm reduction, and prevention of mother-to-child transmission.

### *Communication Strategy*

Communication strategy is an essential element in promotion and prevention programs. Public communication program is included in the eight programs of HIV and AIDS Prevention Strategy for 2007-2010, designed by the KPAN. This is a comprehensive strategy, ranging from communication, information, education, counseling, meetings, fostering family resilience and gender equality through communication and media channels available. It is affirmed that public communication can minimize the degree of vulnerability of vulnerable groups.

In particular, the KPAN has also launched the Plan of Communication Strategy for HIV and AIDS Response in Indonesia in 2008 with the support of HCPI/AusAID.<sup>27</sup> This manual outlined that communication has a fundamental role that must be performed to achieve the goals of the National Strategy. Strategic communication consists of three essential components: advocacy, social mobilisation and behavioural change communication

The component that has been widely used and strategically applied is Behavioural Change Communication (BCC). BCC has been pioneered by FHI (Family Health International) in the previous years. In 2002, with support from USAID, FHI released the BCC framework for HIV and AIDS as part of the implementation of AIDS prevention programs and treatment (Implementing AIDS Prevention and Care – IMPACT).<sup>28</sup> Within this framework, communication is an important part of a comprehensive program that includes both services (medical, social, psychological, and spiritual) and equipment (such as condoms and syringes). For individuals and communities to reduce the level of risk or change behaviours, they need to understand the basic facts about HIV and AIDS, perform key behaviours, learn a set of abilities, and given sufficient access for products and services on HIV and AIDS response.

The KPAN has the full support – including a sizeable funding – in the implementation of public communication from FHI-USAID and HCPI-AusAID as an international partner of KPAN. One of the products of the communication strategy program initiated by the FHI-USAID in 2006 was a public service advertisement. The public service advertisement with the icon of Harry Roesli were shown on several television channels conveying the messages

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<sup>27</sup> Neill McKee, Fonny J. Silfanus, KPAN (2008). *Communication Strategy for HIV and AIDS Response in Indonesia*. Jakarta: KPAN.

<sup>28</sup> FHI dan Institute for HIV AND AIDS (2002). *“Behavior Change Communication: A Strategic Framework.”* Virginia, USA: FHI dan USAID.

of "Check IMS" and "Use Condoms or Get Hit!", and closed with a cameo figures of five religion leaders in Indonesia with a message of Abstinence and Be Faithful. In FHI report to USAID, public service advertisement is considered as able to shake the public in a positive way and with a minimum contestation – a negative reaction only came from the Islamic Defenders Front (*Front Pembela Islam/ FPI*).

Around 2007-2008, FHI implemented a social marketing of condoms through the media entertainment (edutainment) in areas where high risk men are around, such as ports. At the same time they also offered HIV testing and counseling, and free STIs checks. Results of evaluation of this activity have not been discovered by the present study, but interviews with the program manager revealed that this strategy was quite successful in a number of places when it got the attention of local government such as the Banyuwangi District in East Java Province. The condoms social marketing activity that was quite noticeable was the National Condom Week. Commemorating the World's AIDS Day in December 2013, the KPAN supported by a condom manufacturer launched the National Condom Week on 1-7 December 2013. This event was intended to "pick up the ball" (actively come to and invite the population) at the population to reach the target of behavioural change campaign i.e. to use condoms. Mobile campaign and condom distribution was conducted using vans circulating in major public spots such as malls, university campuses, etc in big cities such as Jakarta, Bandung and Yogyakarta. However, this activity received negative responses from various community groups, particularly religious organisations, as well as universities.

Although communication strategy was not assigned a specific role in the 2010-2014 NATIONAL STRATEGIC ACTION PLAN for HIV and AIDS Response, the HCPI-AusAID provided funding to support a communication strategy program for Papua (procurement of IEC materials) and the MSM groups (development of websites). The FHI-USAID also provided training on communication strategy, although there has been no tangible result at the time of the study. The FHI-USAID as the pioneer of this approach disbursed a sizeable funding, including salaries for 5-10 outreach workers of each of the local partner agencies. In the meantime, HCPI focused on harm reduction interventions by empowering community cadres. The role of outreach workers was similar to that of community cadres, i.e. to deliver messages and means of prevention to key population groups. Outreach workers were entitled to facilities such as salaries, transportation allowance, and continuing training. They were also given opportunities for developing innovation. Meanwhile, community cadres conducted their activities on a voluntary basis.

Since 2010, USAID tried to improve the efficiency of aid disbursement in all sectors, including HIV and AIDS response, by reducing the amount and scope of USAID's work. The GFATM fund which was initiated a year later did not provide the same entitlement and facilities as USAID, thus affecting the quality of the overall outreach activities. Without financial incentives, workers were demotivated to perform outreach activities, particularly to targeted key population groups.

HCPI continued the communication strategy and launched “*through the line*” approach by merging the “*above the line*” (through mass media) and “*below the line*” (non mass media) in Papua region. The message was consistently delivered through various media (TV, radio, flyers and posters) to change public perception. The selected role model was a national football player from Papua. The present study, however, did not find a detailed evaluation of the strategy, including whether or not the ownership of Papuan government was developed. However, based on several interviews with a number of stakeholders who were directly involved in the activity, it was revealed that communication strategy outputs resulted from HCPI program may stimulate others. The KPAN was expected to be able to provide assistance to the Papuan government to implement this communication strategy as the local government did not allocate a specific fund for this program.

In addition to public service advertisement and social marketing of condoms, communication strategy was also pursued by capacity building activities for journalists. The capacity building activities aimed to improve knowledge and exploration skills among journalists in HIV and AIDS issue and the relationship with other issues. Both FHI and HCPI provided support for this activity in collaboration with a number of journalist association (AJI and the Press Council). The activities included training on media coverage on HIV and AIDS issues and writing contest. The frequency of this activity was irregular. FHI terminated this activity in 2005, while the support of HCPI was terminated in 2012. This activity was challenged by the high frequency of changes in the topics covered by journalists, high turnover of journalists, and the fact that decision makers of news selection were the news editor instead of journalists.

In general, from the review of communication strategy policies, several conclusions can be drawn. HIV and AIDS campaigns did not always lead to conflicts. It depends on the selection of the messenger (character/ profession respected by society, such as folk artists and doctors), the content of the message (i.e. should not be vulgar but clear), the media and show times. Criticisms towards public service advertisement and social marketing of condoms can instead be used for the benefit of HIV and AIDS response. When the controversy on social marketing of HIV and AIDS was put on the mass media spotlight, it would draw the interest of audience to find out more about HIV and AIDS. Public controversy can be converted as free advertisement that could influence public and stakeholders and gather wider support for HIV and AIDS response.

The quality of public service advertisement, however, needed to be improved. Such an improvement certainly required a substantial amount of funding. Because similar to commercial advertisement, the production and publication of public service advertisement also required research, trials, and management by advertising agencies.

Decentralisation also influenced the implementation of communication strategies. In decentralisation, funding did not come only from the central level but also from a co-sharing mechanism with provincial and district/ municipality levels. Certain adjustments between

the central and local governments in developing communication strategy programs were made by taking into account the capacity of local government.

#### *Prevention in IDUs (Harm Reduction)*

Prevention in IDUs was delivered through the Harm Reduction program. One of the important elements which was of concern in the context of this program was addictive drugs. The implementation of this program in Indonesia experienced a long process involving many parties. The involvement of International Development Partners (AusAID, USAID, and GFATM), NGOs, addicts' organisations and the general public has pushed the government to issue a policy on drugs harm reduction.

Until late 1990s, Harm Reduction has been recognized by the government as one of the effective prevention methods, but it was not yet approved. The distribution of sterile syringes to IDU population was conducted by the Provincial / District Health Offices (through Puskesmas), NGOs and international agencies. This program was carried out without any legal basis. The harm reduction program was just legally acknowledged as per the enactment of the Minister of Health Decree No. 996/Menkes/SK/VIII/ 2002 on the Implementation Manual of Service Facility for Rehabilitation of Addictive Drugs Abuse and Addiction. The KPAN advocated the law enforcement authorities to minimize the friction between the principles of Harm Reduction and Abstinence. The advocacy resulted in a Memorandum of Understanding between the KPAN and BNN in 2003 led by the Minister of People's Welfare as the Chairman of the KPAN, which was endorsed in the Joint Decree of the Minister of People's Welfare No. 20.KEP/MENKO/KESRA/XII/2003 and the Chief of National Police Force No. B/01/XII/2003/BNN on the Establishment of National Team for Integrated Measures for HIV and AIDS Prevention, Transmission, and Countermeasure of Exploitation of Intravenous Addictive Drugs.

After the national team was established, some local agencies as the pioneers of Harm Reduction program such as Puskesmas under the auspices of DKI Jakarta Provincial Health Office and international organisations such as FHI-USAID and IHPCP-AusAID started to distribute syringes to IDU population. Many outreach workers (non health workers) were arrested for carrying sterile or used syringes, but were rarely processed further if they were not proven for drug consumption. Based on the Health Act No. 29/2004, sterile syringes are medical devices that can only be dispensed by health workers. Therefore, the role of Puskesmas in syringe distribution was considered important as it did not conflict with their main tasks and function. Puskesmas has also coverage of services to village level. However, Puskesmas staffs often had limited mobility.

In 2006, it was reported that the spread of HIV and AIDS through IDU transmission had reached 46% of the total HIV and AIDS cases in Indonesia. The Decree of Minister of Health No. 567/2006 concerning the Manual of Implementation of Addictive Drugs Harm Reduction was subsequently issued. In some places, Puskesmas and NGOs had built very close

collaboration that outreach workers were assigned responsibilities to actively distribute syringes to IDUs.

Some regulations which were enacted as a policy framework for Harm Reduction were as follows:

1. Decree of Minister of Health No. 494/Menkes/SK/VII/2006 on the Stipulation of Pilot Hospitals and Satellites for MMT Service.
2. Regulation of Minister of People’s Welfare No. 2/2007 on National Policy on HIV and AIDS Response through Intravenous Addictive Drugs Harm Reduction.
3. Minister of Health Decree No. 486/Menkes/SKIV/2007 on Policies and Strategic Plan on Prevention of Drugs Abuse.
4. Minister of Health Decree No. 420/Menkes/SK/III/2010 on Manual for Hospital-based Therapy and Comprehensive Rehabilitation Services of Drugs Use Disorders
5. Minister of Health Decree No. 421/Menkes/SK/III/2010 on Service Standards for Therapy and Rehabilitation Services of Drugs Use Disorders.
6. Minister of Health Decree No. 350/Menkes/SK/IV on Assignment of Supporting and Satellite Hospitals for MMT and Manual of MMT.
7. Minister of Health Decree No. 378/Menkes/SK/IV/2008 on Manual of Medical Rehabilitation Service in Hospitals
8. Decree of Minister of Health No. 567/Menkes/SK/VII/ on Manual of Implementation of Addictive Drugs Harm Reduction.
9. Circular Letter of Head of Jakarta Provincial/District No. 3884/1778/2009 on Funding for Local Puskesmas for Harm Reduction Program.

In practice, HIV and AIDS prevention programs through harm reduction experienced a lot of changes, including the alignment of policies and barriers in the implementation of the Harm Reduction program. Table 5 presents the achievements of the program based on the targets of 2007 NATIONAL STRATEGIC ACTION PLAN for HIV and AIDS Response.

Table 5 –Achievement of 2008 Target

Type of Service	Total Achievement, % of 2008 Target
<b>LASS (injection)</b>	67 %
<b>MMT (methadone)</b>	12%
<b>HIV Counseling &amp; Testing</b>	18%-41%% of 2008 target
<b>Outreach</b>	69%

Source : HIV and AIDS National Strategic and Action Plan, 2010

The 2011 IBBS data showed a decrease in HIV prevalence among IDUs in comparison with the 2007 IBBS in several districts/municipalities. One of the factors was the duration of being IDUs. The prevalence of HIV among persons who had been IDUs for two years was higher than those who had been IDUs for less than two years. In addition, the proportion of IDUs who shared used needles in the previous week also declined. The majority of IDUs were sexually active either with regular partners, casual partners, FSWs, or clients. Unprotected sex among IDUs was also high. The 2011 IBBS showed that IDUs in several municipalities reported inconsistent condom use with FSWs in the previous year. A study conducted by Atma Jaya Catholic University in 2009 showed that the proportion of IDUs who did not use condoms with their regular partners remained higher than those with casual and commercial partners over the last month.

The proportion of IDUs who used condoms with commercial partners during their last sex was higher than those with casual and regular partners. This implies that partners remained vulnerable to HIV because of low consistency of condom use. There was a need to pay attention to the prevention of IDUs sexual transmission and their sexual networks. The proportion of condom use among IDUs is shown in Figure 15.

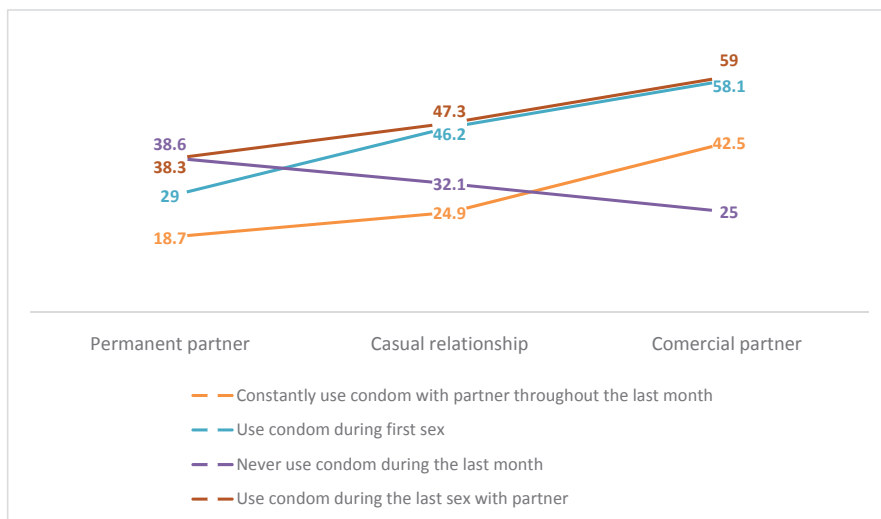


Figure 13 – Use of Condoms by Injection Drug User by Type of Partner

(Source: LPPM Unika Atma Jaya, 2009)

HIV and AIDS prevention among IDUs aim to encourage them to adopt safe behaviours. One of the high risk behaviours that transmit HIV is the share of used needles. The 2004, 2007, and 2011 IBBS showed that the rate of sharing of used needles tended to decline. Improving

behavior in needle use can reduce the risk of acquiring or transmitting HIV through needles. These findings demonstrated the success of harm reduction programs among IDUs. The proportion of IDUs who shared used needles in the previous week by districts/municipalities, is detailed in Figure 16.

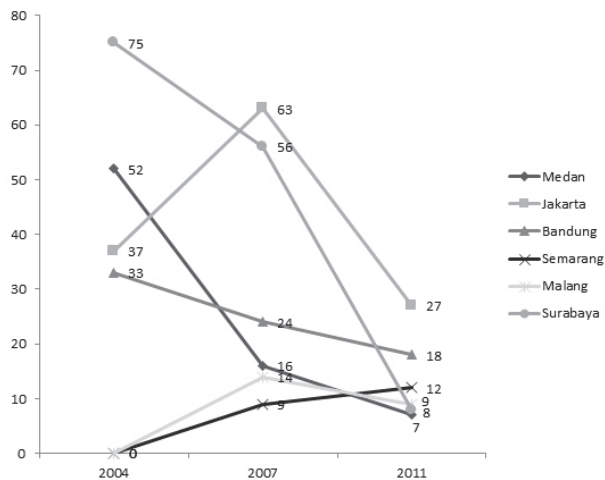


Figure 14 – Proportion of People Who Shared Used Needles in the Previous Week by Municipality in 2004, 2007, 2011

(Source: STBP 2004, 2007, 2011)

### Prevention of Sexual Transmission (PMTS)

The core activities of Prevention of Sexual Transmission targeted 80% of key populations reached by effective program and 60% of key populations adopt healthy behaviours and use condoms on every at risk sex intercourse. The main objective was to reduce the prevalence of STIs by using condoms consistently and treatment of STIs.

One factor that exacerbated HIV transmission was antibiotic resistance used in the treatment of STIs. The Sub-Directorate of AIDS at the Ministry of Health in collaboration with FHI/USAID conducted a series of studies to determine the effectiveness of HIV prevention through standardised, regular examination of STIs for at risk sexual partners, the use of new antibiotic for STI treatment, as well as standardised diagnostics. Diagnosis and treatment using simple laboratory tests were outlined in the Decree of Minister of Health No. 1285/Menkes/SK/X/2002 on the Manual of Response to HIV AND AIDS and STDs, and then updated with the enactment of the Decree o Minister of Health No. 21/2013 on HIV and AIDS Response.

In the period of 2007 to 2010, interventions against STIs in prostitution sites were targeted at the community and not the individual sex workers. Since 2006, Indonesia adopted a 100% Condom Use Program (*Program Penggunaan Kondom/ PPK 100%*), which tried to replicate a

similar model in Thailand. Supported by WHO and various partners, this approach was vigorously developed in Indonesia. FHI was the major international partner highly interested in conducting a pilot intervention to achieve 100% Condom Use. In 2008, based on the experience in other locations, FHI formulated four pillars as prerequisites for the success of interventions as follows: 1) community mobilisation and strengthening of stakeholder's capacity; 2) behavioural change interventions; 3) availability and management of condoms; and 4) STI and HIV services. The KPAN took the initiative to scale up this approach to 72 locations in 15 provinces, and subsequently expanded to 137 locations by 2015.

Indonesia provided Voluntary HIV Counseling and Testing or since 2005 in accordance with the Decree of Minister of Health No. 1507/Menkes/SK/X/2005 on Manual of HIV AND AIDS Voluntary Counseling and Testing Service. VCT is voluntary and confidential. However, the lack of knowledge and stigma in the society made VCT less desirable, especially if individuals were still at asymptomatic stage. With VCT mechanism, health service providers such as hospitals, Puskesmas and medical personnel tended to be passive. This was because VCT only encourage people to get examined and take the test on a voluntary basis. Consequently, the number of HIV cases found through VCT was low

In 2011, the *Provider-initiated HIV Testing and Counseling* (PICT) program were developed to boost the early detection of HIV. One of the initiator of PICT program, Prof. Zubairi Djoerban, compared studies in Los Angeles on VCT and a study on PICT in Oakland. He found that PICT provided more benefits than VCT. For example, VCT can only reach 1,500 patients, while PICT can reach up to 31,000 patients. Routine tests can identify HIV-positive four times as non-routine test, and the prevalence is consistent. With the low coverage of VCT, the Ministry of Health established PICT as the mechanism of test for conducted by health workers. PICT was widely implemented in 2011.

During 2008-2013, a comprehensive HIV control was conducted at the sub-district level under the coordination of Puskesmas. The formulation of comprehensive framework was initiated by FHI/USAID for 2008-2010 programs and was replicated by the KPAN using GFATM funds for 2010-2015 programs. The framework was subsequently adopted by the Comprehensive and continuity HIV and AIDS and STIs services or LKB concept as formulated in the Decree of Minister of Health No. 21/2013 on HIV and AIDS Response. LKB includes all forms of HIV and STIs services, e.g. comprehensive IEC knowledge; promotion of condom use; control/introduction of risk factors; HIV Counseling and Testing; Care, Support and Treatment (CST); Prevention of Mother to Child Transmission (PMTCT); Harm Reduction; STIs services; prevention of transmission through blood donors and other blood products; monitoring and evaluation activities as well as epidemiological surveillance at referral and non-referral Puskesmas including other health facilities, and referral district/municipality hospitals, with active involvement of the public sector.

However, the prevention of sexual transmission program has not shown encouraging results

despite an increasing trend. The main issue in preventing sexual transmission is on the consistency of condom use, although the use of condom during the last sexual intercourse tended to increase as shown in Figure 17. However, the consistency of condom use by FSWs, both FSWs providing direct or indirect services was quite low.

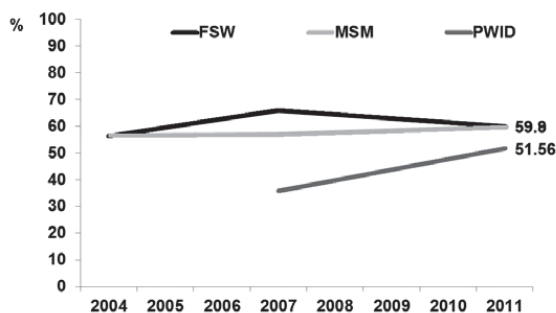


Figure 15 – Use of Condoms by FSW, MSM and PWID, 2004-2011

(Source: Country Report on the Follow up to the Declaration of Commitment on HIV AND AIDS (UNGASS): Reporting Period 2010–2011.)

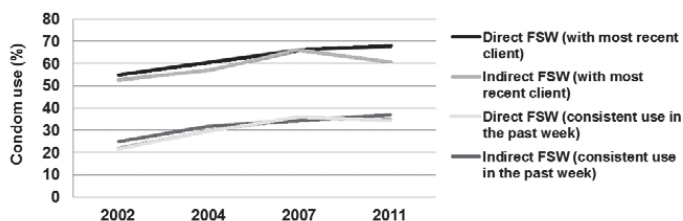


Figure 16 – Use of Condoms by Female Sex Workers, 2002-2011

Only less than 10% of high-risk populations can be reached by the existing prevention programs. Moreover, very few high risk populations had accessed the VCT program, i.e. 18.1% of IDUs; 14.8% of sex workers; and 3.3% of FSWs clients

The following are government policies related to health system management that are indirectly linked to HIV services yet should be considered in the perspective of integration of HIV into the health system this needs to be considered.

1. Law No. 29/2004 on Medical Practice
2. Law No. 36/2009 on Health
3. Law No. 44/2009 on Hospitals
4. Government Regulation No. 7/2011 on Blood Services
5. Regulation of Minister of Health No. 1144/Menkes/Per/VIII/2010 on Organisation and Administration of the Ministry of Health
6. Regulation of Minister of Health No. 001/2012 on Referral System for Individual Health Services

### *Prevention of Mother to Child Transmission (PMTCT)*

In October 2005, the Ministry of Health set up a mid-term work plan on care, support and treatment for PLWHA, as well as the prevention of HIV and AIDS. The mid term workplan was contained in the Regulation of Minister of Health No. 1508/Menkes/SK/X/2005 and aimed to support the 2005-2009 National HIV and AIDS Response Plan. Policies related to PMTCT were as follows:

- Government Regulation No. 33/2012 on Exclusive Breastfeeding
- Regulation of Minister of Health No. 128/2004 on Puskesmas Basic Policies
- Regulation of Minister of Health No. 411/Menkes/Per/III/2010 on Clinical Laboratory
- Regulation of Minister of Health No. 782/Menkes/SK/IV/2011 on Referral Hospitals for PLWHA
- Regulation of Minister of Health No. 1907/Menkes/Per/VI/2011 on Technical Guidelines for Jamkesmas Primary Health Services

In addition, there was a Circulated Letter of Minister of Health No. GK/Menkes/001/1/2013 on Services for Prevention of HIV Transmission from Mother to Child (PMTCT). This letter was addressed to the Heads of Provincial Health Office, Heads of District/Municipality Health Offices, and Heads of Hospitals across Indonesia. The letter elaborated the scope of PMTCT as follows:

- All pregnant women should receive antenatal care;
- Mandatory HIV testing should be offered to all pregnant women in areas with generalized and concentrated epidemics;
- HIV testing should be offered to pregnant women with STIs and TB in the low epidemic areas;
- HIV testing in pregnant women should be delivered in conjunction with other routine laboratory tests;
- Health facilities are required to implement promotion, prevention, inspection; and
- Treatment should be delivered in accordance with the guideline.

### **4.2. Policy on Care, Support, and Treatment (CST)**

At first, the majority of HIV and AIDS programs in Indonesia was referred to various programs that implemented in various countries and guidelines issued by WHO. The terminology used also referred to the WHO terminology, such as care, support and treatment (CST). In 2010-2014 NATIONAL STRATEGIC ACTION PLAN for HIV and AIDS, CST was referred to as *Perawatan, Dukungan dan Pengobatan* (PDP) or treatment, support and medication. The objective of the PDP program was to strengthen and develop the health services as well as establish coordination between services. The PDP program aimed to achieve several targets as follows 1) The availability of quality health services; 2) 100% of PLWHA who need prevention and treatment of OIs can access health services as needed; 3)

ARV is provided to HIV-infected people in need, in accordance with WHO standards for better quality of life; 4) Development of community care to provide psychological and social supports; and 5) Improving the capacity of PLWHA through education and trainings.

Reports from relevant agencies were reviewed in the present study. Report on HIV situation of HIV and AIDS in Indonesia in 2013 from the Directorate General of Disease Control and Environmental Sanitation showed the following results:

- The number of reported HIV infections by heterosexual risk factors tend to increase in 2010-2013;
- The percentage of reported AIDS by risks from 1987 to September 2013 was 60.9% in heterosexuals and 17.4% in IDUs;
- The majority of reported AIDS by risk factors in July-September 2013 was heterosexuals (81.9%).

The report indicated that the transmission of HIV and AIDS through sexual intercourse is still high, despite the implementation of many programs.

In recent years, the PDP programs have shown signs of progress. The number of hospitals, Puskesmas and clinical services increased rapidly in line with the increasing case finding. A number of policies have been formulated to improve service provision. Most policies related to PDP were issued by the Ministry of Health, as well as ministries and technical agencies that were members of the KPAN. Policies of the Ministry of Health are issued as Laws, Regulations, Decrees, Circular Letters and Ministerial Instruction. At the local level, regulations were issued as Decrees of the Head of Provincial and District/Municipality Health Offices. In the 2010-2014 NATIONAL STRATEGIC ACTION PLAN for HIV and AIDS, it was mentioned that VCT, STIs, CST, PMTCT, Sterile Syringe Service, MMT and condom outlets are important components of services. There were two main components of the PDP program for PLWHA, i.e. ARV, outreach and mentoring services as following.

#### *Antiretroviral Therapy (ART)*

##### Policy Summary

**2004-2007:** Increase in the quantity and distribution of ARV services, as well as the standardisation of diagnostic services and tests.

**2010-2011:** Revision of the national manual on ARV therapy to adjust with the global strategy that ARV is not a measure of "HIV treatment" but a "medicine for HIV prevention".

The policy on ARV provision in hospitals was initially issued in 2006. It was triggered by the overwhelming increase in the number of advanced cases found by the Special Study Group at RS Dr. Cipto Mangunkusumo and Dr. Soetomo Hospitals. They subsequently initiated the advocacy of provision of ARVs in hospitals. As a result, in 2006 the Decree of Minister of

Health No. 832/Menkes/SK/X/2006 on Stipulation of Referral Hospitals for PLWHA and Standards of Referral Hospitals and Satellites for PLWHA (25 hospitals) was issued. The number of hospitals increased to 75 in 2007 and 278 in 2011 across Indonesia through the Decree of Minister of Health No. 760/Menkes/SK/VI/2007 on Stipulation of Referral Hospitals for PLWHA and the Decree of Minister of Health No. 782/Menkes/SK/IV/2011 on Referral Hospital for PLWHA, respectively. Treatment of Opportunistic Infections is also important to start after the initiation of therapy. It is regulated through the Decree of Minister of Health No. 241/Menkes/SK/IV/2006 on the Service Standards of Medical Laboratory for Examinations of HIV and Opportunistic Infections.

The 2010-2014 NATIONAL STRATEGIC ACTION PLAN for HIV and AIDS Response determined the target of providing comprehensive service for all eligible PLWHA. Within the spectrum of comprehensive services, HIV positive individuals are entitled to ARVs, treatment, care and a humane, professional and non-discrimination support, and supported by a referral system and adequate supervision and surveillance. The eligibility criteria of PLWHA to receive ARVs were adapted to the global strategy, in line with the 2010 WHO guidelines on Antiretroviral Therapy for HIV Infection in Adults and Adolescents in Resource-limited Settings: Towards Universal Access Recommendations for a Public Health. This document was an update of control strategy.

The main difference in ARV provision according to the latest guidelines is that ARVs are given to PLWHA with CD4 test results of less than 350 cells/cubic mm. In addition, pregnant PLWHA with co-infections of TB and Hepatitis B are given ARVs regardless of CD4 count. The latest guidelines also provided recommendation of ARV therapy regimens. TDF is used as a first-line, followed by the initiation of D4T phase out and initiation of AZT or TDF therapy given the side effects of D4T. The therapy regimen for Indonesia has been determined through the Regulation of Minister of Health No. 21/2013 on HIV and AIDS Control. One of the anticipated effects of this policy was the drastic increase in the number of ARV patients. Therefore, there should be improvement of logistical management and distribution of ARV from the national to the sub-national level. In 2012, the government issued the Presidential Decree No. 76/2012 on Implementation of Patent by the Government of Antiviral and Antiretroviral Drugs, which essentially set the "government's right to use" – a type of mandatory license that exempt the government from the patent restrictions. This step was taken in order to produce seven types of generic drugs that are very important in the treatment of HIV and Hepatitis B.

In the period of 2004-2011, collaboration between TB-HIV was implemented through the Decree of Minister of Health No. 1990/Menkes/SK/X/2004 on Provision of Free AntiTuberculosis Drugs (*Obat Anti Tuberkulosis/ OAT*) and Antiretroviral (ARV) Drugs for HIV and AIDS. This collaboration has been endorsed by the Decree of Minister of Health No. 1990/Menkes/SK/X/2004 on Provision of Free AntiTuberculosis Drugs (*Obat Anti Tuberkulosis/ OAT*) and Antiretroviral (ARV) Drugs for HIV and AIDS.

It is evident that the Ministry of Health has been actively producing regulations with the goal of improving outcomes and quality of HIV and AIDS services. Other policies that have been issued included the Decree of Minister of Health No. 1508/Menkes/SK/X/ 2005 on Long-Term Work Plan on Care, Support and Treatment for PLWHA and 2005-2009 Prevention of HIV and AIDS. The Ministry of Health has issued the 2005-2009 Strategic Plan, followed by the 2010-2014 Strategic Plan. The 2015-2019 Strategic Plan is underway. The most recent Ministry of Health's policy related to HIV and AIDS is a Circular Letter of Minister of Health No. 129/2013, which stipulated the implementation of HIV AND AIDS and STI response to achieve the sixth Millennium Development Goals.

ART program is in fact part of a broader response to HIV and AIDS. The availability of ART program complemented the existing programs and programs which were subsequently developed as outlined in the National Strategy and NATIONAL STRATEGIC ACTION PLAN for HIV and AIDS. ART program supports the prevention strategies by encouraging people with high-risk behaviours to take advantage of counseling and testing services. The ART program has been included in the framework of comprehensive services covering care, support and treatment of PLWHA. The national health systems and basic health services should be strengthened to ensure effective care and treatment of HIV and AIDS. This service is integrated into the health services at district/municipality, provincial as well as national level.

The implementation of ART had a minimal impact towards funding for priority health program that are equally important. Investment in this program should be allocated to strengthen health systems, including capacity building of human resources, procurement of equipment, and organisation of monitoring, procurement and health system management.

Table 6 demonstrates the increase in number of facilities providing VCT, CST, STI, HIV and TB-HIV from year to year.

**Table 6 – Actively Reporting HIV and AIDS Service Facilities, 2011–2013**

Type of Service	Total; by Year					
	2011		2012		Up to September 2013	
VCT	500		503		889	
CST	303	235 Referral Hospitals  68 Satellites	338	239 Referral Hospitals  89 Satellites	380	266 Referral Hospitals  114 Satellites

STIs	643				370	
PMTCT	90				113	
TB-HIV	223				223	

(Source: Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia, 2013)

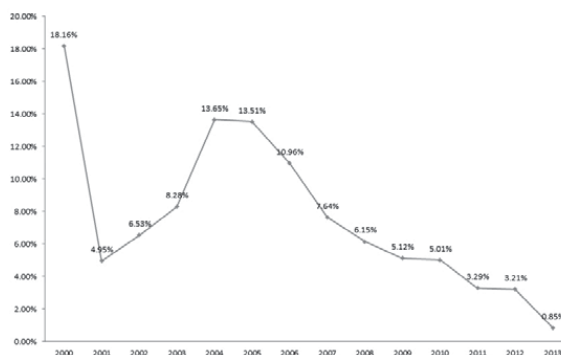


Figure 17 – Case Fatality Rate of Reported AIDS by Year, 2000– September 2013

(Source: Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia, 2013)

The number of PLWHA receiving ARV treatment until September 2013 was 36,483 people. A total of 35,178 persons (96.42%) received the first line of ARV for adults and 3.19% (1,163 people) received the 2<sup>nd</sup> line, while 1.27% was unknown. This figure was higher than in 2013 –there were 31,002 PLWHA receiving ARV treatment, i.e. 96% adults and 4% children. Another indicator of ART success is the mortality rate of PLWHA. Although there is a fluctuation in Case Fatality Rate (CFR), the trend of CFR was declining since 2000 to September 2013. In 2004 and 2005, CFR was higher than it was in 2001, 2002 and 2003. In 2005 the distribution of ARV was still centralized, and only since 2011 that the distribution was decentralized to provinces.

Since 2005, the procurement of ARVs has been under the oversight of the Directorate General of Pharmacy. Funding for ARV procurement comes from two major sources i.e. the Global Fund and the State Budget (*Anggaran Pendapatan dan Belanja Negara/ APBN*). In 2010, 70% of funds for came from the State Budget and 30% from GFATM. The annual budget planning was integrated with the annual budgeting process of the Ministry of Health. ARV is distributed directly to health facilities on a request basis. This centralisation of ARV distribution is implemented to facilitate the monitoring of use and availability of drugs at facility level. Given the disease characteristics which require the consumption of specific ARV drugs, ARV should be taken in a timely manner and for a lifetime. However, centralised distribution was often a problem due to the long chain of distribution resulting

in delays and out-of-stock of supplies. In 2011, the distribution was delegated to the districts in order to facilitate and simplify the distribution system. In addition, local stakeholders, such as Local KPADs, Provincial/District Health Offices, civil society organisations and PLWHA can monitor the procurement and distribution.

#### *Outreach and mentoring*

It is important to note that outreach and mentoring programs are still poorly available in Indonesia. Low coverage of outreach and mentoring can lower the quality of program. Since the first AIDS case in Indonesia was reported in Bali in 1987, the increase in case finding was a result from advocacy and outreach activities by the civil society groups. For example in Bali, outreach and advocacy activities were initiated by Yayasan Kerthi Praja for FSWs and Yayasan Citra Indonesia Usadha for homosexuals. Furthermore, Yayasan Hati-Hati began to reach the group of IDUs. These activities were replicated by other organisations in other provinces in Indonesia. It was widely recognized that NGOs initiatives were driven by people with mutual interests and were supported by donors. The first line of NGO programs was outreach and mentoring services. As a result, those who were vulnerable to HIV were increasingly exposed to information and started to access services.

In line with the development of programs, there were always pros and cons from various parties towards outreach and mentoring. Outreach and mentoring programs are in fact the first point of entry into prevention and treatment. At present, however, the outreach and mentoring programs are scrutinized to distribution of IEC materials, distribution of preventive measures, and referrals to health services. Fieldwork activities are coordinated by a Community Organizer. IEC program through public counseling and edutainment is the preferable method. Such activity often takes place at certain times, such as in December prior to the World's AIDS Day. Stigma and discrimination remain common issue facing high-risk groups in their daily activities. Stigma and discrimination prevented them from accessing health services. This is where the crucial role of outreach and mentoring programs should take place. However, the current programs focused more on public counseling and programs which are infrequently conducted and sometimes ineffective. HIV and AIDS response in Indonesia seemed to be heavily focused on coordination activities, formulation of regulation, and meetings, while the community empowerment activities and tangible programs are limited.

### **4.3. Policy on Management of Strategic Information**

There are several sources of information related to HIV and AIDS in Indonesia, e.g. case reports, sentinel surveys, surveillances, BSS, IBBS, Indonesia Demographic and Health Survey (IDHS), estimation, modeling, and results of research including operational research. Some resources of information were supported by policies, including others:

- Decree of Minister of Health No. 1116/Menkes/SK/VIII/2003 on Manual of Implementation of Epidemiology Surveillance System.
- Decree of Minister of Health No.1479/Menkes/SK/X/2003 on Manual of Implementation of Surveillance Systems for Epidemiology of Integrated Communicable and Non-Communicable Diseases.
- Decree of Minister of Health No. 1508/Menkes/SK/X/ 2005 on Intermediate Work Plan on Care, Support and Treatment for PLWHA and 2005-2009 HIV and AIDS Prevention.

The Ministry of Health outlined the strategic information on treatment PLWHA and ART, as seen in the following text box:

<p><b>Developing an Integrated Information System on PLWHA Treatment and ART</b></p> <p><b>Expected outcomes:</b></p> <p>The availability of information system on treatment for PLWHA for the use of monitoring and evaluation that is integrated with the information management system.</p> <p><b>Activities:</b></p> <ul style="list-style-type: none"> <li>• To develop National AIDS Registry model.</li> <li>• To establish a medical record database system at the level of service provider institutions</li> <li>• To establish information database system that is related with services, care and support and treatment (manuals, policies, planning, etc.)</li> <li>• To define the structure of reporting system for HIV AND AIDS cases and the use of drugs for each level of institution with guaranteed confidentiality.</li> <li>• To update the existing and accessible national information system.</li> <li>• To develop monthly reporting system.</li> <li>• To develop the reporting system on cohort analysis of six monthly and annual PLWHA treatment and ART.</li> <li>• To distribute results of regular report for planning and decision making.</li> </ul>
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Source: Ministry of Health of Republic of Indonesia, 2005

Ideally, strategic information system should be able to provide a variety of data and information that can be accessed and used to design policies to evaluate programs. Prior to 1996, information about HIV and AIDS was limited to case reports from hospitals. In 1996, IBBS was conducted on FSWs, factory workers, and high-risk men (sailors and truck drivers) in Jakarta, Surabaya and Manado. Sentinel surveys were also compiled from several surveys in the provinces, however, data comparison over time was not possible. Moreover, there were many provinces that did not report regularly to the central government. In addition, the implementation of the survey was not up to the government's standard guideline. Through regulations, the Ministry of Health provided direction on the implementation of sentinel surveys and established a centralised IBBS (only implemented at the national level).

Routine surveys by BPS, and IBBS by the Ministry of Health in the past three years, were centrally managed surveys. These surveys involved BPS personnel and Local Health Offices at provincial and district levels. BPS is one of the most centralised government agencies, and such a central mechanism in implementing survey is evidently effective for surveillance. This is a good lesson learnt for establishing surveillance system.

The utilisation of data and BPS survey results by district/province and should be studied further. The 2005-2009 and 2010-2014 National Strategy for HIV and AIDS Response had used data as the basis for determining strategies. Provinces and district government had increasingly utilizing data to develop local action plans, despite limitations of capacity in data analysis. Using the existing survey data, KPA could monitor and evaluate the success of intervention against the plan and recommend improvements and changes.

To date, there are still many challenges related to strategic information management as follows.

- The information reporting mechanism from local to central level has not been finalised. The reporting of HIV and AIDS cases should be coordinated by the Provincial or District/Municipality KPA, while the Provincial/District Health Offices is responsible to provide data.
- Provincial/District data are usually obtained from the third level public hospitals (RSUP) or reporting private hospitals, except data of patients receiving ARVs at satellite hospitals. There are no rewards or sanctions for those who did or did not report.

BPS and the Ministry of Health have produced a number of routine surveys that should support HIV and AIDS surveys, for example the Indonesia Youth Reproductive Health Survey (IYARS), Village Potential Statistics (*Potensial Desa Statistik/ Podes*), Basic Health Research (*Riset Kesehatan Dasar/ Riskesdas*) which identifies the availability of human resources up to village level; Indonesian Demographic and Health Survey (IDHS) to examine indicators related to maternal and child health. However, the available HIV and AIDS data is rarely linked with data from these surveys. These data are also still underutilized in policy and planning processes.

#### **4.4. Policy on Human Resources, Access and Logistic Management**

At present, there is a wide variation in the types and number of human resources working in HIV and AIDS response. Human resources in HIV and AIDS program may include field level personnel (peer educators, outreach workers, supervisor of field programs, field level program manager), service level personnel (staff counselors, specialists, physicians, laboratory workers, nurses, administrators, nutritionists, midwives, case managers) and personnel at the coordination/ KPA level in districts and municipalities (program managers,

monitoring and evaluation/surveillance officers, finance administration managers, secretaries/managers).

Nearly all health workers receive compensations (i.e. fees or salaries) from the foreign aid. Only health personnel assigned by the government and some coordinators in some municipalities/districts are funded by the state. While the field level officers are paid using foreign aid, the government also provided provided full support for health workers as stipulated in government regulations. For example, midwives may be hired on a contract basis with an incentive to attract them to work at the village level.

Several policies concerning human resources management in health including HIV and AIDS are as follows.

- Government Regulation No. 32/1996 on Health Personnel (State Paper of the Republic of Indonesia 1996 Amendment to State Paper of the Republic of Indonesia No. 3637). It is stated that health personnel are all people who devote themselves in the health sector and have the knowledge and/or skills through education in the health sector, of which certain fields require the authority for provision of health services.
- Regulation of Minister of Health No. 1199/Menkes/PER/X/2004 which underlied the development of the Manual for Health Personnel Recruitment with Employment Agreement to Work in Government Health Facilities.
- Regulation of Ministry of Health No. 161/Menkes/Per/1/2010 on Registration of Health Personnel.
- Regulation of Minister of Health No. 060/Menkes/SK/I/2009 on VCT Team Trainer.

Similar to other areas in the health sector, HIV and AIDS response is challenged by human resources problem, such as shortage, unequal distribution, high turnover within or between institutions, and human resources development. The 2010-2014 National Strategic Action Plan for HIV and AIDS described that human resource needs is calculated to achieve at least 80% of target of comprehensive service program. The basis of human resource needs calculation included number, type of program and service, and number and type of workforce based on the standard minimum requirement. In addition to human resources to run the programs, the human resource needs for management personnel of Provincial KPA, District KPA and Municipality KPA should be calculated as well.

There are at least three service providers for human resources in HIV and AIDS response, namely the government, CSO/CBOs and the private sector. The existing human resources policies related to HIV and AIDS response have not clearly regulated human resources issues in CSO/CBO and private sector. The 2010-2014 National Strategic Action Plan for HIV and AIDS has determined the following personnel needed for managing CSO/ CBO: field level personnel, peer educators, outreach workers, field program supervisor, and field level

program managers. Meanwhile, the availability of human resources at the private sector is very limited.

The allocation of human resources starts from setting the annual targets and programs. For example the annual target and needs of Harm Reduction program (LASS) and MMT services can be calculated. By taking into account the standard minimum requirement for one type of service, the number of required personnel by type of personnel, type of services in a year can be obtained. From calculations, it was found that human resources needs to organize the programs increased every year.

Human resources challenges related to HIV and AIDS response are in recruitment, capacity building, and remuneration system for non-civil-servant personnel. The personnel of National and Provincial KPA Secretariat currently consists of secretaries and a few full-time staffs. In Provincial KPA, there are also full-time staffs who are employed with donor funding. Full-time staffs are usually not available in provinces without donor funding

Human resources issues are not only occurring in HIV and AIDS programs. Other public health programs also face barriers in the recruitment and retention of human resources. Adequate retention package for (potential) health workers should be provided. Moreover, capacity building, career path, education and health insurance for health workers have not been addressed by the government. Such a package is important to attract and retain qualified health personnel.

### *Logistics*

The main logistical need in HIV and AIDS response is pharmaceutical supplies. A policy related to pharmaceutical supply is the Government Regulation No. 72/1998 on Assurance of Pharmaceutical Supplies and Medical Devices (State Paper of Republic of Indonesia No. 138 year 1998, Amendment to State Paper of Republic of Indonesia No. 3781). This policy regulates the centralized procurement of methadone and ARV. Centralized procurement is also applied to condoms and syringes. To anticipate fraud, which is difficult to control from the central level, it was decided that the procurement of condoms and syringes for supporting GFATM and AusAID programs should be done centrally through the KPAN. Supplies are then distributed directly to KPADs and their NGO partners in program implementations.

Despite the increasing number of health services that provided ART services, there were times when ARVs supplies in some hospitals were out. According to the 2013 Ministry of Health Report, the proportion of adults who were under ARV therapy has increased during the last three years. The policy of centralized purchasing of ARVs should be reviewed, because it may be the obstacle to adequate ARV supplies. The Government Regulation concerning centralization of ARV procurement was developed before the era of decentralisation, therefore it is necessary to adjust the ARV procurement policy post decentralisation era.

Table 7 shows the pharmacy services at the health facilities which provided ARV.

**Table 7 – Total of ARV Service Providers in Indonesia**

Indicator	Year		
	2011	2012	September 2013
Health Services providing ART Service	180 Referral Hospitals	249 Referral Hospitals	284 Referral Hospitals
Percentage of adults with HIV and AIDS against children with HIV and AIDS undergoing ARV	Adults: 95% Children: 5% Total 24,410 patients	Adults: 95,8% Children: 4,2% Total 31,002 patients	Adults: 96% Children: 4% Total 37,871 patients
Health Services providing ART Service and has experience an out of stock of a minimum one type of drug within the last 12 months	9 Hospitals	3 Hospitals	1 Hospital

(Source: Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia, 2013)

Preventive tools and materials needed in HIV and AIDS response are LASS, condoms and lubricant materials. The supply and logistical management of these materials – including planning, procurement, storage, use, supervision – must be understood and implemented by stakeholders. A reliable logistical management system must ensure that preventive materials should be received by the recipients timely, sufficiently, and under maintained quality. Logistical management shall be implemented under the principles of good governance.

However, 2011 IBBS showed that IDUs typically accessed at least four types of providers to purchase sterile syringes, and the largest provider was private pharmacies. Further studies should be conducted to determine the accessibility of sterile syringe and condom.

Policies related to the procurement of materials in government sector are as follows:

- Presidential Decree No. 54/2010 on Procurement of Government Goods/ Services.
- Presidential Decree No. 70/2012 on Second Amendment to the Presidential Decree No. 54/2010 on Procurement of Goods/ Services as well as the Technical Guidelines.

Procurement of goods and services is one area that is prone to frauds. The health sector is especially not spared from the risks of fraud. One of the goals in setting the procurement of

goods and services is to reduce the irregularities through the implementation of the principles of good governance. *E-katalog* of medical devices has been implemented since the end of 2012. Procurement of materials for HIV and AIDS prevention and response should follow this policy. Condoms, apart from being an HIV and AIDS prevention tool also function as contraceptives, thus raised the question of whether their procurements are included in the procurement for medical devices or contraceptions. Or, is there a special provision for materials for HIV and AIDS prevention? For example, in 2012 the Ministry of Health procured Contraceptive Condoms for the Fiscal Year of 2012 with a budget ceiling of USD 25,231,735 . Another challenge is that distribution of condomsthrough condom outlets conducted as pilot projects in several locations in Indonesia often encountered resistance from the general public.

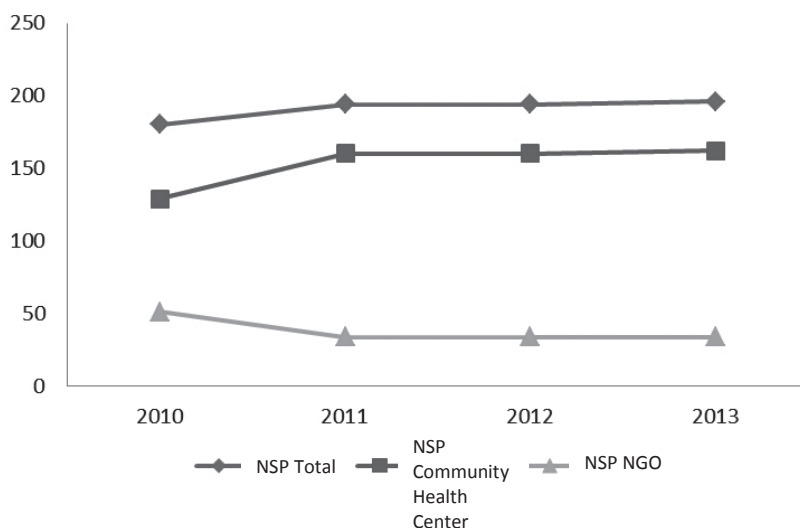


Figure 18 – Sterile Syringe Service Program in 19 Provinces, 72 Districts/Municipalities

(Source: Directorate General of Health Promotion Development, Ministry of Health of Republic Indonesia, 2013)

At the field level, the availability of tools and the distribution to users often caused problems of its own, especially the distribution of syringes. Although there is a national policy on the management and distribution of syringes as prevention tools, but problems are still encountered at the field level, such as the distribution by NGOs or clinics. Currently IDUs are encouraged to pick up their own sterile syringes in Puskesmas. Sterile syringes provided in some designated Puskesmas should be easily accessible to IDUs. At the beginning of the program, field workers took an active role to promote and distribute sterile syringes.

Distribution of sterile syringes and condoms in Puskesmas or by Puskesmas staffs is more

favorable because it is less likely to be opposed by the community, religious leaders, and law enforcement officers. However, the availability of syringes cannot be ensured in some Puskesmas. There have been many patients who come to Puskesmas for accessing treatment instead for accessing prevention measures.

#### 4.5. Rights-based Policy

Another policy issue is human rights which every person is entitled to without exception. It is a rights that must be guaranteed by the Indonesian and International laws, including the rights to life, freedom from torture, freedom of assembly, freedom of expression, to information, to education, to work, and the right to health. The State has an obligation to respect, protect and meet the rights of its citizen.

Promotion of human rights in the context of HIV and AIDS must be an integral part of the response. Human rights barriers should be eliminated. Service users should not be prevented to access prevention, treatment and support services. Policies are developed to ensure that HIV and AIDS response programs do not violate human rights.

Violations of human rights are not uncommon in HIV and AIDS response. For example, IDUs are often treated unfairly as they are suspected as drug dealers. FSWs often have to deal with exploitation, oppression and harassment when dealing with law enforcement officers (during raids), denied access to treatment, social security and health insurance, education (for children of PLWHA) and occupations.

In the period of 2007-2009, during the Harm Reduction implementation, there was a shift of perspectives among the law enforcement officers on the rights of IDUs including health and social support during the legal process. IDUs were positioned as users, not as drug dealers. The shift in the perspectives was followed by several policies, among others:

1. The Ministry of Law and Human Rights published the Manual for MMT Program in Penitentiary Facilities/ Prisons in 2007. The book is an elaboration and a follow-up of the 2005-2009 National Strategy for Response to HIV and AIDS and Drugs Abuse in Penitentiary Facilities and Prisons in Indonesia.
2. Law No. 35/2009 on Narcotics Section 54 reflects the shift in the perspectives on crime that must be followed by the law enforcement officers, including prosecutors. The Government subsequently followed it up with Government Regulation No. 25/2011, which allows an addict defendant to undergo medical and social rehabilitation. Such a regulation did not only show a change in the perspective on rights of the perpetrators, but also as the commitment of the State to fulfil one aspect of human rights. By law, the application of discretion through rehabilitation is made possible by the Article 54 of the Narcotics Law, which obliged IDUs and victims of drug abuse to undergo medical and social rehabilitation.
3. The Junior Attorney General for General Criminal Acts issued a Circular Letter No.

B136/E/EJP/01/2012 on Verdict of Medical and Social Rehabilitation for Drug Addicts (KPAN 2011).

4. Decree of Minister of Health No. 269/Per/III/2008 on Medical Record.

Support for fulfillment of human rights for PLWHA did not only come from HIV and AIDS organization. Since 2012, there has been increase in the support from non HIV and AIDS activists. The Public Legal Aid Agency (*Lembaga Bantuan Hukum/LBH*) Masyarakat has been actively engaged in human rights campaign and advocacy for PLWHA. They provided assistance and counseling for PLWHA, especially by mobilising paralegals to sensitise the law enforcement system and officers regarding the IDU status. During the legal process, law enforcement officers should be aware that IDUs are under addictive status in order to prevent further HIV transmission. The LBH was also involved in the design of the 2015-2019 National Strategic Action Plan for HIV and AIDS.

The success of the implementation of human rights policy for IDUs may be indicated by the increasing number of IDUs accessing prevention services (syringes and methadone) without the fear violating the law. During the last few years, there has been an increase in the number of MMT services in penitentiary facilities/ prisons, the number of Puskesmas providing sterile syringes, as well as of the number of paralegals for addicts. Anecdotal evidence also shows that IDUs listed as participants in the LASS and MMT programs in Puskesmas have been protected by law in order to continue their access during the legal process. The number of IDUs who received a rehabilitation verdict has also increased.

However, the rights of access to health services for PLWHA are often denied by health workers. A 2013 study on Community Access to Treatment Services (CATS) in Indonesia found that nearly one-fifth (18%) of PLWHA respondents experienced unpleasant treatment, stigma and discrimination due to their HIV status. In addition, female PLWHA are twice as likely to experience stigma and discrimination. Perpetrators of stigma and discrimination vary and could even be the health workers. Surprisingly, respondents in Jakarta reported, 10% of perpetrators of stigma and discrimination were health workers who denied to provide health services to PLWHA.

Human rights based policies in HIV and AIDS often encountered challenges because of conflicting values and norms in the society. There are many contradictions between central and local regulations. For example, there is still lack of clarity and contradictions between regulations in condom distribution, prostitution especially those in disguise (entertainment spots such as cafes, bars, discotheques, and night clubs), and extramarital sex. As a consequence, it is difficult to determine the effectiveness of policy and law enforcement within the context of local regulations on HIV and AIDS response. For example, the Medan Municipality Government Regulation Article 15 (2) letter c stated that only husband-wife couples are allowed to use condom. Such a regulation may prevent access of non-married couples to condoms. Barriers to accessing condoms may result in unsafe sex and increased

STI occurrence.

#### **4.6. Policy on Multi-sectoral Governance**

From 1987 to 2013, there have been 10 international level policies, 66 national level policies, and 55 local regulations (17 Provincial Regulations and 38 District/Municipality Regulations) concerning HIV and AIDS. It can be generally concluded that the policy-making process has been strengthened and improved in responding to social and political circumstances. In particular, the transition in the centralized decision making during the New Order Era (1987-1998) to the decentralised Autonomy Era (2001 to 2013) was quite evident. However, the majority of policies issued during the last two decades focused on the technical aspect of treatment. There has been a gap in the policy which aim to mainstream the HIV and AIDS issues across sectors. The negative impacts of the decentralized governance on HIV and AIDS response have not been adequately assessed and addressed.

Policies related to HIV and AIDS response in Indonesia can be broadly classified into two major categories. First is the multi-sectorial policy, i.e. policies issued by the KPAN as an institution in charge for coordinating the planning, implementation, monitoring and evaluation of HIV and AIDS response in Indonesia. Second is sectorial policies issued by ministries/ institutions members of the KPAN, such as HIV and AIDS policies in the health sector issued by the Ministry of Health.

In the early phase after the discovery of AIDS in Indonesia in 1987, the first policy was issued by the health sector, i.e. the establishment HIV and AIDS Response Committee under the Directorate General of Communicable Disease Control and Environmental Sanitation of the Ministry of Health. Subsequently, the Presidential Decree No. 36/1994 on AIDS Commission (KPA) was signed by the President. This Decree stipulated the cross-sectorial nature, objective, activities, structure (chairman, deputy chairman and members), establishment of Provincial and District/Municipality KPAs, as well as source of funding of the KPAN.

In response to the epidemic development, global response, as well as the need to improve HIV and AIDS prevention, control and response, the Presidential Decree No. 75/2006 on National AIDS Commission was enacted. Interestingly, the Law on Health was not included in the Decree as the legal basis, instead it mentioned the Presidential Decree No. 36/1994 and Presidential Decree No. 75/2006 set Article 4, paragraph 1 of the 1945 Constitution as the legal basis.

In the next period, policies concerning the institutional governance and strengthening of KPAN, Provincial KPA, and District/Municipality KPA were issued. At the outset, the Minister of People's Welfare was appointed as the Chairman of the KPAN and issued policy direction, the Regulation of Minister of People's Welfare No. 07/2007 on 2007-2010 National Strategy for HIV and AIDS Response and the Regulation of Minister of People's Welfare No. 8/Per/Menko/Kesra/2010 on the 2010-2014 National Strategic Action Plan for HIV and AIDS

Response. The National Strategic Action Plan includes the Strategic Direction of the National Policy, Principles and Basis of Policy, Goals and Strategies, as well as geographical and focus areas. The implementation of this action plan included leadership and governance, coordination strategies of the implementation, and principles of partnership. It also regulates the requirements and resource mobilisation including human resource needs, funding, facilities and infrastructure. To ensure the implementation of National Strategic Action Plan, a monitoring and evaluation framework was developed and consisted of Annual Target of Program Coverage, Framework and Performance Indicators, Monitoring and Evaluation Mechanism, and Capacity Building.

At the local level, district and provincial government also developed HIV and AIDS control strategies. Several provinces in Indonesia have developed their Local Strategy and Action Plans (SRAD) on HIV and AIDS Response, such as the DKI Jakarta Provincial Strategy, Action Plan on HIV and AIDS Response, and the 2011-2014 East Java Provincial SRAD.

Furthermore, in 2007 the KPAN mandated that in order to strengthen the institutional response, a working group or organisational units in 18 ministries/ institutions were established. The results of National Survey on Response to HIV and AIDS in 2006-2007 showed that all 18 ministries/ institutions had issued policies and developed work plans and budgets on HIV and AIDS Response. However, until 2007, not all ministries/institutions that are members of the KPAN have formulated policies, work plans and budgets for HIV and AIDS, for example the Ministry of Communication and Information, Ministry of Culture and Tourism, Ministry of Foreign Affairs, Ministry of Finance, Ministry of Trade, National Planning and Development Agency, BPOM, Ministry of Agriculture, Cabinet Secretary, Ministry of Research and Technology, BPPT, Indonesian Public Health Experts Association (IAKMI) and KADIN.

The following policies were issued by departments to respond to HIV and AIDS:

- Regulation of Minister of Home Affairs No. 20/2007 Article 13, Paragraph 1 to Paragraph 4. Government Regulation No. 38/2007 Article 7 that Health is Mandatory Affairs of Provincial/ District/Municipality Governments.
- Presidential Instruction No. 3/2010 no 2, 3 and 7 which mentioned that the funding sources of HIV and AIDS are the State Budget, other non-binding source, Provincial and District/Municipality Budget.
- Regulation of Minister of Home Affairs No. 20/2007 on General Manual of the Establishment of AIDS Commission and Community Empowerment in the Context of HIV and AIDS Response. The legal basis of this regulation included 1) Law No. 23/1992 on Health (State Paper of Republic of Indonesia 1992 Number 100, Amendment to State Paper of Republic of Indonesia No. 3495); 2) Law No. 32/2004 on Local Government; Law No. 39/2008 on Ministry; and 3) Government Regulation No. 58/2005 on Local Financial Management.

- Regulation of Minister of People's Welfare No. 3/PER/Menko/Kesra/III/2007 on Structure, Tasks and Membership of National AIDS Commission.
- Regulation of Minister of People's Welfare No. 4/PER/Menko/Welfare/III/2007 on Manual and Administration of National, Provincial, District/Municipality AIDS Commission.
- Regulation of Minister of People's Welfare No. 5/PER/Menko/Welfare/III/2007 on Organisation and Administration of the Secretariat of the National AIDS Commission.
- Regulation of Minister of People's Welfare No. 6/PER/Menko/Welfare/III/2007 on the National AIDS Commission Executing Team.

#### 4.7. Policy on Funding

In the 2010-2014 National Strategic Action Plan for HIV and AIDS Response, it was mentioned that there were four focus areas that required funding, i.e. prevention (57%); care, support and treatment (28%); impact mitigation (2%); and creation of a supportive environment (13%), including the funding for the institutional operations of KPAN. The program-based activities were focused on the 137 districts and municipalities, where more than 80% of the key populations were located. In addition, funding was also necessary for infrastructures of prevention; care and treatment, including condom outlets, VCT, STIs, CST, PMTCT, sterile syringe, and MMT services.

To date, sources of funding for HIV and AIDS came from other non-binding sources i.e. International Development Partners (IDP). The continuity of funding has always been an issue in Indonesia, although the trend of public funding (State Budget, District/Municipality Budget) showed an increase. In 2011, the KPAN reported the overall funding sources from the State Budget, District/Municipality Budget and IDP. The majority of IDP funding came from the multinational GFATM funds (31.07%), Australia (18.99%), United States (18.70%), the United Kingdom (18.23%), the United Nations (10.21%), and other countries (2.80%).

Based on the KPAN analysis on the availability of funds for financing HIV and AIDS response, the funding needs for 2010-2014 National Strategic Action Plan was still high, which put a demand for external funding from the MPI. Despite the dependency on foreign funding, the government has set an "exit strategy" policy. As an example was the Decree of the Director General of Disease Control and Environmental Health -the lead principal recipient of the GFATM grants No. HK.03.05/D/I.4/532/2012 on Manual of GFATM Grant Exit Strategy.

The funds for Harm Reduction at the national level was mostly distributed to the KPAN and the Ministry of Health. The funds came from bilateral funding (i.e. 1,194 million USD in 2009, 1,437 million USD in 2010), multilateral funding (193 million USD in 2009, 228 million USD in 2010) and a small contribution from the State and Local Budget (USD 173 million in 2009, 68.7 million USD in 2010). This shows that while the external funding for the Harm Reduction showed an increase the internal funding decreased. Nevertheless, the external

funding for Harm Reduction showed a decreasing trend. Since 2010, the amount of support from USAID began to decrease. However, it is notable that the militancy and civil society movement in HIV and AIDS were mostly initiated by NGOs supported by USAID. The GFATM funding disbursed through KPAN had provided support for logistics and outreach services by the community. However, the use of this fund was perceived to be superficial because it did not address the aspects of policy advocacy nor that it built a supportive environment and quality of contacts between officers and IDUs. After a year, the source of funding at the local level did not change, except in Jakarta. In this area, the supply of syringe was taken over by the local government and directly distributed to Puskesmas.

In 2006, a total of 19 provinces and 73 districts/municipalities had allocated budget for HIV and AIDS response. The figure increased to 33 provinces and 166 districts/municipalities in 2010. However, the budget plan typically did not meet the needs of programs. Efforts have been made to increase the proportion of local funding and reduce dependency to international aid. However, the 2007 Regulation of Minister of Home Affairs was considered by the local governments to have a weak legal power as a basis to raise local budget. The large funding gaps in HIV and AIDS response is a classical issue, particularly concerning the legal basis to allocate funding. Some problems or questions that were often raised included: What should be done regarding to the absence of account code for budget allocation? Is the KPAN eligible to receive grant? Can grants be continuously carried out? What if it cannot finance the salaries of KPA staffs regularly? Is it possible to fund NGOs using Local Budget?

The other problem related to funding is the utilisation of allocated funds. The funding of HIV and AIDS is mostly used for operational activities and programs. The mobilisation of financial resources is coordinated by the KPAN. Funds from the government sector and IDP are allocated to finance the implementation of response from central to local levels. The mobilisation of funds from the government sector follows on the allocation mechanism of government budget. Meanwhile, for the use of funds from bilateral and multilateral international partners, the KPAN is required to prepare and submit a proposal for assistance to the partners. Programs that will be funded by international partners are determined based on the agreement of both parties in a consultative meeting. Other financial assistance for HIV and AIDS is collected in one financial management system run by the KPAN, i.e. the AIDS Partnership Fund Indonesia (*Dana Kemitraan AIDS Indonesia/ DKAI*). The utilisation of these funds is entirely the responsibility of the KPAN. The overall management of funds is run by the KPAN Secretariat or other designated agency. At the local level, funds coming from the civil society e.g. from private sector as part of company's Corporate Social Responsibility (CSR) are collected by the KPADs and used for program implementation based on the local action plan.

The status of KPAN, Provincial KPA, and District/Municipality KPA is ad hoc coordination institutions and not SKPD. Therefore, the operational budget for these required specific

sources and mechanisms. The majority of funding for the National and Provincial KPA Secretariat came from other non-binding parties including those from the IDPs.

The National Health Insurance (JKN) launched in 2014 and local health insurance may also be an important source of fund. For example, people with disability who also require lifetime support as PLWHA had attempted to obtain special health insurance from the Yogyakarta government. Based on Yogyakarta Provincial Regulation No. 4/2012 on Protection and Fulfillment of the Rights of Persons with Disability can be an input for the planning of specific health insurance for groups of persons with disabilities including PLWHA within the framework of National or Local Health Insurance (JKN, Jamkesda).

#### **4.8. Policy on Impact Mitigation**

A policy issued in relation to impact mitigation is the Decree of Minister of Health No. 21/2013 on HIV and AIDS Response Article 40. Impact mitigation is an effort to reduce the health and socio-economic impacts of HIV and AIDS. The 2010-2014 NATIONAL STRATEGIC ACTION PLAN mentioned that the strategies to reduce negative impacts of the epidemic includes increasing access of PLWHA to social mitigation programs. This is done by providing opportunities for PLWHA and AIDS affected groups, orphans, single parents, and widows to gain access to support income generation, to improve skills and pursue education programs to increase quality of life. The Ministry of Social Affairs also provided services such as support/ provision of shelters for PLWHA and AIDS affected people.

Access to health insurance for key populations and PLWHA has been an issue to date, especially with the recent implementation of BPJS and National Health Insurance. The main constraint is related to the administrative procedures to access JKN. Most key populations and PLWHA are marginalized and often do not have the administrative requirements of citizenship, such as Family Card, Citizen ID Card and other residency data. As a result, it is difficult for them to access the JKN services.

## HIV AND AIDS POLICY STAKEHOLDERS IN INDONESIA

MANY parties are involved in the processes of planning, preparation, and implementation of policies and programs on HIV and AIDS response in Indonesia, including the International Development Partners, KPAN, Ministry of Health, Civil Society Organisations, Key Population Groups and Private Sector. The role of these parties can be observed from the involvement in the planning process, implementation of policies and programs. This section will explain the role and policies of the relevant stakeholders in HIV and AIDS response in Indonesia

### 5.1. International Development Partners

HIV and AIDS is a global issue which the response involves many actors. A key stakeholder that has initiated the HIV and AIDS response in Indonesia is the International Development Partners (IDPs). The collaboration between the Indonesian government and IDP takes place in many domains, ranging from funding, capacity building, program implementation, to technical assistance. As mentioned in the 2003-2007 National Strategic Action Plan for HIV and AIDS, the financial assistance (loans, grants) from donors, international agencies and international non-governmental organisations have greatly assisted the implementation of HIV and AIDS response programs in Indonesia.

The IDP's role in funding for HIV and AIDS response in Indonesia has started since the discovery of the first AIDS case in Indonesia. The first World Bank loan was allocated for financing institutional development in HIV AND

*Each of the various parties involved in the policy making on HIV and AIDS response in Indonesia has their own interest. The cooperation between the Government of Indonesia with International Development Partners focused on funding supports, capacity building and technical assistance. The Presidential Decree No. 75/2006 started the revitalise the role and functions of the National and sub national KPAs. Changes in the government system from the centralisation to decentralisation era have changed the roles and functions of the relevant government institutions including the local governments, especially in the health sector.*

AIDS and STI prevention, as well as pilot projects for the prevention and reduction of HIV AND AIDS and STI transmission in Jakarta and Riau in March 1996. However, due to the crisis of 1998, there was a cut down of USD 19.8 million, bringing the total loan to USD 4.5 million by 30 September 1999 (World Bank, 2005).<sup>29</sup>

<sup>29</sup> " The World Bank Report No. 32572 Project Performance Assessment Report Indonesia HIV AND AIDS and STDs Prevention and Management Project (LOAN NO. 3981)." June 13, 2005. The World Bank funding of USD 24.8 million was disbursed through the International Bank for Reconstruction and Development (IBRD) financing scheme. The loan was approved on 27 February 1996, signed on 29 March 1996, effective on 15 May

Australia has been a major donor for HIV and AIDS in Indonesia since 1995. The Indonesia HIV and AIDS Prevention and Care Project (IHPCP) Phase I and II was implemented and extended until February 2008. The project was widely known for the HIV and AIDS prevention programs through the Harm Reduction Program among IDUs and integration of the program into the Indonesian government system. With funding from the Indonesian Partnership Fund for HIV and AIDS (IPF) and the local government, IHPCP expanded its activities especially in West Java, Papua and West Papua.<sup>30</sup> Since 2008, all Australian aid for HIV and AIDS prevention activities in Indonesia was implemented under the Australia-Indonesia Partnership for HIV (AIPH) that completed in 2015. This assistance contributed significantly to the achievement of MDGs in Indonesia especially in scaling up of HIV and AIDS response and prevention of HIV transmission, improve quality of life of PLWHA, and mitigate the socio-economic impact of HIV and AIDS..

The United States Government through USAID provided financial assistance through FHI under the HAPP, ASA phase I and II, as well as the SUM programs. USAID assistance via the HAPP program was implemented in North Jakarta, DKI; Surabaya, East Java; Manado/Bitung, North Sulawesi; and via PATH in Irian Jaya. The program focused on service i.e. IEC and BCC as the basic strategy as well as supporting elements for STI and HIV and AIDS services. The supporting elements of the services included policy development assistance, technical assistance, education and training, administration and management, institutional capacity building, biomedical/applied research, strengthening surveillance systems, and monitoring and evaluation.<sup>31</sup>

GFATM – or usually called the Global Fund is a multilateral financial institution that focuses its works to address the epidemic of AIDS, Tuberculosis and Malaria. Particularly for AIDS, the Government of Indonesia received Round 1 and Round 4 funding through the Directorate General of Disease Control and Environmental Sanitation, Ministry of Health as the Principal Recipient. Furthermore, Indonesia received the Global Fund Round 8 funding term for the period of 2009-2014 for 12 provinces in Indonesia, as well as the Round 9 for the period of 2010-2015 for 21 provinces. The Global Fund's funding to encourage the expansion of HIV and AIDS programs was quite large and included the provision of ARV drugs for PLWHA in Indonesia. GFATM also provided funding to NGOs working on HIV and AIDS prevention programs for risk groups such as IDUs, FSWs, MSM, and transgenders.

The management of funding from GFATM as a multilateral funding partner was regulated by the Coordinating Minister of People's Welfare as the chairman of the KPAN through the Decree No. 21/Kep/Menko/Kesra/2009 on Appointment of the Main Grant Recipient Round 8 of AIDS Component of the KPAN. One important distinction between GFATM cooperation and other IDPs was in the development of a Country Coordinating Mechanism (CCM). CCM

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1996 and closed on 30 September 1999.

<sup>30</sup> DFAT. 2007. "The Australia-Indonesia Partnership for HIV AND AIDS 2008-2015 Including HIV Cooperation Program for Indonesia: Final Partnership and Program Design." September 2007

<sup>31</sup> See Piet. David L. et .al. (1999). "External Assessment of USAID/ Indonesia's HIV and AIDS Program."

was established as the Global Fund's commitment to encourage the government ownership towards the proposed program and participation of various relevant parties in decision making on issues around AIDS, tuberculosis and malaria. CCM is a national level multi-stakeholder mechanism that develops and submits proposals to the Global Fund based on national priorities. Once the funds are disbursed, the CCM will monitor the progress of implementation. CCM consists of representatives from government, multilateral or bilateral agencies, NGOs, academic institutions, private sector and PLWHA. The main functions of the CCM include:

1. To coordinate the development and submission of proposals at the national level;
2. To select the Principal Recipient;
3. To supervise the implementation of approved funds and proposal for further funding;
4. To ensure linkages and consistency between Global Fund funding and the development of the national health system.

Thus, CCM has a role and is involved in the preparation of national strategies and dialogues regarding the use of funds allocation.<sup>32</sup>

**Table 8 – International Development Partners working on HIV and AIDS Response in Indonesia, 1996 - 2015**

<b>Period</b>	<b>Name of Partner</b>	<b>Work Area</b>	<b>Hit Point</b>
1996–1999	World Bank	Jakarta, Riau	Institutional development and piloting of Sexually Transmitted Diseases interventions
1995–2008	IHPCP/AusAID	Jakarta, Bali, Makassar, Papua, & West Papua	Supporting within interventions
2008–2015	HCPI/ AusAID	Jakarta, Banten, West Java, Central Java, East Java, Bali, Papua,	Promoting national policy, involvement of government units (puskesmas), budget increase by local government for Harm Reduction, expansion of scale and scope of Harm Reduction (including MMT)

<sup>32</sup> Further explanation of the GFATM and CCM's role can be seen: <http://www.theglobalfund.org/en/ccm/>

Period	Name of Partner	Work Area	Hit Point
		& West Papua	
	HAPP, ASA, SUM/USAID	Jakarta, West Java, Central Java, East Java, Bali, North Sulawesi, Papua, West Papua	Community-based approach, and creating conducive environment for  STD and HIV and AIDS services (policy, technical guidelines, professional development, applied research & surveillance)
	Partnerships Funds		Institutional development of AIDS Commissions at national and local levels (personnel, office operations)
2009–2014	GFATM	Round 8: 12 provinces	Ensuring the interventions to take place in 141 prioritized municipalities/districts, provision of ARV
2010–2015	GFATM	Round 9: 21 provinces	

## 5.2. Ministry of Health

The Ministry of Health (MoH) of Republic of Indonesia was assigned to assist the President in administering government's affairs in the health sector. In carrying out these tasks, the Ministry of Health held several functions as following.

1. Formulation of national policy, implementing policy, and technical policy in health sector;
2. Implementation of government affairs in the MoH's respective sectors;

3. The management of government's assets under the MoH responsibility;
4. Control over the execution of MoH duties;
5. Submission of report on evaluation results, suggestion, and consideration in MoH's duties and functions to the President.

In administering its functions, the Indonesian MoH has the following authority:

1. To establish national health policy to support macro development.
2. To produce the manual for identification of the minimum service standards that is compulsory for the district/municipality in the health sector.
3. To prepare a national health plan at macro level. The Ministry of Health has developed the Strategic Plan for 2009-2014 and the Decree No. 21/2013 on HIV and AIDS.
4. To specify the requirements for accreditation of educational institutions and for professional/ expert certification, and position requirements in the health sector including HIV and AIDS. Counselors are professionals who are needed in HIV and AIDS response. The Ministry of Health issued a Decree of Minister of Health No. 150/Menkes/SK/X/2005 on Manual of HIV and AIDS Voluntary Counseling and Testing Service. The Ministry of Health also issued a concept of HIV team and delivered special training for the team. This team consists of two counselors, one medical specialist, one physician, one nurse, one case governance officer, two laboratory technicians, and one monitoring and evaluation staff. As for the trainer of HIV and AIDS Counseling and Testing, it is regulated in the Decree of Minister of Health No. 60/Menkes/SK/I/2009.
5. To provide guidance and supervision of the implementation of local autonomy, including providing guideline, mentoring, training, direction and supervision in the health sector.
6. To set up the application of international treaty or agreement ratified on behalf of the state in the health sector.
7. To determine the licensing standards by local government in the health sector.
8. To prevent nationwide outbreaks and disasters in the health sector.
9. To establish national information system policy in the health sector.
10. To determine the qualification requirements of business services in the health sector.
11. To perform settlement of dispute between provinces in the health.
12. To determine policies on control of fertility rate and reduction of number of maternal, infant and child mortality.
13. To determine the policy on public health insurance system.
14. To determine the manual for standards of education and empowerment of health personnel.
15. To determine the manual for health care financing.
16. To determine the manual for screening, development and application of medical

technology and health research ethics standards.

17. To set up the standards of nutritional value and manual for technology certification in health and nutrition.
18. To determine accreditation standards of health facilities and infrastructure.
19. To conduct epidemiological surveillance and set up the eradication and response to epidemics, infectious diseases and outbreaks.
20. The provision of certain essential drugs and medicines for primary health service (national buffer stock).
21. Other authorities in accordance with the provisions of the applicable laws and regulations, as follows: the placement and relocation of certain health workers; and the licensing and development of production and distribution of medical devices.

In reference to HIV and AIDS response, of which the Directorate General of Disease Control and Environmental Sanitation plays a major role, the Director General has the tasks of formulating and implementing policies and technical standardisation in disease control and environmental sanitation.

In carrying out the tasks, the Directorate General holds the following functions:

1. Formulation of policies in disease control and environmental sanitation;
2. Implementation of policy in disease control and environmental sanitation;
3. Development of norms, standards, procedures, and criteria in disease control and environmental sanitation;
4. Provision of technical guidance and evaluation in disease control and environmental sanitation; and
5. Implementation of the administration of the Directorate General of Disease Control and Environmental Sanitation.

Technically, the Directorate General is the primary partner of KPAN on HIV and AIDS response at the national level. The ultimate responsibility and authority remains in the Ministry of Health, including providing responses and leading the efforts on HIV and AIDS response. There is no central mechanism to oversee the role of the Ministry of Health in HIV and AIDS response.<sup>33</sup> A review by WHO and Ministry of Health in 2007 suggested that the capacity of MoH to coordinate and implement all elements of health sector response including peer support should be strengthened through the establishment of a main working group under the Minister of Health.

In the document of cabinet session on HIV and AIDS response in 2002, a scheme on multiministerial response was formulated, including the Ministry of Health response strategies that emphasized the provision of health services. This included coordination, care and treatment, health system, prevention programs, and HIV and AIDS surveillance. Furthermore, the MoH issued a number of policies related to the role and functions of the

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<sup>33</sup> WHO and the Ministry of Health (2007). "Review of the Health Sector Response to HIV and AIDS in Indonesia

MoH in HIV and AIDS response.

Radical change from the centralized government system to decentralized system had inevitably changed the role and functions of the MoH. The Government Regulation No. 38/2007 on Division of Government Affairs between the Central Government, Provincial Government and the District/Municipality Government determined the MoH role in the health sector, which encompassed health strategies, financing, human resources, drugs and medical Supplies, community empowerment and health system management.<sup>34</sup>

As a policy-maker at the national level,<sup>35</sup> the MoH has issued a policy on HIV and AIDS prevention, care, support and treatment, as well as community participation. Many regulations of the Minister of Health related to various guidelines for prevention, care, support and treatment have been produced. For example, the Decree of Minister of Health No. 1285/Menkes/SK/X/2002 on Manual of Response to HIV and AIDS and STIs, which was updated by Decree No. 21/2013 on HIV and AIDS. The Decree of Minister of Health No. 021/Menkes/SK/1/2011 contained the Ministry of Health's Strategic Plan for 2010-2014, which outlined the direction of the policy and strategy of the MoH including HIV and AIDS response.

#### *Policies on Care Support and Treatment*

In 2004, MoH appointed 25 ART referral hospitals, which was subsequently increased to 75 in 2006. This was followed by the issuance of the Decree of Minister of Health No. 832/Menkes/SK/X/2006 on the Stipulation of Referral Hospital for PLWHA and Service Standards of Referral Hospitals and Satellites for PLWHA, the Decree of Minister of Health No. 760/Menkes/SK/VI/2007 on Stipulation of Referral Hospitals for PLWHA, and the Decree of Minister of Health No. 782/Menkes/SK/IV/2011 on Referral Hospital for PLWHA. The list of 278 referral hospitals for PLWHA was attached to the Decree. Other regulations included the Decree of Minister of Health No. 1190/Menkes/SK/X/2004 on Provision of Free Anti Tuberculosis Medicines and ARV for HIV and AIDS, the Decree of Minister of Health No. 241/Menkes/SK/IV/2006 on Service Standards of Medical Laboratory for Examinations of HIV and Opportunistic Infections.

#### *Prevention Policy*

The Ministry of Health also issued a number of policies related to harm reduction, including: the Regulation of Minister of Health No. 567/Menkes/SK/VII/ on Implementation Manual of Addictive Drug Harm Reduction and the Decree of Minister of Health No. 350/Menkes/SK/IV on Stipulation of Supporting and Satellite Hospitals for MMT and Manual of MMT.

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<sup>34</sup> See Attachment of Government Regulation No. 38/2007 Section B, Division of Government Affairs in the Health Sector.

<sup>35</sup> See Attachment of Table HIV and AIDS Policy 1987-2014

### 5.3. The National AIDS Commission

The Presidential Decree No. 36/1994 on AIDS Commission mandated the Establishment of KPAN, which is KPANa cross-sectorial commission responsible to ensure a comprehensive, integrated, and coordinated HIV and AIDS prevention and response in Indonesia. The aims of KPAN are as follows:

- a. To conduct activities on AIDS prevention and response under the provisions of the applicable laws and regulations and/or global strategy of HIV and AIDS prevention and response launched by the United Nations;
- b. To increase public awareness of the danger of AIDS and improve the cross-sector, comprehensive, integrated, and coordinated AIDS prevention and/or response.

In 2006, through the Presidential Decree No. 75/2006 it was stipulated that the Management of National AIDS Response was to be conducted by the KPAN, chaired by the Coordinating Minister of People's Welfare, the Minister of Health as the 1<sup>st</sup> Deputy Chairman and the Minister of Home Affairs as the 2<sup>nd</sup> Deputy Chairman. This regulation revitalized the role and functions of the KPAN. The KPAN is a subordinate of and accountable to the President with the following tasks:

- a. To establish policies and national strategic plans and general manual for AIDS prevention, control and response;
- b. To determine the necessary strategic steps in activity implementation;
- c. To coordinate the activity implementation of AIDS counseling, prevention, service, monitoring, control, and response;
- d. To conduct dissemination of information about AIDS to various media, in connection with spot-on campaigning that does not create public unrest;
- e. To conduct local and international cooperation on AIDS prevention and response;
- f. To coordinate management of data and information on issues related to AIDS;
- g. To control, monitor, and evaluate the implementation of AIDS prevention, control, and response;
- h. To provide guidance to Provincial and District/Municipality KPAs on AIDS prevention, control, and response.

As mandated by the Presidential Regulation, the KPAN issued the 2007-2010 KPAN Strategy and Action Plan. The strategy was developed with the participation of related parties by applying epidemiological approach, health and social services. In early 2007, the National Strategy and Action Plan was established based on the Regulation of Minister of People's Welfare No. 7/2007. The National Action Plan document functions as an extensive description of the National Strategy. The Action Plan is an implementation manual of AIDS prevention programs focusing on the high risk populations in order to reduce the rate of HIV and AIDS transmission in Indonesia.

In early 2006, scaling up of HIV and AIDS control was implemented through improving the KPA performance at the selected 100 districts and municipalities acceleration program. The issuance of Presidential Decree No. 75/2006 on KPAN in July 2006 had strengthened the government's support to build a more intensive, comprehensive, integrated and coordinated HIV and AIDS prevention and response. In 2006-2007, the KPAN conducted the Survey of National Response to HIV and AIDS in 2006-2007 i.e. the National Sector Status KPAN to 31 departments/ institutions of KPAN members including those both appointed by the Presidential Decree No. 36/1994 and Presidential Decree No. 75/2006. It was found that 18 of 31 departments/ institutions had developed a working group or appoint an organisational unit to develop policies and action plans as well as allocate a budget to address HIV and AIDS.<sup>36</sup> The findings were as follows:

1. A Working Group had been established by the Coordinating Minister of People's Welfare; State Minister of Women Empowerment; Minister of Defense; Director General of Community Correction, Ministry of Law and Human Rights; Minister of Health; Minister of Education; Minister of Social Affairs; Minister of Manpower and Transmigration, and BKKBN.
2. A structural Unit (Echelon III) for HIV and AIDS response had been established in the Ministry of Health, Ministry of Social Affairs, BKKBN, and PMI.
3. A structural unit with the responsibility for implementing HIV and AIDS response programs was established in the Department of Defense, Indonesian National Army, Ministry of Law and Human Rights, Ministry of Transportation, Ministry of Education, Ministry of Home Affairs, Ministry of Religious Affairs, Ministry of Youth and Sports, BNN, National Police Force, and IDI.
4. Ministries/Agencies that had not yet established a working group or appointed a unit in charge and provided a budget for HIV and AIDS response, included the Ministry of Communication and Information, Ministry of Culture and Tourism, Ministry of Research and Technology, National Development Planning Agency, BPPT, Cabinet Secretariat, IAKMI, and KADIN.
5. Departments/Agencies, which had a role and responsibility according to the 2003 National Strategy but not mentioned in the 2007 National Strategy were the Ministry of Foreign Affairs, Ministry of Defense, Ministry of Industry and Trade, BPOM and Ministry of Agriculture.

#### **5.4. Provincial AIDS Commission**

The Provincial KPA is chaired by the Governor. This entity has the tasks of formulating policies, strategies, and measures that are needed for HIV and AIDS response in the province according to the policy, strategy and manual stipulated by the KPAN. Provincial KPA is to report regularly to the Chairman of the KPAN. The regulations concerning working procedures of Provincial KPA are regulated by the Governor based on the working

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<sup>36</sup> See Report of the KPAN in 2007, "Institutional Strengthening of the KPA to Lead Strategic Response."

procedures established by the Chairman of the KPAN. This is stipulated in details in the Presidential Decree No. 75/2006.

Correspondingly, the Regulation No. 20/2007 also stipulated that Provincial KPA is chaired by the Governor and is responsible to the Governor. The relationship with the KPAN is on the coordination, consultation, and technical assistance. The tasks of Provincial KPA are as follows:

1. To coordinate the formulation and development of policies, strategies, and roadmap on HIV and AIDS response based on the policies, strategies, and guidelines established by the KPAN;
2. To lead, manage, control, monitor, and evaluate the implementation of HIV and AIDS response in the province;
3. To gather, mobilise, supply, and utilize the resources generated from central, local, community, and foreign aid effectively and efficiently for HIV and AIDS response programs;
4. To coordinate the implementation of tasks and functions of each institution registered in the Provincial KPA membership;
5. To establish local cooperation in the context of HIV and AIDS response;
6. To disseminate information on HIV and AIDS response to authorities and public;
7. To facilitate District/Municipality KPA;
8. To encourage the establishment of NGOs/ HIV and AIDS Care Group; and
9. To monitor and evaluate the implementation of HIV and AIDS response and to submit periodic reports to KPAN.

Implementation of such policies by Provincial KPA can be monitored from the programs that had been developed and implemented. The Provincial KPA also has to undertake a strategic role such as to advocate policy development and formulation of HIV and AIDS response strategy at the provincial level. For example, the East Java Provincial KPA had coordinated the formulation of 2011-2014 East Java Provincial Strategy and Action Plan HIV and AIDS. The HIV and AIDS response in East Java was based on the East Java Provincial Regulation No. 5/2004 on HIV and AIDS Prevention and Response in East Java. East Java Provincial KPA also contributed to coordinate the planning for East Java Local Strategy and Action Plan execution through planning and budgeting forum led by Bappeda.

To coordinate the implementation of the Local Strategy and Action Plan at the provincial and district/municipality levels, there are coordination between related programs, coordination between implementation of various policies, and implementation coordination between areas across East Java Province. The implementation of monitoring and evaluation by Provincial KPA is also undertaken in coordination with all relevant stakeholders in the province and District/Municipality KPA in East Java. The coordination activities are undertaken through meetings led by Provincial or District/Municipality KPA. All parties

involved in the coordination are responsible to prepare materials related to the coordination meeting agenda. Results of this meeting are provided to the parties for further action. The KPA Secretary is usually responsible to prepare the materials and agenda prior to the coordination meetings.

The role of Provincial KPA as the coordinating agency at the provincial level in some areas in this study is in accordance with the local situation and issues. The Bali Provincial KPA had set vision, mission, and strategies on HIV and AIDS response in Bali. The vision of Bali Provincial KPA is controlling the HIV and AIDS epidemic towards Bali Mandara (advanced, safe, peaceful and wealthy). The mission of Bali Provincial KPA is as follows:

1. Improving the effectiveness of prevention of HIV and AIDS transmission or decreased number of HIV and AIDS cases;
2. Improving the quality of life of PLWHA and OHIDHA;
3. Increasing the participation of multi-stakeholders in addressing issues on HIV and AIDS on an ongoing basis;
4. Reducing the negative social and economic impacts of as a consequence of HIV and AIDS on individuals, families, and communities.

The strategies of Bali Provincial KPA to achieve the mission and vision are as follows:

1. Improve and expand real and effective prevention efforts and test the innovative methods and approach;
2. Enhance the sustainability of prevention, care, and treatment within the marginalized groups, which have been carried out more by NGOs with donor funding;
3. Improve and strengthen primary and referral health service systems to anticipate the increase in number of PLWHA who need access to care and treatment;
4. Increase the capacity and empower those involved in HIV and AIDS prevention and response at the provincial and district/municipality through continuous education and training;
5. Enhance surveys and studies to obtain data for the development of HIV and AIDS programs;
6. Increase participation and empower individuals, families and communities in HIV and AIDS prevention within their environment;
7. Increase the capacity of the program implementation to conduct monitoring and evaluation of HIV and AIDS;
8. Mobilisation of resources and harmonize the utilisation at all levels.

### **5.5. District/Municipality AIDS Commission**

District/Municipality KPA is chaired by the Regent/Mayor. District/Municipality KPA is assigned to formulate policies, strategies, and measures necessary for HIV and AIDS

response in the district/municipality according to the policy, strategy and manual stipulated by the KPAN. District/Municipality KPA is to report regularly to the Chairman of the KPAN. The provisions concerning working procedures of District/Municipality KPA are regulated by the Regent/Mayor based on the working procedures established by the Chairman of the KPAN.

In the Regulation of Minister of Home Affairs No. 20/2007, the tasks of District/Municipality KPA are stipulated as follows:

- a. To coordinate the formulation and development of policies, strategies, and required steps on HIV and AIDS response based on policies, strategies, and guidelines established by KPAN;
- b. To lead, manage, control, monitor, and evaluate the implementation of HIV and AIDS response in the district/municipality;
- c. To collect, move, supply, and utilize the resources sourced from central, local, community, and foreign aid effectively and efficiently for HIV and AIDS response activities;
- d. To coordinate the implementation of tasks and functions of each institution that is registered in the District/Municipality KPA membership;
- e. To establish local cooperation in the context of HIV and AIDS response;
- f. To disseminate information on HIV and AIDS response to authorities and public;
- g. To facilitate the implementation of tasks of Sub-district Heads and Village Authorities on HIV and AIDS response;
- h. To encourage the establishment of NGOs/HIV and AIDS Care Group; and
- i. To monitor and evaluate the implementation of HIV and AIDS response and to submit periodic reports to KPAN.

The implementation of this policy can be monitored from the number of District/Municipality KPA that have been established throughout Indonesia, as well as the number of regulations that already exist to date. A study on the role performed by District KPA conducted by Rijadi Azikin (2009)<sup>37</sup> in the District of Grobogan showed that out of the five main tasks of Grobogan District KPA that were studied, only four basic tasks were implemented, as detailed below:

1. The development of policy plans i.e. the 2008-2012 Strategic Plan for HIV and AIDS Prevention and Response. The Strategic Plan had been socialized to all members of Grobogan District KPA through an AIDS Seminar.
2. Education on the danger and prevention of AIDS for communities through AIDS Seminar, integrated education on HIV and AIDS in 19 sub-districts, education in

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<sup>37</sup> Rijadi Azikin (2009). Implementation of the Main Tasks of KPAD (KPADs) on HIV and AIDS Response in the District of Grobogan. Thesis, University of Diponegoro.

villages with AIDS risks, education by presenting PLWHA, and education in brothel complex to FSWs.

3. Dissemination of information on AIDS through mass media, including radio shows, articles on AIDS on *Gema Bersemi* Magazine, posters on AIDS at health service facilities, banners on AIDS on billboards, and distribution of pocket books on HIV and AIDS.
4. Reporting on accountability and tasks implementation to the Regent through routine mechanism in the guidelines. The reported data include the updates on the number of HIV and AIDS patients, financial matters, and results of the activities of related institutions on a monthly basis. The report of activity implementation is submitted to KPAN, Provincial KPA, and the Regent.

The Medan Municipality KPA serves as a coordinating center for inter-institution and cross-sector coordination and entry point for donor. However, the Provincial KPA has limited power to take the overall coordination responsibility for all actors engaged in HIV and AIDS issues. The Provincial Health Office plays an important role in the procurement and distribution of ARV, as well as other technical assistance particularly in human resources capacity building. Puskesmas and hospitals play an important role in providing CST for key populations. Cross-sector coordination particularly with civil society organisations, peer support groups, as well as key populations is closely related to comprehensive health services. Regular meetings are conducted in the clinic, so that key populations can be served immediately after being given information.

## **5.6. Civil Society Organisation**

The 2010-2014 National Strategic Action Plan outlined that the civil society plays crucial role and supports the government in HIV and AIDS response. Among the civil society organisations are people infected with HIV and AIDS and key populations, NGOs, community organisations, professionals, professional organisations, and higher education institutions. CSOs are able to be the main driving force and play an active role in HIV and AIDS response, in the process of policy formulation, planning and implementation of each program, and monitoring and evaluation.

### **5.6.1 Non-Governmental Organisation (NGO)**

NGOs play an important role in HIV and AIDS response in Indonesia. They initiated the outreach work to marginalized and unknown groups. NGOs also help key populations to be able to access services, establish peer support groups, and conduct policy advocacy. NGOs had been engaged in the distribution of syringes. Prior to 2006, syringe distribution was considered illegal, thus putting NGO outreach workers at risk of being arrested, questioned by police, or even being legally processed. Harm Reduction workers were always in conflict

with the law enforcement. The health system was considered as an entrance for sterile syringes to be accepted as means of HIV prevention. However, health workers were put in a difficult situation against the law enforcement. Even in the United States, such a problem in sterile syringe distribution could not be resolved. Most law enforcement and the community adopted abstinence principle as the main prevention measure for HIV and AIDS. Therefore, the harm reduction approach was certainly opposed by the law enforcement and society. This was a difficult choice between new public health measures and traditional law enforcement. Under the coordination of the KPAN, the pioneer of Harm Reduction in Indonesia chose an innovation approach which intended to challenge particular norms in the society. IDUs and drug addicts, who are often unable to release themselves from drug addiction, were framed to be the victims of kingpins or drug dealers. This new perspective was brought into the society. Sympathy and support from the society was immediately generated, including those from the law enforcement authorities. According to law, there is no difference between the weight of sentence for addicts and for dealers. This has encouraged a join movement against the unfair treatment towards drug addicts. The increase in the scale and expansion of the stakeholders' support brought positive impacts on IDUs behavioural change. For instance, the reluctance to bring sterile syringes due to fear of law enforcement showed a decline. In 2007, only 25% of IDUs could demonstrate that they carried needles with them. This figure increased to 30% in 2011. In addition, 50% of IDUs admitted to participate in the Sterile Syringe Service Program within the previous week.

NGOs working on HIV and AIDS response in Indonesia can be classified into NGOs working in the field of prevention or care and support. This type of NGOs is spread out across Indonesia. Based on the key population group as the beneficiaries, NGOs can also be grouped into those working in FSW, gay and MSM, transgender and IDU groups.

Networks of NGOs aiming at policy advocacy were established, such as AIDS Community Care Indonesia and the NGOs working in harm reduction that created *Jangkar* network. Others specialized in the provision of support and empowerment of PLWHA such as Yayasan Spiritia. Other NGOs working for transgender groups established networks as well for example Perwakos in Surabaya, Srikandi Pasundan in Bandung, and Kebaya in Yogyakarta.<sup>38</sup> Yayasan Citra Usadha Indonesia in Bali reached out to client of sex workers and homosexual community, while Yayasan Kerthi Praja provides assistance to FSWs.

Several NGOs at local level have been the driving agents in advocating policies such as Hotline Surabaya, Gaya Nusantara and Perwakos in East Java. These NGOs were actively encouraging the development of East Java Provincial Regulation on HIV and AIDS. In 1995, NGOs working on AIDS conducted a Workshop on Ethics and Human Rights related to HIV and AIDS Epidemic and Prevention. This workshop resulted in the Pacet Statement on Ethics and Human Rights related to HIV and AIDS Epidemics.

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<sup>38</sup> Refer to: <http://aids-ina.org/modules.php?name=Networking>

In line with the development and situation of HIV and AIDS in Indonesia, NGOs also experienced a dynamic involvement in HIV and AIDS issues. An NGO working in prevention through provision of IEC materials now became an NGO providing VCT service and distribution of preventive materials such as sterile syringes, condoms and lubricants. NGO involvement in empowerment activities for key populations and PLWHA is very strong. The development of peer support groups is one example of the activities of NGOs in empowering affected groups.

### 5.6.2 Key Population Communities

In addition to the national NGOs that have long established such as PKBI, Spiritia and YPI, there are currently six networks of communities affected by HIV, including Jangkar, IPPI, GWL-INA, PKNI, JOTHI and OPSI. These networks represent hundreds of community-based activists throughout Indonesia. The Indonesia UNGASS AIDS Forum consists of JOTHI, IPPI, PKI, GWL-INA, OPSI, MAP, JSG, IKON, Our Voice, LP3Y, PITA, KPI, Gerbang, Pantura Plus, Rempah, Bina Hati, Stigma, and Solidaritas Perempuan.

While other community organisations in general typically rely on membership fees to fund their activities, GWL-INA, OPSI and JOTHI depend more on international partners as their funding sources. International funding is usually disbursed directly to the organisations or through the KPAN. However, these organisations also have their own challenges. For example, JOTHI and OPSI are still dealing with the organisation's internal management issues, while GWL-INA is overwhelmed by the involvement from international partners.<sup>39</sup>

The "branding" movement to change the perception towards IDUs by framing them as victims was in line with the restructuring of the community organisations for IDUs. The Indonesia Drug User Brotherhood (*Ikatan Persaudaraan Pengguna Napza Indonesia/ IPPNI*) was initiated by several groups of IDUs in major areas such as Jakarta, Surabaya, West Java, and Central Java. Since 2008 the organisation changed its name to Indonesia Drug Victims Brotherhood (*Persaudaran Korban Napza Indonesia/ PKNI*). PKNI focused its activities on promoting the needs and rights of drug users. There have been many important advances in CSO activities, however, more attention should be addressed on the following issues:

1. Most CSOs depend on donors or projects for funding and design of programs. Financial contribution from governments and communities is lacking. This situation puts them in a vulnerable position, particularly when the main source of funding is terminated or withdrawn.
2. The majority of these CSOs perform specific activities focusing on HIV and AIDS. Only a few CSOs deal with broader and cross-cutting issues such as gender, poverty, access to justice and human rights. Therefore, they are often isolated from the

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<sup>39</sup> FHI-Stop AIDS Action, FHI-ASA and Health Policy Initiative Programs, Indonesian Partnership Fund (IPF) through the KPAN. With more technical capacity, GWL-INA becomes the executor of 2013 CATS Survey, which was financed by APN+ Local.

country's economic, social, cultural, and political development.

3. Field studies also showed that the most CSOs reported only to donors. There is a lack of transparency and accountability to their community constituents.

#### *Indonesia Drug Victims Brotherhood (Persaudaran Korban Napza Indonesia/ PKNI)*

Many national policies on illicit drug are potential to bring negative impacts to the community, particularly the drug users as victims. Drug users often experience violence and criminalisation by the authorities. Being triggered by this worrisome situation and the need to articulate the rights of drug users, a number of drug users in several provinces initiated organisational and educational activities. A few groups of drug users organized themselves into organisations and conduct advocacy to voice their rights. A national organisation called IPPNI was established on 10 June 2006, which later became a platform to defend the rights of drug users as human beings.<sup>40</sup> At the 1<sup>st</sup> Congress of Members in Makassar on 17 June 2008, which was attended by 65 drug users from 13 provinces in Indonesia, it was agreed to change the name of the organisation to PKNI.

#### *Sex Workers*

The present study found two organisations representing sex workers, namely Indonesia Sex Workers Organisation and Indonesia Change Organisation, both refers to as OPSI, and are organized by the same board of organisation. The organization used two names as a strategy to deal with public opposition against the existence of sex workers organisations. OPSI is an organisation for all types of sex workers including homosexual or heterosexual female, male, and transgender sex workers. Founded at the National Workshop on 27 and 28 November 2008 at Sahid Jaya Hotel, Jakarta, OPSI aims to fight for the fulfillment of the constitutional rights of sex workers as citizens, eliminate stigma against sex workers, encourage full involvement of sex workers in HIV and AIDS policy making and encourage the state's recognition of the status of sex workers. Their vision is that the state sufficiently carry out its obligations to respect, protect and fulfill the human rights of sex workers in Indonesia and empower sex workers in Indonesia. The OPSI membership is divided into three types:

1. Ordinary Member (currently active sex workers)
2. Special Member (former sex workers)
3. Distinguished Member (consists of experts who support and side with sex workers).

#### *Indonesia Gays, Transgender and MSM*

GWL-INA (*Gay, Waria, dan LSL Indonesia*) network has been founded since 4 February 2007 in Surabaya. This network has gone through very dynamic development. In the first two years, the network performed almost all communication and coordination activities through

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<sup>40</sup> <http://www.pkni.org/sejarah-pkni/>

Yahoo Group mailing list facilitated by four volunteers as moderators. Since March 2009, the communication was done through the National Secretariat of GWL-INA in Jakarta. The mailing list moderators became also volunteers and coordinators of the national secretariat of the GWL-INA network. They were appointed directly by the members attended the establishment of the network in 2007. With the technical support and funding from the Australian Federation of AIDS Organisations Inc. (AFAO), Burnet Indonesia and Gaya Nusantara, the network secretariat was operational until today. Some donors such as FHI-ASA and Health Policy Initiative have provided financial support to establish the GWL-INA Working Group and increased the capacity of the network to perform advocacy in December 2007 and February 2008. The GWL-INA Working Group has also gained official recognition based on the Decree of the KPAN.

In October and November 2008, with AFAO's funding support, the network was able to organise its first coordination meetings and consultations in Batam, Makassar and Surabaya. These meetings produced important recommendations for the sustainability of GWL-INA network in the future. One of the key recommendations was to conduct the first GWL-INA national meeting to legally certify the network, develop the organisation structure based on election, and strengthen the national secretariat to facilitate the work of the GWL-INA network. Until now, the GWL-INA national secretariat receives technical and funding support from many organisations. The operational activities of the network secretariat have been running with funding support from the IPF through KPAN.

The main tasks carried out by the GWL-INA Secretariat are as following:

- Institutional strengthening of GWL-INA network;
- Institutional strengthening of the national secretariat of GWL-INA network;
- Improve communication and coordination with members of the network through GWL-INA mailing list, also with the Board via electronic mail addressed directly to the board of management;
- Improve communication and coordination with stakeholders and donors by participating in various coordination meetings on HIV response programs at the national level;
- Develop terms of reference and propose to donors for capacity building activities for network members when necessary.

The GWL-INA national secretariat was also involved in ICAAP IX in Bali in August 2009. The network was represented by the National Secretariat. It implied that the existence of GWL-INA network has received the recognition from the ICAAP local committee.

## **5.7. Private Sector**

The involvement of private sector in HIV and AIDS cannot be separated from the influence of global policy driven by the International Labor Organisation (ILO). The mobilisation of the

private sector was carried out through various high-level tripartite meetings at the national and local level throughout 2003. On 25 February 2003, a meeting was held between the government represented by the Minister of Manpower and Transmigration and the Coordinating Minister of People's Welfare, Indonesian Chamber of Commerce and Industry (*Kamar Dagang dan Industri Indonesia/ KADIN*), Indonesian Employers' Association (*Asosiasi Pengusaha Indonesia/ Apindo*), as well as the representatives of the Workers Unions (KSPI – Congress of Indonesian Workers Union, KSPSI – Confederation of Indonesian Prosperous Workers Union, SBSI – Indonesian Prosperous Workers Union) in Jakarta. The result was a Tripartite Declaration of Commitment on HIV and AIDS Response in the World of Work as follows:

- Recognizing that the HIV and AIDS epidemic in Indonesia potentially threatens the profitability and productivity of businesses as well as the health of the workforce and wider community;
- Expressing deep concern that the threat of HIV and AIDS harms the sustainable national development and human resources in Indonesia;
- Urging all parties in the workplace to cooperate with all communities' potentials to prevent the escalation of HIV and AIDS transmission;
- Urging all parties in the workplace to work together within the framework of tripartite: (a) using the principles of the ILO Code of Practice on HIV and AIDS and the World of Work as the basis for the implementation of HIV and AIDS prevention and response programs in the workplace; (b) prioritizing HIV and AIDS prevention programs in the workplace, including encouraging employers and unions to support the program; (c) encouraging and supporting the elimination of stigma and discrimination against laborers/ workers living with HIV and AIDS.

Furthermore, the Ministry of Manpower and Transmigration issued the Decree No. 68/MEN/IV/2004 on HIV and AIDS Prevention and Response in the Workplace. In 2013, the Coordinating Minister of People's Welfare appointed Indonesian Business Coalition on AIDS (IBCA) as the executive coordinator of the World's AIDS Day 2013 through the Decree of Coordinating Minister of People's Welfare No. B20/Menko/Kesra/I/2012 dated 31 January 2012 regarding the Chairman of National Committee of World's AIDS Day of 2013. The theme of 2013 was "Prevent HIV and AIDS! Protect Workers, Family and Nation" and the sub-theme was "Prevention of HIV and AIDS in the workplace increases the performance of the business world, society, and government, and protects the health of families for the nation's, protection of the rights to gain access, as well as creating a conducive, and free of stigma and discrimination environment." Implementation of activities in commemoration of the 2013 World's AIDS Day under the theme was expected to raise awareness about HIV and AIDS among the society, especially the business sector and the garnered commitment of employers, workers and governments to HIV and AIDS response and prevention in the

workplace (KPAN, 2013).<sup>41</sup>

The private sector was appointed as chief organizer of the 2013 World's AIDS Day commemoration at national level with hope that IBCA<sup>42</sup> could be the driving agent and motivator of active involvement of the private sector in HIV and AIDS control and prevention, especially in the workplace for workers and their families. IBCA is an affiliate of the Asia Pacific Business Coalition on AIDS (APBCA), a similar alliance at Asia Pacific local level. IBCA's vision is to reduce the negative impact of HIV and AIDS on the continuity of the business and economic growth by building a network of high-quality information and best practices, eliminating stigma and discrimination associated with HIV and AIDS, as well as building sustainable partnerships between the private sector and other stakeholders in Indonesia. One of the IBCA programs that was launched at the Highlight of 2013 World's AIDS Day Event was VCT@Work program and the signing of the commitment placard of 100 companies to routinely perform HIV and AIDS prevention and response program in the workplace.

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<sup>41</sup> See

[http://www.aidsindonesia.or.id/ck\\_uploads/files/Artikel%20KPAN\\_Peringatan%20Hari%20AIDS%20Sedunia%202013\(1\).pdf](http://www.aidsindonesia.or.id/ck_uploads/files/Artikel%20KPAN_Peringatan%20Hari%20AIDS%20Sedunia%202013(1).pdf)

<sup>42</sup> Profile IBCA see: <http://www.weforum.org/pdf/GHI/Indonesia.pdf>

## INTEGRATION OF HIV AND AIDS RESPONSE INTO THE HEALTH SYSTEM

### 6.1. Institutional Integration: Contestation of Central and Local Governments

The HIV and AIDS response have resulted in a specific entity i.e. the KPAN. Seven years since the first AIDS case was discovered, the KPAN was established through the Presidential Decree No. 36/1994. This institution is undertaking the mandate to improve the efforts of AIDS prevention, control and response; maintain the continuity of strategic steps in AIDS response; reduce the impact of AIDS epidemic in the fields of health, social, economic and political; and improve the effectiveness of AIDS response coordination to be more intensive, comprehensive and integrated.

The establishment of the KPAN was an initiative of the central government and thus was assigned at central level. When decentralisation was implemented, the establishment of the KPA was mandated to the local level, thus KPAD was established. This new mechanism brought some challenges. By organizational structure, KPAD is not the subordinate of the KPAN. Nevertheless, in terms of program design and agenda, KPAD is a reflection of the KPAN's programs and policies. Furthermore, the KPAD is highly dependent on the KPAN because of the lack of funds and human resources. Available funding is mostly allocated for non-program budgets. Several donors such as the GFATM and IPF provided budget to strengthen this central-local relationship.

Although the KPAN is not a superordinate of the KPAD, however, in terms of programs the KPAD can act as an implementing agency of the KPAN. The KPAD may also occasionally handle the contract with donors. As a consequence, there is a tendency of international partners to dictate the KPAN and the Ministry of Health in terms of program planning for efficiency reasons. They are also likely to rely on the central institution as an intermediate partner between the partner and the KPAD. Local governments in the study location often created regulations concerning HIV and AIDS under the encouragement of KPAN and funding support from donors. As a result, the existing local regulations often only serve as policy documents that are not followed up with clear funding mechanisms and programs which accommodate the needs and characteristics of the local community.

Depending on the areas, KPADs showed different institutional responses and progress. In

*The presence of Government Regulation No. 38/2007 on Division of Government Affairs between the Central Government, Provincial Government, District/ Municipality Government; the issuance of Presidential Regulation No. 72/2007 on National Health System, as well as Laws on Health, SJSN, and BPJS became an opportunity to integrate HIV and AIDS programs into national health system.*

provinces with responsive civil society, for example in East Java, North Sumatra, and Bali, KPADs tend to be more active. However, it was common to find the lack of synergy between KPAD policy and the priorities of local health programs, which led to bottlenecks in the implementation of HIV and AIDS response.

The isolation of HIV and AIDS response from the local political-economy context is significant for HIV and AIDS programs. On the one hand, in terms of program efficiency, integration of local context into a policy can take considerable time and cost. On the other hand, when given authority and responsibility to design a policy or program, the local governments are not always fully aware of the issues related to HIV and AIDS. Thus, important components are not included in the policy and program. For example, STIs screening is not performed in many of the provinces.

**Table 9 – The Role of Local Government in HIV and AIDS Response**

Province	District/Municipality
<ul style="list-style-type: none"> <li>• Implementation of provincial scale of epidemiologic surveillance.</li> <li>• Management of secondary and tertiary referral health services for HIV and AIDS.</li> <li>• Registration, accreditation, certification of health facilities in relation to HIV and AIDS as per government laws/regulations.</li> <li>• Provision of recommendation for health facilities permit for HIV and AIDS appointed by central government.</li> <li>• Empowerment of health personnel for HIV and AIDS at provincial level</li> <li>• Functional and technical training at provincial level.</li> <li>• Management/implementation, mentoring, control of local health insurance. Mentoring and control on the implementation of national health insurance (Assistance Task).</li> <li>• Provision and management of drugs buffer stock, medical devices, other reagents and vaccines.</li> <li>• Execution of health promotion at provincial</li> </ul>	<ul style="list-style-type: none"> <li>• Implementation of epidemiologic surveillance and investigation of outbreaks at district/municipality level.</li> <li>• Implementation of HIV AND AIDS prevention and response at district/municipality level</li> <li>• Management of basic and secondary referral health services at district/municipality level</li> <li>• Provision of recommendation for specific health facilities appointed by central and provincial governments.</li> <li>• Management/implementation of health insurance based on local conditions.</li> <li>• Use of strategic health personnel.</li> <li>• Empowerment of district/municipality health personnel at district/municipality level.</li> <li>• Technical training at district/municipality level.</li> <li>• Registration, accreditation, certification of specific health personnel as per government laws/regulations at district/municipality</li> </ul>

Province	District/Municipality
<p>level.</p> <ul style="list-style-type: none"> <li>• Mentoring and control of norms, standards, procedures, and criteria in health area.</li> <li>• Implementation of medical research and development in support of provincial policy formulation.</li> <li>• Management of health surveys (surkesda) at provincial level.</li> <li>• Monitoring of the use of medical science and technology at provincial level</li> <li>• Implementation of foreign aid cooperation at provincial level</li> <li>• Management, monitoring, evaluation and supervision at provincial level.</li> <li>• Management of health information system at provincial level</li> </ul>	<p>level.</p> <ul style="list-style-type: none"> <li>• Issuance of practice license for specific health personnel.</li> <li>• Provision and management of medicine for basic health services, medical devices, reagents, and vaccines at district/municipality level.</li> <li>• Sampling/collection of samples of pharmaceutical supplies in the field.</li> <li>• Local inspection on production facilities and distribution of pharmaceutical supplies.</li> <li>• Execution of health promotion at district/municipality level</li> <li>• Implementation, mentoring, and control of health operations.</li> <li>• Implementation of medical research and development in support of policy formulation at district/municipality level</li> <li>• Management of district/municipality health surveys (surkesda).</li> <li>• Monitoring of the use of medical science and technology at district/municipality level</li> <li>• Implementation of foreign cooperation at district/municipality level</li> <li>• Management, monitoring, evaluation and supervision at district/municipality scale</li> <li>• Management of health information system at district/municipality level</li> </ul>

There is also unclear mechanism in budgeting of HIV and AIDS response program and other health programs. The regulation of the Ministry of Home Affairs budget allocation for KPAD has already been implemented. However, the majority of budget was allocated for administrative activities. Funds for programs and services are administered by the

Provincial/District Health Office and included in the budget item for infectious disease control. Therefore, HIV and AIDS program has to compete with other infectious disease to obtain budget. At the provincial level, the fund allocation mechanism for KPAD varies. In some provinces, budget is allocated by the local government secretary (Sekretaris Daerah), related departments, or social assistance and grants from donor. Donor grants (e.g. GFATM and IPF) are managed by the KPAN. With the local budget allocation, the administrative and secretarial activities of KPAD can be maintained. However, in terms of program, KPAD is still significantly dependent on KPAN and external grants. The dependence of local entities on the central institutions is partly due to the dominant centralized approach since the early phase of HIV and AIDS response in Indonesia. To date, the strong influence of central institution is still evident in the policy process, program planning and implementation. The existing policies such as the Regulation of Coordinating Minister of People's Welfare, Regulation of Minister of Health, Regulation of Minister of Home Affairs, and the National Strategic Action Plan showed that the role of the central government in many aspects in HIV and AIDS response is very strong. Almost all policies and programs on HIV and AIDS response at local levels are derived from the national programs. It implies that the HIV and AIDS response in Indonesia remains a vertical program. This also means that the issue of HIV and AIDS is still considered by the government as merely a health problem and not as a cross-cutting issue.

Access to budget is one of the factors influencing the dominant role of central government in HIV and AIDS response. Another factor is access to data. Most of the data and surveys used as the basis for the program planning are administered by the central government. As a consequence, the "evidence-based programming" seems to be predominated by the central government. In many cases, programs initiated by the local stakeholders are not supported by strong data and evidence. Instead, local initiatives are often based on case studies or anecdotal evidence. For example, the shift in program priority to IDUs and inmates in the penitentiary facilities is a recommendation that was developed based on central surveillance data. Programs at the local level subsequently adapt with this priority shift. It is unclear whether there is enough evidence at the local level to support the shift of program priority to IDUs and inmates in prisons.

Until now, the predominance of top-down, vertical approach in HIV and AIDS program still prevails. From the technical aspect of the program, there is a reasonable evidence to keep the top-down approach going. However, many critics have also been raised towards the vertical approach especially in terms of contextualisation of the programs with local stakeholders' agenda.<sup>43</sup> Vertical approach tends to bring the agenda and ideas that are considered "different". If the participation of local stakeholders is insufficient, the sense of ownership will be low, and thus the support as well as resource generation by the local government will also be low. Moreover, there is also a risk of lacking conformity with local

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<sup>43</sup> See Rifat. Atun, Sara Bennett San Antonio Duran (2008). "When do vertical (stand-alone) programmes have a place in health systems?". Policy Brief. Health System and Policy Analysis. WHO

programs and priorities.

Given the increase in the geographical scope of HIV and AIDS epidemic in Indonesia in the coming years and the context of decentralized governance system, the vertical approach also have weaknesses from limited coverage of the programme. The involvement of local stakeholders has become increasingly important. The central government, i.e. the Ministry of Health, has become aware of this problem. As a result, the MoH has produced policies to ensure program sustainability through the regulation regarding the implementation of the Minister of Health Regulation No. 21/2013 on Comprehensive and continuity HIV and AIDS and STIs services.

Decentralisation provides the local government an authority to manage its own affairs, including the health services. Decentralisation opens opportunities for increased efficiency, flexibility and responsibility in health services. As a consequence, the central government's capacity to participate in the process of priority setting and budget is limited. The problems arised from the reform in the intergovernmental relations within the decentralized system have also affected the health sector. Table 10 presents the contestation between the central-local policies and the challenges based on the findings during the field visit.

Table 10 – Vertical Policy Approach in HIV and AIDS Response

Dimension	Response	Challenges	Remarks/Examples
Policy and Institutional	<ul style="list-style-type: none"> <li>• National policies and their sub-policies at provincial and district/municipality levels in the forms of Ministerial Regulation, Ministerial Decree, Mutual Agreement Decree, National Strategy, Local Regulation and Local Strategy and Action Plan.</li> <li>• Establishment of KPAN, Provincial KPA, District/Municipality KPA and strengthening program of KPAN, Provincial KPA, District/Municipality KPA.</li> <li>• Increase in the donor funding so that the area and program coverage can be improved.</li> <li>• Planning at national level and the use of national data.</li> </ul>	<ul style="list-style-type: none"> <li>• The turnover local leaders is very influential on the sustainability KPAD and their programs.</li> <li>• Regulations that are not in line with the objectives of the program, such as local regulations on anti-indecency, the shutting down of brothel complex.</li> <li>• Local planning use the results of national estimation or national data. Data or data estimation at local level is not available.</li> <li>• Integration of HIV and AIDS in the health sector strategic plan and local development in general.</li> </ul>	<ul style="list-style-type: none"> <li>• Bali: The Provincial KPA's activity depends on the figure of the KPAD chairman; when the chairman is replaced, programs will be changed.</li> <li>• Local regulation only functions as a political action but minimum implementation.</li> <li>• Banyumas District: Inconsistency between local development program and Provincial/District's Strategic Plan. The HIV and AIDS response outlined in the Strategic Plan is merely administrative document. The development of the strategic plan has not gone through participatory approach. Very little preparation was done. Some activities in HIV and AIDS response plan were not implemented in order to maintain the image of the region.<sup>44</sup></li> <li>• There are many differing perception of stakeholders in relation with KPAD's function as it is often not in line with Regulation No. 20/2007 on General Manual of the Establishment of the National AIDS Commission and Community</li> </ul>

<sup>44</sup> See Marcoes Natsir L. et al. (2005). "Prevention of STIs and HIV AND AIDS in the Era of Local Autonomy." Research Report. Yogyakarta: Center for Population and Policy Studies, Gadjah Mada University and the Ford Foundation.

Dimension	Response	Challenges	Remarks/Examples
			Empowerment in HIV AND AIDS Response. <sup>45</sup>
Health Services	<ul style="list-style-type: none"> <li>• An increase in the availability of ART service.</li> <li>• 25 supporting hospitals and Puskesmas available to provide VCT service.</li> <li>• An increase in the capacity of health personnel at local level supported by donors.</li> </ul>	<ul style="list-style-type: none"> <li>• Responsibility of increasing the capacity of health personnel in the non-donors areas becomes unclear</li> <li>• The disintegration of HIV and AIDS response program from the existing programs in primary health service and the lack of integrated coordination between health service provision and health programs of Provincial/District Health Office.</li> <li>• HIV and AIDS responses tend to focus on centrally determined targets, lacking in contextualization and rigid regulations.</li> <li>• Skepticism on the sustainability of services post donor assistance.</li> </ul>	<ul style="list-style-type: none"> <li>• Cases in some regions, such as Malang and Surabaya, service users switch to donor-assisted services as these are perceived to provide better and friendlier services.</li> <li>• Stigma and discrimination in health service still occur against PLWHA. Cases occurred in Bali and Surabaya.</li> </ul>
Community	<ul style="list-style-type: none"> <li>• There are community mobilization efforts by affected communities and key populations at national level</li> <li>• Representatives of affected communities and key populations at KPAN, Provincial and District/Municipality KPAD</li> </ul>	<ul style="list-style-type: none"> <li>• Conflict of interests between the beneficiaries and community organisations that claim to be the representatives of beneficiaries</li> </ul>	<ul style="list-style-type: none"> <li>• Generally, community representatives at KPAN, Provincial, and District/Municipality KPAD are those who have been exposed, and active in various activities for a long time, thus regeneration is slow.</li> </ul>

## 6.2. Integration into the Health Sector

It is no doubt that the HIV and AIDS response needs to be integrated into the existing health service system. This integration should include several aspects. HIV and AIDS response needs to be integrated into the institutional mechanism of the service providers, such as the inter-unit service in hospitals. The integration of institutional mechanism also requires

<sup>45</sup> Amirudin et al. TT. "Stakeholders' Perception against Local Functions on HIV AND AIDS Response."

institutional strengthening, both in the internal unit and inter-unit in a particular institution. Focusing programs on only one unit, for example, clinics, could be one of the factors that leads to low IDU visits. The administration aspects of programs and services should also be strengthened. The cooperation between the HIV and AIDS departments or units with general medicine department, pharmacy, and other areas must be strengthened in all aspects including program planning, budget allocation planning, implementation, and integrated monitoring and evaluation.

The integration of HIV and AIDS program into the existing health system is not only limited to integration into the institutional mechanism, but also at the conceptual level of programs. For example, the integration of HIV and AIDS response program into STI and reproductive health services and integration of PMTCT services with Mother and Child Health services. Some provinces have developed integration between these services. For example, the East Java has integrated treatment of opportunistic infections as part of the management of chronic diseases. This is financed by the government insurance scheme i.e. Jamkesda for HIV and AIDS. Bali has strengthened the development of human resources through training and incentives for health workers for HIV response programs. The Jakarta provincial government attempted to strengthen the health information system, infrastructure, and logistical management that will improve the overall quality of health service.

In relation with the quality of health service, policies on service quality assurance on care and treatment programs have been developed. The 2010-2014 National Strategic Action Plan provides a strategic guideline to achieve quality assurance of health services, by (1) increasing the availability of qualified health personnel to provide friendly services that meet the needs of PLWHA; (2) ensuring the availability of logistical support for essential drugs for HIV and AIDS treatment; (3) increasing the role of community-based services to complement services provided by the government. However, in reality, the strategic guideline is not implemented. The success of guidelines highly depends on the adherence of Ministry of Health and Provincial/Districts Health Office to translate the guidelines into their work programs. The findings in the visited regions show that such an adherence is hard to find because in practice there are no incentives and sanctions.

There was a wide variation in the prevention measures implemented in the study locations ranged from the distribution of IEC materials to distribution of preventive materials such as condoms, lubricants and syringes. Some programs involved community empowerment components in order to garner support from various parties. Anecdotal data from key informants indicated good results. For example, prevention through needles can reduce the sharing of used needles and encourage addicts to use sterile needles and equipment. However, consistency of condom use remains a challenge in the past two decades, despite various interventions ranging from individual and group outreach to structural interventions.

Other components to consider in the prevention effort are outreach and advocacy. In the late 1990s, individual outreach programs dominated the prevention components. The largest cost in this strategy was salaries for outreach workers. In the mid-2000s, when the model estimates showed that the coverage of number of key populations became the center of the epidemic response, the effectiveness of individual outreach to improve program coverage was still questionable. The lack of outreach and mentoring programs today could degrade the quality of the program. On the other hand, advocacy and outreach efforts by civil society groups were continued. As an example, in Bali, the outreach and advocacy programs were initiated by Yayasan Kerthi Praja for FSWs and Yayasan Citra Indonesia Usadha for homosexuals. Yayasan Hati-Hati began to reach out to groups of IDUs.

In line with the development of programs, there are pros and cons towards the strategies and approach to outreach and counseling activities. At present, most of field activities are coordinated by community organizers. Their focus of attention is not only individuals, but also the environment or community where the key groups reside and conduct their activities. The most common outreach and counseling methods are within the IEC approaches, either through the distribution of preventive materials, assistance and advocacy for public services, to referrals to health services. The format and patterns of IEC programs through mass education and edutainment have become the options commonly used to achieve the targeted program coverage.

Meanwhile, the CST program for PLWHA has recently shown signs of progress. The number of hospitals, Puskesmas, and service clinics increased rapidly, in line with the increased findings. A number of policies have also been developed to improve the provision of services by service providers. Nevertheless, there are still gaps related to CST for PLWHA, i.e. issue of access to services, human resources, service providers, and funding. The main issue is the problem of adequacy, equity and quality. As for the funding, there are still problems in terms of source, allocation, and adequacy of funds. The most common problems in CST for PLWHA are stigma and discrimination experienced by PLWHA and key populations.

The government has attempted to provide services and promote easy access to clients. However, gaps in the services are still found because of the following factors: 1) Geographic barriers and service facilities. Service facilities are typically only available in big municipalities and in the provinces where donors exist; 2) Barriers in access because of program oriented service and not client oriented services. The availability of services are highly dependent on donor support. For instance, when programs are still supported by donors, the availability of services is ensured. However, when support from donor is terminated, services become difficult to access, or even stop.

In the broader health sector, integration may take place through the achievement of health indicators stipulated in the Minimum Service Standards (MSS) at the District/Municipality Health Office, which includes 1) Primary Health Service (18 indicators); 2) Referral Health

Service (2 indicators); 3) Epidemiological Research and Response to Outbreak (1 indicator); and 4) Health Promotion and Community Empowerment. In some of the study locations, HIV and AIDS have not been included in the MSS indicators. This shows that the integration of HIV and AIDS into health care needs to be mainstreamed.

### **6.3. Integration into the Non-Health Sector**

The integration of HIV and AIDS response into the non-health sectors such as the legal sector is also important. The agreement between the State Police Chief as BNN Chairman and The Minister of People's Welfare as the KPAN Chairman has become an example of successful integration at the policy level, i.e. the integration of Harm Reduction among IDUs. Despite many challenges in the implementation, many activists and organization working in Harm Reduction perceive that this policy has been supporting and protecting their workers from criminalisation<sup>46</sup>, including Harm Reduction activities in penitentiary facilities.

The government efforts to integrate HIV and AIDS response with illegal drug response have encountered many challenges. For example, in terms of budget planning, HIV and AIDS and drug control should be in line. However, there is often unequal treatment to users. To overcome this issue, some policies have been issued, such as the MoU between the Minister of People's Welfare and BNN on HR 2003 and Regulation of Minister of People's Welfare No. 2/2007 National Policy on HIV and AIDS Response through Intravenous Addictive Drugs Harm Reduction. There are also policies that perceive drug users as victims, i.e. the Circular Letter of the Supreme Court No. 4/2010 which provides recommendation that drug users who are exposed to legal sanctions may be referred to a rehabilitation center. The Attorney General's Office has also issued a circular letter to Prosecutors not to criminalize addicts who are arrested by police. The Law on Narcotics No. 3/2009 also mentioned that addicts are required to undergo medical rehabilitation or social rehabilitation as they are perceived as victims who need to be restored because they are similar to the sick being restored at hospitals. Furthermore, the government also issued the Government Regulation No. 25/2011 concerning compulsory reporting for addicts or drugs abusers. Adult addicts are expected to report themselves to the receiving institution. Young addicts must be reported by their parents in order to receive rehabilitation immediately. Article 13 of this Government Regulation mentions that an investigator or a judge can temporarily put an addict at rehabilitation center, corresponding to the level of the ongoing legal process. Unfortunately, based on interviews with some addicts, it was still revealed that when they are arrested and the legal process is underway, they were held in prisons/ penitentiary facilities, instead of being treated in a rehabilitation center such as in BNN or elsewhere.

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<sup>46</sup> Refer to the results of BSS and IBSS of IDUs.

#### 6.4. Challenges of Integration

It can be concluded that the efforts of integrating HIV and AIDS response into the health system still encounter many challenges including the availability of human resources, availability and quality of service, funding limitation, as well as stigma and discrimination.

Qualified human resources, both at managerial and executive levels on the field, are urgent necessities. The majority of informants mentioned that the number and qualities of technical personnel on the field, such as outreach workers and assistants, HIV and AIDS counselors, case managers, and buddies are still considered inadequate. At the level of health care providers, the Ministry of Health has a policy on Manual for Procurement of Health Workers with Employment Agreement in Government Health Facility (Regulation of Minister of Health No. 1199/Menkes/PER/X/2004). This regulation is still considered as an insufficient legal protection, as human resources for HIV and AIDS are not only necessary in government health facilities, but also in other related institutions.

The availability and equitable distribution of health service facilities such as hospitals, Puskesmas, and health clinics are issues that still need attention in integration effort. Equitable access in terms of distance, availability and quality, are important factor for PLWHA and key populations. This is especially important given their mobility which is now not only concentrated in big municipalities.

The limited budget is a clear indication of level of government support on HIV and AIDS issues. The KPAN data in 2008 and 2010 showed that the proportion of domestic funding by local governments has increased. Nevertheless, a large proportion of funding is still contributed by foreign aid. Budget allocation is also challenged by the enforcement of the Law on Universal Health Coverage which also includes aspects of services. Policies related to health service within the scheme of national health insurance have been issued, i.e. Regulation of Minister of Health and the Minister's Circular Letter. Access of PLWHA and key populations to health services in the UHC era is another challenge of the new health insurance system.

Stigma and discrimination are still major issues in HIV and AIDS. Efforts to reduce stigma and discrimination have been underway, from the program planning to the development of an enabling environment. However, until now stigma and discrimination are still commonly found among the society and the service providers. For example, transgenders especially PLWHA transgender still face very strong discrimination and stigma. It has been reported by respondents in this study that there has been improvement in the attitude and behaviour of health personnel towards PLWHA. However, a few discriminative attitude was still found. There is still a need for increasing knowledge and capacity building of health workers on HIV and AIDS. The Ministry of Health has responded to this need by launching the Manual of Elimination of Discrimination Stigma for Program Management, Health Service Personnels and Cadres in 2012.

## CONCLUSIONS AND RECOMMENDATIONS

### 7.1. Conclusions

The present study, concludes that the health system responses to HIV and AIDS epidemic in Indonesia reflect complex contestations between various approaches, principles, and actors operating within a constantly changing sociological context.

First, there is discordance between the vertical and horizontal strategies to address the increasing number of HIV/AIDS cases. The vertical strategy relies on a rigid and highly centralized technical intervention. In contrast, the horizontal strategy emphasizes multi-sectoral and decentralized approaches. Secondly, in policy making processes, political and economic considerations often outweigh epidemiological evidence as the basis for decision making. For instance, evidence has shown that the use of condom in high risk population should be promoted; however political considerations have prevented widespread campaign on condom use. There is often a conflicting role between the central and local governments. With strong access over epidemiological data, there is a predominance of central government actors particularly in technical intervention. Finally, disagreement is often found between school of thoughts represented by different institutions working in HIV/AIDS, for example USAID and AusAID (now DFAT), GFATM, local and international NGOs, and government agencies.

Institutional responses (e.g. establishment of entities and institutions) and enforcement of the regulations/policies are the two most widely adopted measures in HIV/AIDS strategies. These measures are considered to ensure sustainability of the programs because they will enable the government to continue investments made by donors. The current study shows that the effective implementation of newly developed policies and regulations as well as institutional structures are heavily relying on the existing health systems and governance. In other words, the development of HIV/AIDS strategies often use too much assumption that the health sector and other sectors outside HIV/AIDS area would have sufficient capacity to deliver comprehensive response. Through case studies in the study location, it was apparent that institutional responses and development of regulations were more of a normative basis against which performance in HIV/AIDS response will be measured and therefore be made in place. However, institutional structures and regulations are ineffective due to inadequate implementation. For instance, almost all provinces have established the Local AIDS Commissions (*Komisi Penanggulangan AIDS Daerah/ KPAD*). However, for various reasons, the role of these institutions tends to be confined to merely fulfill their institutional mandates. The implementation of local government regulations (*Peraturan Daerah/ PERDA*) on HIV and AIDS was also ineffective due to the absence of adequate resources and punishment. There were also overlaps or contradiction between regulations at local government level.

Many of the successful HIV and AIDS programs or initiatives are those which have been effectively integrated into the primary health care system. For example are the Prevention from Mother to Child Transmission or PMTCT program and Mother and Child Health or program as well as the integration with the existing health insurance/health insurance scheme.

The enactment of Government Regulation No. 38/2007 on the Division of Government Affairs between the Central Government, Provincial Government, and the District/Municipality Government has been an opportunity for a better integration of current HIV and AIDS response programs into the health care system. The implementation of the Universal Health Coverage in 2014 i.e. national health insurance by the Social Security Executing Agency for Health (*Badan Penyelenggara Jaminan Sosial Kesehatan/ BPJS Kesehatan*) has been a challenge for HIV and AIDS response program in Indonesia particularly on the measures of treatment, support, care, and impact mitigation.

Lastly, the role of civil society represented by the key population has not been optimal. Although the identities of existing communities such as people living with HIV and AIDS (PLWHA) and Intravenous Drug Users (IDUs) are quite well accepted by the society, however, this is not the case for Female Sex Workers (FSWs), transgenders, Men who have Sex with Men (MSM), and homosexuals.

## 7.2. Recommendations

This study provided a number of strategic recommendations in working toward the integration of HIV and AIDS into the health system:

1. To manage the existing contestations on HIV and AIDS response so as not to mutually negate one another, it is necessary to develop a roadmap on integration of HIV and AIDS programs into the implementation level of the health system.
2. Given the effectiveness of HIV and AIDS response programs at the operational level is dependent on the adaptability of the existing primary health care system, the strengthening of primary health services is a "*necessary and sufficient condition*".
3. Given the success of HIV and AIDS programs in the decentralisation era is highly dependent on the local government response, the preparation of program scheme that provides some room to local initiatives but remains outcomes-oriented, such as the mechanism of "*performance-based financing*", which has started to be implemented in health sectors, needs to be formulated.
4. There has to be a change on the existing strategy in the HIV and AIDS response policy socialisation by taking into account the relations and dynamics of interaction between the Local Government (*Pemerintah Daerah/ PEMDA*), Local Parliament (*Dewan Perwakilan Rakyat Daerah/ DPRD*) and key populations. Socialisation of policies and programs through political parties needs to be in the agenda so that the issue of HIV and AIDS can become a priority in areas with high case fatality rate.

5. A review of various policies that potentially lead to stigma and discrimination against key populations is a step that needs to be taken in the HIV and AIDS response.
6. There has to be policies and concrete efforts to help the key populations in accessing Health Insurance in the current BPJS era. This serious review needs to take place immediately.
7. There is a need to develop policies to govern the repositioning of relevant agencies responsible for HIV and AIDS response and adapting to the changes of the existing government organisation system within the decentralized environment. The positions of the KPAN, Provincial KPA and District/Municipality KPA must be reinforced.

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## Annex 1

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No	Name of Manual/ Renstra	Policy	Year
1	Manual of Response to HIV AND AIDS and STDs	Decree of Minister of Health No. 1285/Menkes/SK/X/2002	2002
2	Manual of Service Facility for Rehabilitation of Addictive Drugs Abuse and Addiction	Decree of Minister of Health No. 996/Menkes/SK/VIII/2002	2002
3	Manual of Implementation of Health Epidemiological Surveillance System	Decree of Minister of Health No. 1116/Menkes/SK/VIII/2003	2003
4	Manual of Development of Health Human Resources Planning at Provincial, District/Municipality and Hospital Levels	Decree of Minister of Health No. 81/Menkes/SK/I/2004	
5	Manual of HIV and AIDS Voluntary Counseling and Testing Service	Decree of Minister of Health No. 1507/Menkes/SK/X/2005	2005
6	National Manual of Medical Research Ethics	Decree of Minister of Health No. 1031/Menkes/SK/VII/2005	2005
7	Manual of Medical Audit in Hospital	Decree of Minister of Health No. 496/Menkes/IV/2005	2005
8	Manual of PMTCT		2006
9	Manual of HIV and AIDS Voluntary Counseling and Testing		2006
10	Manual of Credit Score Assessment of Health Functional Positions within Ministry of Health	Decree of Minister of Health No. 153/Menkes/SK/2006	2006
11	Pedoman Manual of Governance on STIs		2006
12	Manual of Implementation of Addictive Drugs Harm Reduction	Decree of Minister of Health No. 567/Menkes/SK/VIII/2006	2006
13	Strategic Plan on HIV and AIDS Response in Indonesia 2002-2007		2007
14	Manual of Implementation of Health Promotion in Puskesmas	Decree of Minister of Health No. 585/Menkes/SK/2007	2007
15	Manual of Medical Rehabilitation Service in Hospitals	Decree of Minister of Health No. 378/Menkes/SK/IV/2008	2008
16	Manual of Implementation Procedure of Harm Reduction in Puskesmas		2008
17	Manual of Implementation of Collaborative Response to TB and HIV Diseases	Decree of Minister of Health No. 1278/Menkes/SK/XII/2009	2009
18	Manual of HIV and AIDS Program Management		2009
19	Manual of TB Response	Decree of Minister of Health No. 364/Menkes/SK/V/2009	2009
20	Manual of Implementation of Behavioural Change Intervention		2010
21	Manual of Cognitive Rehabilitation	Decree of Minister of Health No.	2010

		263/Menkes/SK/2010	
22	Manual of Prevention of HIV and AIDS and STIs Transmission for District/Municipality 2010		2010
23	Implementation Procedure for Compulsory Reporting Drug Addicts	Decree of Minister of Health No. 2171/Menkes/SK/X/2011	2011
<b>II</b>	<b>Standards</b>		
1	Service Standards of Medical Laboratory for Examinations of HIV and Opportunistic Infections	Decree of Minister of Health No. 241/Menkes/SK/IV/2006	2006
<b>III</b>	<b>Stipulation</b>		
1	Stipulation of Pilot Hospitals and Satellites for MMT Service	Decree of Minister of Health No. 494/Menkes/SK/VII/2006	2006
2	Stipulation of Referral Hospitals for PLWHA	Decree of Minister of Health No. 760/Menkes/SK/VI/2007	2007
3	Stipulation of Supporting and Satellite Hospitals for MMT and Manual of MMT	Decree of Minister of Health No. 350/Menkes/SK/IV/2008	2008
4	Compulsory Reporting Receiving Institution	Decree of Minister of Health No. 1305/Menkes/SK/VI/2011	2011
5	Referral Hospitals for PLWHA	Decree of Minister of Health No. 782/Menkes/SK/IV/2011	2011

## Annex 2

### Regulations and Policies on HIV and AIDS 1987-2013

Year	Policy				
	Type of Policy	Prevention	CST	Impact Mitigation	Governance
<b>National Policy</b>					
1988	Decree of Minister of Health No. 339/IV/1988 on Establishment of of HIV and AIDS Response Committee in Indonesia.				Click here
	Instruction of Minister of Health No. 72/ii/1988 on Compulsory Reporting on Patients with Indication of AIDS				
	Decree of Directorate General of Infectious Diseases and Environmental Sanitation Control of the Ministry of Health of the Republic of Indonesia No. 2/6/1988 on Technical Guidelines on Compulsory Reporting on Patients with Indication of AIDS				
1992	Decree of Minister of Health No. 662/VII/1992 on Compulsory HIV Testing on Blood Donors				
	Decree of Directorate General of Infectious Diseases and Environmental Sanitation Control of the Ministry of Health of the Republic of Indonesia  No. 668 30/11/1992 on National Policy of HIV AND AIDS Response and Implementation across Indonesia				
1993	Decree of Governor of South Sulawesi No. 18 dated 30 January 1993 on Establishment of AIDS Commission at District/Municipality Level				
	Decree of Regent of Gorontalo No. 66 dated 27 February 1993 on Establishment of AIDS Commission at District/Municipality Level				

	Decree of Regent of Minahasa No. 212 dated 22 September 1993 on Establishment of AIDS Commission at District/Municipality Level				
	Decree of Regent of Bolaang Mongondow No.45 dated 13 April 1993 on the Establishment of AIDS Commission at District/Municipality Level				
	Decree of Mayor of Manado No. 122 Year 1993 on Establishment of AIDS Commission at District/Municipality Level				
1994	Presidential Decree No. 36/1994 on Establishment of AIDS Commission				
	Decree of Coordinating Minister of People's Welfare on No. 9/VI/1994 STRANAS 1994				
	Decree of Coordinating Minister of People's Welfare B-182/Menko/Kesra/VI/1994 on Follow Up of Establishment of National AIDS Commission on Presidential Decree No. 36/1994				
	Decree of Coordinating Minister of People's Welfare No. 8/VII/1994 on Structure, Tasks, and Function of AIDS Response Commission Members				
	Decree of Coordinating Minister of People's Welfare No. 12/VII/1994 on Establishment of HIV and AIDS Response Working Group				
	Decree of Minister of Education and Culture No. 0286/P/1994 Establishment of HIV and AIDS Response Working Group in the Ministry of Education and Culture				
	Decree of Coordinating Minister of People's Welfare No. 9/VI/1994 on Amendment of HIV and AIDS Response Team at Provincial Level into AIDS Commission				
	Instruction of Minister of Home Affairs No. 26/1994 on HIV and AIDS Prevention and Reponse in the Ministry of Home Affairs				
	Decree of Minister of Social Affairs No. 50/HUK/1994 on Establishment of HIV and				

	AIDS Response Technical Team in Social Affairs Domain				
1994	Decree of Directorate General of Infectious Diseases and Environmental Sanitation Control of the Ministry of Health of Republic of Indonesia No. 4/Juli/1995 on Presidential Decree No. 36/1994 and Regulation of Coordinating Minister of People's Welfare No. 9/1994 on Amendment of HIV and AIDS Response Team into AIDS Commission				
1995	Decree of Governor of North Sulawesi No. 298 A Year 1995 on Establishment of Provincial AIDS Commission in North Sulawesi				
	Decree of Coordinating Minister of People's Welfare No. 5/II/1995 on Strategy on HIV and AIDS Response for the Fourth Five Year Development ( <i>Pembangunan Lima Tahun/ PELITA VI</i> ).				
1996	Ministerial Decree No. 107/KT-005/E2/96 on National Family Planning Coordination Board ( <i>Badan Koordinasi Keluarga Berencana Nasional/ BKKBN</i> ) Establishment of HIV and AIDS Response Technical Team and Secretariat through improvement of family welfare.				
	Decree of Head of East Java Province Local Office for Social Affairs No. 49/IV/C-I/VII/1996 on Establishment of HIV and AIDS Response Technical Team in Social Affairs Domain in the East Java Province Local Office				
1997	Decree of Minister of Education and Culture of Republic of Indonesia No. 303/U/1997 on Manual of HIV and AIDS Prevention through Education				
	Decree of Minister of Education and Culture of Republic of Indonesia No. 9/U/1997 on Manual of HIV and AIDS Prevention through Education				
	Presidential Instruction No. 3/2002 on Countermeasure of Exploitation and Illicit				

2002	Trafficking of Addictive Drugs				
	Decree of Minister of Health No. 1285/Menkes/SK/X/2002 on Manual of Response to HIV and AIDS and STDs				
2003	Joint Decree of the Minister of People's Welfare No. 20.KEP/MENKO/KESRA/XII/2003 and Chief of National Police Force No. B/01/XII/2003/BNN on Establishment of National Team for Integrated Measures for HIV AND AIDS Prevention, Transmission, and Countermeasure of Exploitation of Intravenous Addictive Drugs				
2004	Decree of Minister of Health No.781/Menkes/SK/VII/2004 on 25 ARV Referral Hospital				
	East Java Provincial Government Regulation No. 05 Year 2004 on HIV and AIDS Prevention and Response in East Java				
2005	Decree of Minister of Health No. 1441/MENKES/SK/X/2005 on Ministry of Health's HIV and AIDS Response Working Group				
	Decree of Minister of Health No. 1507/Menkes/SK/X/2005 on Manual of HIV and AIDS Voluntary Counseling and Testing Service				
	Regulation of Minister of Health No. 1575/Menkes/Per/XI/2005 on Organisational Structure and Governance of the Ministry of Health				
2006	Decree of Minister of Health No. 241/Menkes/SK/IV/2006 on Service Standards of Medical Laboratory for Examinations of HIV and Opportunistic Infections				
	Decree of Minister of Health No. 832/Menkes/SK/X/2006 on Stipulation of Referral Hospitals for PLWHA and Standards of Referral Hospitals and Satellites for PLWHA				

	Decree of Minister of Health No. 567/Menkes/SK/VIII/2006 on Manual of Implementation of Addictive Drugs Harm Reduction				
	Decree of Minister of Health of Republic of Indonesia No. 494/Menkes/SK/ VIII/2006 on Stipulation of Pilot Hospitals and Satellites for MMT Service and Manual of MMT.				
2006	Presidential Regulation No. 75/2006 on National AIDS Commission				
2007	Presidential Regulation No. 1 Year 2007 on Ratification, Enactment, and Dissemination of Regulating Law				
	Government Regulation No. 38 Year 2007 on Division of Government Affairs between the Central, Provincial, and District/Municipality Levels (State Gazette of Republic of Indonesia Year 2007 No. 82, Amendment of State Gazette of Republic of Indonesia No. 4737)				
	Regulation of Minister of People's Welfare No. 2/PER/MENKO/KESRA/I/2007 on HIV AND AIDS Response Policy through Intravenous Addictive Drugs Harm Reduction				
	Regulation of Minister of People's Welfare No. 3/PER/MENKO/KESRA/III/2007 on Structure, Tasks, and Function of National AIDS Commission Members				
	Regulation of Minister of People's Welfare No. 4/PER/MENKO/KESRA/III/2007 on Manual and Governance of National, Provincial, and District/Municipality AIDS Commissions				
	Regulation of Minister of People's Welfare No. 5/PER/MENKO/KESRA/III/2007 on Organisation and Governance of National AIDS Commission Secretariat				
	Regulation of Minister of People's Welfare No. 6/PER/MENKO/KESRA/III/2007 on National AIDS Commission Executing Team				

	Regulation of Minister of People's Welfare No. 7/PER/MENKO/KESRA/III/2007 on National Strategy for AIDS Response 2007-2010				
	Regulation of Minister of Home Affairs No. 20/2007 on General Manual of Establishment of Local Level AIDS Commission, General Manual of Establishment of AIDS Commission and Community Empowerment for HIV AND AIDS Response at Local Level				
	Decree of Minister of Health of Republic of Indonesia No. 760/Menkes/Sk/VI/2007 on Stipulation of Referral Hospitals for PLWHA				
	Decree of Minister of Health of Republic Indonesia No. 812/Menkes/Sk/Vii/2007 on Policy on Palliative Treatment				
	Decree of Minister of Health of Republic Indonesia No. 11 971/Menkes/Lsk/X112007 on HIV AND AIDS Response Working Group in the Ministry of Health				
<b>2007</b>	National Manual of ARV Therapy, Guidelines of Clinical Governance on HIV Infection for Adults and Teenagers (Second Edition) of the Ministry of Health of Republic of Indonesia, Directorate General of Infectious Diseases and Environmental Sanitation Control 2007				
	National Joint Policy on TB/HIV First Edition of the Ministry of Republic of Indonesia 2007				
	Manual of Network Development of CST Service for HIV AND AIDS Development the Ministry of Health of Republic of Indonesia, Directorate General of Infectious Diseases and Environmental Sanitation Control 2007				
<b>2008</b>	Regulation of Minister of Health No. 269/Menkes/Per/III/2008 on Medical Record				
	Decree of Minister of Health No. 350/Menkes/SK/IV/2008 on Stipulation of Supporting and Satellite Hospitals for MMT				

	and Manual of MMT				
	Decree of Minister of Health No. 378/Menkes/SK/IV/2008 Manual of Medical Rehabilitation Service in Hospitals				
	Badung District Government Regulation No. 1 Year 2008 on HIV and AIDS Response				
	Bulukumba District Government Regulation No. 5 Year 2008 on HIV and AIDS Response				
	Malang District Government Regulation No. 14 Year 2008 on HIV and AIDS Response in Malang District				
	East Nusa Tenggara District Government Regulation on HIV and AIDS Prevention and Response				
	DKI Jakarta Provincial Government Regulation No. 5 Year 2008 on HIV and AIDS Response				
<b>2009</b>	Law No. 10 Year 2009 on Tourism (State Gazette of Republic of Indonesia Year 2009 No. 11, Amendment to State Gazette of Republic of Indonesia No. 4966)				
<b>2009</b>	Law No. 11 Year 2009 on Social Welfare (State Gazette of Republic of Indonesia Year 2009 No. 12, Amendment to State Gazette of Republic of Indonesia No. 4967)				
	Law No. 35 Year 2009 on Narcotics (State Gazette of Republic of Indonesia Year 2009 No. 143, Amendment to State Gazette of Republic of Indonesia No. 5063)				
	Law No. 36 Year 2009 on Health (State Gazette of Republic of Indonesia Year 2009 No. 144, Amendment to State Gazette of Republic of Indonesia No. 5063)				
	Law No. 44 Year 2009 on Hospitals (State Gazette of Republic of Indonesia Year 2009 No. 153, Amendment to State Gazette of Republic of Indonesia No. 5072)				
	Central Java Provincial Government Regulation No. 5 Year 2009 on HIV and AIDS				

	Response				
	West Kalimantan Provincial Government Regulation No. 2 Year 2009 on HIV and AIDS Prevention and Response in West Kalimantan Province				
	East Luwu District Government Regulation No. 7 Year 2009 on HIV and AIDS Prevention and Response				
	Bekasi Municipality Government Regulation No. 3 Year 2009 on HIV and AIDS Prevention and Response in Bekasi Municipality				
<b>2010</b>	Regulation of Minister of Health No. 411/Menkes/Per/III/2010 on Clinical Laboratory				
	National Action Plan on Response to HIV and AIDS and Addictive Drugs Abuse at Technical Executing Units (Unit Pelaksana Teknis/ UPT) for Community Correction in Indonesia of Year 2010-2014 at the Directorate General of Community Correction of the Ministry of Law and Human Rights of Republic of Indonesia				
	Semarang District Government Regulation No. 3 Year 2010 on HIV and AIDS Response in Semarang District				
	DI Yogyakarta Provincial Government Regulation No. 12 Year 2010 on HIV and AIDS Response				
	Papua Provincial Government Regulation No. 8 Year 2010 on HIV and AIDS Response				
<b>2011</b>	Decree of Minister of Health No. 782/Menkes/SK/IV/2011 on Referral Hospitals for PLWHA				
	National Manual of Clinical Governance for HIV Infections and ARV Therapy for Adults, Directorate General of Disease Control and Environmental Sanitation 2011, Ministry of Health of Republic of Indonesia				
	National Manual of Response to STIs 2011, Directorate General of Disease Control and				

	Environmental Sanitation 2011, Ministry of Health of Republic of Indonesia				
	2011 National Manual of Prevention from Mother to Child Transmission Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia				
<b>2012</b>	Regulation of Governor of DI Yogyakarta No. 37 Year 2012 on HIV and AIDS Reponse Implementation				
	2012 Implementation Manual of Sustainable and Comprehensive HIV-STI Services, Ministry of Health of Republic of Indonesia				
	2012 Implementation Manual of Comprehensive HIV and AIDS and STI Services at Penitentiary, Prisons, and Correctional Centers, Directorate General of Disease Control and Environmental Sanitation of Ministry of Health and Directorate General of Community Correction of Ministry of Law and Human Rights of Republic of Indonesia				
<b>2013</b>	Regulation of Minister of Health of Republic of Indonesia No. 21 Year 2013 on HIV and AIDS Reponse				
	Circular Letter No. GK/Menkes/001/I/2013 on Services for Prevention from Mother to Child Transmission				
	Circular Letter No. 129 Year 2013 on Implementation of Response to HIV and AIDS and STIs, Ministry of Health of Republic of Indonesia				

### Annex 3

#### Regulations and Policies on HIV and AIDS 1987-2013

Year	Policy	Description	Click here
1988	<i>Decree of Minister of Health No. 339/IV/1988 on Establishment of HIV and AIDS Response Committee in Indonesia.</i>	Regulates the Establishment of HIV and AIDS Response Committee in Indonesia.	
	<i>Instruction of Minister of Health No. 72/ii/1988 on Compulsory Reporting on Patients with Indication of AIDS</i>	Addressed to health workers and health service facilities, that it is compulsory to report patients with indication of AIDS to the Directorate General of Infectious Diseases and Environmental Sanitation Control ( <i>Dirjen (Pemberantasan Penyakit Menular dan Penyehatan Lingkungan Pemukiman/ P2MPLP)</i> ).	
	<i>Decree of Directorate General of Infectious Diseases and Environmental Sanitation Control of the Ministry of Health of Republic of Indonesia No. 2/6/1988 on Technical Guidelines on Compulsory Reporting on Patients with Indication of AIDS</i>	This is a further guideline of Decree of the Instruction of Minister of Health No 72/ii/Menkes/Inst/1988 stipulates the operation procedures for implementation of reporting on patients with indication of AIDS.	
	<i>Law of Republic of Indonesia No. 4 Year 1984 on Infectious Disease Epidemiy</i>	The issuance of this Law becomes the means of an early safeguard for citizens from the epidemiological disaster, in order to build the community capacity for healthy living. The law also stipulates that the Minister has defined the types of disease and specific areas that are prone to epidemiy.	
1992	<i>Decree of Minister of Health No. 662/VII/1992 on Compulsory HIV Testing on Blood Donors</i>	This Decree of Minister of Health is addressed to all health services across Indonesia, that it is compulsory for all blood donors to take HIV testing.	
	<i>Law No. 23/1992 on Health</i>	This Law stipulates that eradication of infectious diseases to be done through counseling, education, immunisation, elimination of disease sources and carriers, quarantine measures and	

Year	Policy	Description	Click here
		other required efforts.	
	<i>Decree of Directorate General of Infectious Diseases and Environmental Sanitation Control of the Ministry of Health of Republic of Indonesia No. 668 30/11/1992 on National Policy of HIV and AIDS Response and Implementation across Indonesia</i>	This Decree of Directorate General of Infectious Diseases and Environmental Sanitation Control ( <i>Dirjen (Pemberantasan Penyakit Menular dan Penyehatan Lingkungan Pemukiman/ P2MPLP)</i> of the Ministry of Health is the regulating law of National Policy on HIV and AIDS Response and Implementation across Indonesia.	
1993	<i>Decree of Governor of South Sulawesi No. 18 dated 30 January 1993 on Establishment of AIDS Commission at District/Municipality Level</i>	In order to implement the HIV and AIDS response national policy in South Sulawesi Province, the Governor established the South Sulawesi Provincial AIDS Commission.	
	<i>Decree of Regent of Gorontalo No. 66 dated 27 February 1993 on Establishment of AIDS Commission at District/Municipality Level</i>	As per the Decree of South Sulawesi Governor No 18 dated 30 January 1993, a District AIDS Commission was also established for Gorontalo District.	
	<i>Decree of Regent of Minahasa No. 212 dated 22 September 1993 on Establishment of AIDS Commission at District/Municipality Level</i>	Following the Decree of South Sulawesi Governor No 18 dated 30 January 1993 on formation of the district level AIDS Commission, this Regent Decree was issued.	
	<i>Decree of Regent of Bolaang Mongondow No.45 dated 13 April 1993 on Establishment of AIDS Commission at District/Municipality Level</i>	As per the Decree of South Sulawesi Governor No 18 dated 30 January 1993, an AIDS Response Team was also established at Bolaang Mongondow District in support of the HIV AND and response national policy.	
	<i>Decree of Mayor of Manado No. 122 Year 1993 on Establishment of AIDS Commission at District/Municipality Level</i>	As per the Decree of South Sulawesi Governor No 18 dated 30 January 1993, an AIDS Response Team was also established at Manado Municipality in support of the HIV and AIDS response national policy.	
1994	<i>Presidential Decree No. 36/1994 on Establishment of AIDS</i>	With the purpose of a comprehensive, integrated, and coordinated HIV and AIDS prevention and response in Indonesia, a cross-sector AIDS	

Year	Policy	Description	Click here
	<i>Commission</i>	Commission was established as per the Presidential Decree No. 36 Year 1994.	
	<i>Decree of Coordinating Minister of People's Welfare on No. 9/VI/1994 STRANAS 1994</i>	This Decree of Minister of People's Welfare governs the 1994 National Strategy for HIV and AIDS Response.	
	<i>Decree of Coordinating Minister of People's Welfare B-182/Menko/Kesra/VI/1994 on Follow Up of Establishment of National AIDS Commission on Presidential Decree No. 36/1994</i>	This is a follow up Decree of the Presidential Decree No 36/1994 on the establishment of National AIDS Commission.	
	<i>Decree of Coordinating Minister of People's Welfare No. 8/VII/1994 on Structure, Tasks, and Function of AIDS Response Commission Members</i>	This Decree stipulates the regulations on Structure, Tasks, and Function of the AIDS Commission Members.	
	<i>Decree of Coordinating Minister of People's Welfare No. 12/VII/1994 on Establishment of HIV and AIDS Response Working Group</i>	This Decree stipulates the Establishment of HIV and AIDS Response Working Group.	
	<i>Decree of Minister of Education and Culture No. 0286/P/1994 Establishment of HIV and AIDS Response Working Group in the Ministry of Education and Culture</i>	This Regulation governs the Establishment of HIV and AIDS Response Working Group in the Ministry of Education and Culture.	
	<i>Decree of Coordinating Minister of People's Welfare No. 9/VI/1994 on Amendment of HIV and AIDS Response Team at Provincial Level into AIDS Commission</i>	This Regulation amends the HIV and AIDS Response Team at provincial level to AIDS Commission.	
	<i>Instruction of Minister of Home Affairs No. 26/1994 on HIV and AIDS Prevention and Reponse in the Ministry of Home Affairs</i>	In this Instruction, the Minister of Home Affairs regulates the HIV and AIDS Response in the Ministry of Home Affairs.	

Year	Policy	Description	Click here
	<i>Decree of Minister of Social Affairs No. 50/HUK/1994 on Establishment of HIV and AIDS Response Technical Team in Social Affairs Domain</i>	The Minister of Social Affairs regulates the Establishment of HIV and AIDS Response Technical Team in Social Affairs Domain.	
1994	<i>Decree of Directorate General of Infectious Diseases and Environmental Sanitation Control of the Ministry of Health of Republic of Indonesia No. 4/Juli/1995 on Presidential Decree No. 36/1994 and Regulation of Coordinating Minister of People's Welfare No. 9/1994 on Amendment of HIV and AIDS Response Team into AIDS Commission</i>	This Regulation is a follow up action of the Presidential Decree No. 9/1994 on the Amendment of HIV/AIDS Response Team into AIDS Commission.	
1995	<i>Decree of Governor of North Sulawesi No. 298 A Year 1995 on Establishment of Provincial AIDS Commission in North Sulawesi</i>	This Governor Decree is the executing regulation of the decree issued in the previous year on the Establishment of AIDS Commission at South Sulawesi Province.	
	<i>Decree of Coordinating Minister of People's Welfare No. 5/II/1995 on Strategy on HIV and AIDS Response for the Fourth Five Year Development (Pembangunan Lima Tahun/ PELITA VI).</i>	This Decree reviews the Strategy on HIV and AIDS Response for the Fourth Five Year Development (Pembangunan Lima Tahun/ PELITA VI).	
1996	<i>Ministerial Decree No. 107/KT-005/E2/96 on National Family Planning Coordination Board (Badan Koordinasi Keluarga Berencana Nasional/ BKKBN) Establishment of HIV and AIDS Response Technical Team and Secretariat through improvement of family welfare.</i>	In this Regulation, the Minister of Health decided that it is required to establish an HIV and AIDS Response Technical Team and Secretariat within the National Family Planning Coordination Board (Badan Koordinasi Keluarga Berencana Nasional/ BKKBN) through improvement of family welfare.	
	<i>Decree of Head of East Java Province Local Office for Social Affairs No. 49/IV/C-I/VII/1996 on</i>	As well as North Sulawesi, in the following year East Java Province also establish an HIV and AIDS Response Technical Team in Social Affairs Domain	

Year	Policy	Description	Click here
	<i>Establishment of HIV and AIDS Response Technical Team in Social Affairs Domain in the East Java Province Local Office</i>	in the East Java Province Local Office	
1997	<i>Decree of Minister of Education and Culture of Republic of Indonesia No. 303/U/1997 on Manual of HIV and AIDS Prevention through Education</i>	The Minister of Education and Culture's response to HIV and AIDS in Indonesia is delivered through the issuance of this Ministerial Decree that governs the Manual of HIV and AIDS Prevention through Education.	
	<i>Decree of Minister of Education and Culture of Republic of Indonesia No. 9/U/1997 on Manual of HIV AND AIDS Prevention through Education</i>	Instruction of the Minister of Education to its ministry administration on the HIV and AIDS Prevention through Education.	
2002	<i>Presidential Instruction No. 3/2002 on Countermeasure of Exploitation and Illicit Trafficking of Addictive Drugs.</i>	In this Regulation, the President of Republic of Indonesia ratified the Instruction to all government administration on the Countermeasure of Exploitation and Illicit Trafficking of Addictive Drugs.	
	<i>Decree of Minister of Health No. 1285/Menkes/SK/X/2002 on Manual of Response to HIV and AIDS and STDs</i>	This Ministerial Decree regulates the Manual of Response to HIV and AIDS and STDs.	
2003	<i>Joint Decree of the Minister of People's Welfare No. 20.KEP/MENKO/KESRA/XII/2003 and Chief of National Police Force No. B/01/XII/2003/BNN on Establishment of National Team for Integrated Measures for HIV and AIDS Prevention, Transmission, and Countermeasure of Exploitation of Intravenous Addictive Drugs.</i>	This Decree is a collaborative result of the Coordinating Minister of People's Welfare and Chief of National Police Force on Establishment of National Team for Integrated Measures for HIV and AIDS Prevention, Transmission, and Countermeasure of Exploitation of Intravenous Addictive Drugs.	
2004	<i>Decree of Minister of Health No.781/Menkes/SK/VII/2004 on 25 ARV Referral Hospital</i>	In response to the high rate of HIV and AIDS epidemic in Indonesia, the Minister of Health issued a Ministerial Decree that stipulates 25 ARV	

Year	Policy	Description	Click here
		referral hospitals.	
	<i>East Java Provincial Government Regulation No. 05 Year 2004 on HIV and AIDS Prevention and Response in East Java</i>	This East Java Provincial Government Regulation governs the HIV and AIDS Prevention and Response in East Java.	
2005	<i>Decree of Minister of Health No. 1441/MENKES/SK/X/2005 on Ministry of Health's HIV and AIDS Response Working Group.</i>	In this Ministerial Decree, the Minister of Health governs the Ministry of Health's HIV and AIDS Response Working Group.	
	<i>Decree of Minister of Health No. 1507/Menkes/SK/X/2005 on Manual of HIV and AIDS Voluntary Counseling and Testing Service</i>	This regulating law governs the Manual of HIV and AIDS Voluntary Counseling and Testing Service	
	<i>Regulation of Minister of Health No. 1575/Menkes/Per/XI/2005 on Organisational Structure and Governance of the Ministry of Health</i>	The Organisational Structure and Governance of the Ministry of Health is regulated under this Ministerial Decree.	
2006	<i>Decree of Minister of Health No. 241/Menkes/SK/IV/2006 on Service Standards of Medical Laboratory for Examinations of HIV and Opportunistic Infections</i>	In this Regulation, the Minister of Health governs the Service Standards of Medical Laboratory for Examination of HIV and Opportunistic Infection.	
	<i>Decree of Minister of Health No. 832/Menkes/SK/X/2006 on Stipulation of Referral Hospitals for PLWHA and Standards of Referral Hospitals and Satellites for PLWHA</i>	This Ministerial Decree regulates the Stipulation of Referral Hospitals for PLWHA and Standards of Referral Hospitals and Satellites for PLWHA	
	<i>Decree of Minister of Health No. 567/Menkes/SK/VIII/2006 on Manual of Implementation of Addictive Drugs Harm Reduction</i>	In this Decree the Minister of Health ratified the Manual of Implementation of Addictive Drugs Harm Reduction to be implemented across health services in Indonesia.	

Year	Policy	Description	Click here
	<i>Decree of Minister of Health of Republic of Indonesia No. 494/Menkes/SK/ VIII/2006 on Stipulation of Pilot Hospitals and Satellites for MMT Service and Manual of MMT.</i>	In the same year, another Regulation of the Minister of Health was issued on the Stipulation of Pilot Hospitals and Satellites for MMT Service and Manual of MMT.	
2006	<i>Presidential Regulation No. 75/2006 on National AIDS Commission</i>	This Presidential Regulation governs the Structure and Governance of the National AIDS Commission.	
2007	<i>Presidential Regulation No. 1 Year 2007 on Ratification, Enactment, and Dissemination of Regulating Law</i>	This Regulation stipulates the type of generally binding regulating laws written by government institution or authority. All of HIV and AIDS regulating laws either at national or local level must refer to this regulation.	
	<i>Government Regulation No. 38 Year 2007 on Division of Government Affairs between the Central, Provincial, and District/Municipality Levels (State Gazette of Republic of Indonesia Year 2007 No. 82, Amendment of State Gazette of Republic of Indonesia No. 4737)</i>	This Regulation stipulates the local government authority to govern and administer its own authority based on the rights and obligations of each government level to safeguard, service, empower, and improve the community welfare. HIV and AIDS response is to be under each region's authority defined by each local government's commitment.	
	<i>Regulation of Minister of People's Welfare No. 2/PER/MENKO/KESRA/I/2007 on HIV and AIDS Response Policy through Intravenous Addictive Drugs Harm Reduction</i>	This Regulation stipulates the prevention measures on HIV and AIDS transmission across IDUs, their couples, and the wider community, and the integration of harm reduction on addictive drugs use in the community health system, under the HIV and AIDS prevention, care, support, and treatment, and recovery of drugs addiction, through community health approach.	
	<i>Regulation of Minister of People's Welfare No. 3/PER/MENKO/KESRA/III/2007 on Structure, Tasks, and Function of National AIDS Commission Members</i>	The Minister of People's Welfare governs the Structure, Tasks, and Function of National AIDS Commission Members under this Regulation.	

Year	Policy	Description	Click here
	<i>Regulation of Minister of People's Welfare No. 4/PER/MENKO/KESRA/III/2007 on Manual and Governance of National, Provincial, and District/Municipality AIDS Commissions</i>	In this same year, another regulation was issued on Manual and Governance of National, Provincial, and District/Municipality AIDS Commissions.	
	<i>Regulation of Minister of People's Welfare No. 5/PER/MENKO/KESRA/III/2007 on Organisation and Governance of National AIDS Commission Secretariat</i>	This Regulation governs the Organisation and Governance of National AIDS Commission Secretariat.	
	<i>Regulation of Minister of People's Welfare No. 6/PER/MENKO/KESRA/III/2007 on National AIDS Commission Executing Team</i>	This Regulation of Minister of People's Welfare on National AIDS Commission Executing Team.	
	<i>Regulation of Minister of People's Welfare No. 7/PER/MENKO/KESRA/III/2007 on National Strategy for AIDS Response 2007-2010</i>	This Regulation stipulates the National Strategy for AIDS Response 2007-2010 in response to the ongoing epidemic in Indonesia at that time.	
	<i>Regulation of Minister of Home Affairs No. 20/2007 on General Manual of Establishment of Local Level AIDS Commission, General Manual of Establishment of AIDS Commission and Community Empowerment for HIV and AIDS Response at Local Level</i>	The emerging AIDS Commissions at local level in response to HIV and AIDS in their regions was the basis of the Minister of Home Affairs in 2007 to issue a General Manual of Establishment of Local Level AIDS Commission, General Manual of Establishment of AIDS Commission and Community Empowerment for HIV and AIDS Response at Local Level.	
	<i>Decree of Minister of Health of Republic of Indonesia No. 760/Menkes/Sk/VI/2007 on Stipulation of Referral Hospitals for PLWHA</i>	This Regulation elaborates that in order to improve access to health services for PLWHA across Indonesia it is considered important to add more referral hospitals. This is a response to the increase of HIV and AIDS cases and to improve	

Year	Policy	Description	Click here
		service for PLWHA.	
	<i>Decree of Minister of Health of Republic Indonesia No. 812/Menkes/Sk/Vii/2007 on Policy on Palliative Treatment</i>	Based on patients' extensive requirements, availability of human resources, and condition of palliative treatment service facilities that have not been unevenly distributed in Indonesia whilst patients have right to receiving quality, comprehensive, and holistic services, this Regulation governs the palliative treatment for PLWHA that will provide directives for the health service facilities that is not limitedly delivered in hospitals in Jakarta, Yogyakarta, Surabaya, Denpasar, and Makassar.	
	<i>Decree of Minister of Health of Republic Indonesia No. 11 971/Menkes/Lsk/X112007 on HIV and AIDS Response Working Group in the Ministry of Health</i>	This Regulation governs some of tasks of the HIV AND AIDS Response Working Group of the Ministry of Health of Republic Indonesia, which are: to conduct reviews on operational and strategic policies; to develop education method and approach pattern in HIV and AIDS response; to develop governance method of HIV and AIDS cases; to facilitate fulfillment of facilities , infrastructure, and reagents and drugs supplies; to coordinate with cross-program and cross-sector and related stakeholders, including in relation with Provincial and/or District/Municipality Minimum Service Standards; to advocate, communicate, and consider the emerging issues on social and health aspects of HIV and AIDS, including in relation with international agreements.	
2007	<i>National Manual of ARV Therapy, Guidelines of Clinical Governance on HIV Infection for Adults and Teenagers (Second Edition) of the Ministry of Health of Republic of Indonesia, Directorate General of Infectious Diseases and Environmental Sanitation Control 2007</i>	This Manual is a revised version of the initial Manual in response to the development of medical technology, elaborating the Decree of Minister of Health and referring to the latest WHO Manual of ARV Therapy. This Manual is a reference to all related parties in HIV and AIDS response, particularly the ARV therapy.	

Year	Policy	Description	Click here
	<i>National Joint Policy on TB/HIV First Edition of the Ministry of Republic of Indonesia 2007</i>	This Policy on TB/HIV is necessary to respon to the development of TB/HIV epidemy in Indonesia, a result of TB/HIV collaborative testing in a number of Health Service Units ( <i>Unit Pelayanan Kesehatan/ UPK</i> ) across priority regions and external review on HIV and AIDS by JEMM TB. All implementation manual on TB/HIV collaborative programs across Indonesia is stipulated under this regulation.	
	<i>Manual of Network Development of CST Service for HIV and AIDS Development the Ministry of Health of Republic of Indonesia, Directorate General of Infectious Diseases and Environmental Sanitation Control 2007</i>	This Manual is a reference for the implementation of comprehensive service programs (counseling, prevention, care, treatment, and regulatory and legal support) across Indonesian districts/municipalities in purpose of achieving the universal access (WHO, 2006) by 2008.	
2008	<i>Regulation of Minister of Health No. 269/Menkes/Per/III/2008 on Medical Record</i>	This Regulation elaborates that patients' medical records, including PLWHA patients with information on their identity, diagnosis, medical record, and examination and treatment record must be kept confidential by doctors, dentists, specific health personnel, management officers, and head of health service facilities.	
	<i>Decree of Minister of Health No. 350/Menkes/SK/IV/2008 on Stipulation of Supporting and Satellite Hospitals for MMT and Manual of MMT</i>	In response to HIV and AIDS epidemy taking place in a number of Indonesian regions, the Minister of Health issued this Ministerial Decree on Stipulation and Satellite Hospitals for MMT and Manual of MMT.	
	<i>Decree of Minister of Health No. 378/Menkes/SK/IV/2008 Manual of Medical Rehabilitation Service in Hospitals</i>	This Regulation is a reference for the implementation of medical rehabilitation services, improvement of service quality, and development of services in hospitals, of which included a comprehensive rehabilitation services from promotive to preventive, curative, and rehabilitative. These services emphasize on the prevention rehabilitation strategy.	
	<i>Badung District Government Regulation No. 1 Year 2008 on</i>	This Regulation is a form of local government commitment in response to the development of	

Year	Policy	Description	Click here
	<i>HIV and AIDS Response</i>	HIV and AIDS cases in Badung District. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
	<i>Bulukumba District Government Regulation No. 5 Year 2008 on HIV and AIDS Response</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in Bulukumba District. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
	<i>Malang District Government Regulation No. 14 Year 2008 on HIV and AIDS Response in Malang District</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in Malang District. This regulation states that HIV AND AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
	<i>East Nusa Tenggara District Government Regulation on HIV and AIDS Prevention and Response</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in East Nusa Tenggara Province. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	

Year	Policy	Description	Click here
	<i>DKI Jakarta Provincial Government Regulation No. 5 Year 2008 on HIV and AIDS Response</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in DKI Jakarta Province. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
2009	<i>Law No. 10 Year 2009 on Tourism (State Gazette of Republic of Indonesia Year 2009 No. 11, Amendment to State Gazette of Republic of Indonesia No. 4966)</i>	In relation with the HIV and AID Response in Indonesia, this regulation includes a stipulation on the strengthening of coordination and network on tourism management, government to conduct inter-sectors strategic coordination in the domains of policy, program, and tourism activities. From the health sector, health service area and environmental sanitation are included in the inter-sectors strategic coordination, as governed by the Law.	
2009	<i>Law No. 11 Year 2009 on Social Welfare (State Gazette of Republic of Indonesia Year 2009 No. 12, Amendment to State Gazette of Republic of Indonesia No. 4967)</i>	This regulation governs social security as a form of social protection to be provided by the government, such a basic supplies, clothing, housing (temporary or half-way houses), cash, health treatment and medicines, primary health services (health and education), technical mentoring/supervision, and provision of cemetery.	
	<i>Law No. 35 Year 2009 on Narcotics (State Gazette of Republic of Indonesia Year 2009 No. 143, Amendment to State Gazette of Republic of Indonesia No. 5063)</i>	This regulation states under the Article 56 that medical rehabilitation for drug addicts is to be undertaken at hospitas designated by the minister. Particular rehabilitation institution managed by government instutions or community may execute medical rehabilitation for drug addicts upon the minister's approval. This stipulation emphasizes that medical rehabilitation	

Year	Policy	Description	Click here
		for intravenous drug addicts may be provided a series of therapy to prevent transmission for instance HIV and AIDS transmission through syringes under a strict supervision of the Ministry of Health.	
	<i>Law No. 36 Year 2009 on Health (State Gazette of Republic of Indonesia Year 2009 No. 144, Amendment to State Gazette of Republic of Indonesia No. 5063)</i>	This regulation governs the government's accountability to plan, manage, implement, maintain and supervise the implementation of an evenly and affordable health services for communities. Responsibilities of the government's include human resources, health facilities, health services, patients' protection, improvement, and prevention of diseases.	
	<i>Law No. 44 Year 2009 on Hospitals (State Gazette of Republic of Indonesia Year 2009 No. 153, Amendment to State Gazette of Republic of Indonesia No. 5072)</i>	This regulation governs about hospitals in general. The governance of PLWHA patients are also stipulated in this regulation.	
	<i>Central Java Provincial Government Regulation No. 5 Year 2009 on HIV and AIDS Response</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in Central Java Province. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
	<i>West Kalimantan Provincial Government Regulation No. 2 Year 2009 on HIV and AIDS Prevention and Response in West Kalimantan Province</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in West Kalimantan Province. This regulation states that HIV AND AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	

Year	Policy	Description	Click here
	<i>East Luwu District Government Regulation No. 7 Year 2009 on HIV and AIDS Prevention and Response</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in East Luwu District. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
	<i>Bekasi Municipality Government Regulation No. 3 Year 2009 on HIV and AIDS Prevention and Response in Bekasi Municipality</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in Bekasi Municipality. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
2010	<i>Regulation of Minister of Health No. 411/Menkes/Per/III/2010 on Clinical Laboratory</i>	This Regulation governs about medical laboratory that executes clinical specimens on diagnosis, treatment, and recovery of illness. This stipulates in detail the types and classifications of clinical laboratory, operations, requirements, permits, referrals, recording and reporting, and maintenance and supervision.	
	<i>National Action Plan on Response to HIV and AIDS and Addictive Drugs Abuse at Technical Executing Units (Unit Pelaksana Teknis/ UPT) for Community Correction in Indonesia of Year 2010-2014 at the Directorate</i>	This National Action Plan includes the manual for the Technical Executing Unit for Community Correction for 2010-2014 in accordance with the Regulation of Minister of Law and Human Rights on National Action Plan on Response to HIV and AIDS and Addictive Drugs Abuse.	

Year	Policy	Description	Click here
	<i>General of Community Correction of the Mnisitry of Law and Human Rights of Republic of Indonesia</i>		
	<i>Semarang District Government Regulation No. 3 Year 2010 on HIV and AIDS Response in Semarang District</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in Semarang District. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
	<i>DI Yogyakarta Provincial Government Regulation No. 12 Year 2010 on HIV and AIDS Response</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in DI Yogyakarta Province. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
	<i>Papua Provincial Government Regulation No. 8 Year 2010 on HIV and AIDS Response</i>	This Regulation is a form of local government commitment in response to the development of HIV and AIDS cases in Papua Province. This regulation states that HIV and AIDS response must be implemented institutionally, systematically, comprehensively, participatively, and sustainably through promotion, prevention, counseling, and confidential voluntary testing, treatment, and care and support.	
2011	<i>Decree of Minister of Health No. 782/Menkes/SK/IV/2011 on Referral Hospitals for PLWHA</i>	This Decree of Minister of Health decides on the 278 referral hospitals for PLWHA across Indonesia to receive palliative treatment, ARV therapy, and also opportunistic infection treatment.	

Year	Policy	Description	Click here
	<i>National Manual of Clinical Governance for HIV Infections and ARV Therapy for Adults, Directorate General of Disease Control and Environmental Sanitation 2011, Ministry of Health of Republic of Indonesia</i>	This 2011 edition of National Manual on ARV Therapy states the recommendations on ARV therapy and its supervision as a sustainable post-treatment component in Indonesia, e.g. prevention and treatment of opportunistic infections including the time to start the therapy, selection of medicines, monitoring and compliance of therapy, substitution of medicines, side effects or toximunicipality, switching to next stage of therapy, and its long-term monitoring.	
	<i>National Manual of Response to STIs 2011, Directorate General of Disease Control and Environmental Sanitation 2011, Ministry of Health of Republic of Indonesia</i>	This Regulation governs the management of STIs at health services since STIs have contributed such high impact in HIV and AIDS response.	
	<i>2011 National Manual of Prevention from Mother to Child Transmission Directorate General of Disease Control and Environmental Sanitation, Ministry of Health of Republic of Indonesia</i>	This National Manual of Prevention from Mother to Child Transmission is a revision of the 2006 version. The Manual was issued as one of the Ministry of Health's efforts in HIV and AIDS response in Indonesia, particularly on PMTCT through four programs and in reference with the 2010 WHO recommendation on the fact that all pregnant mothers were basically offered HI testing, provision of ARV and safe birthing methods for all HIV-positive pregnant mothers, and provision of the best nutrients for all babies delivered by HIV-positive mothers.	
2012	<i>Regulation of Governor of DI Yogyakarta No. 37 Year 2012 on HIV and AIDS Repsonse Implementation</i>	This regulation is the executing regulation of DI Yogyakarta Provincial Government Regulation No. 12 Year 2012 and a form of the local government commitment in response to the development of HIV and AIDS cases in DI Yogyakarta Province.	
	<i>2012 Implementation Manual of Sustainable and Comprehensive HIV-STI Services, Ministry of Health of Republic of Indonesia</i>	This Manual is a new concept that has been initiated by the Ministry of Health since 2004 and subsequently renewed with more intensive focus on the strengthening of networks, referrals, and community components, with	

Year	Policy	Description	Click here
		District/Municipality level as the comprehensive central point.	
	<i>2012 Implementation Manual of Comprehensive HIV and AIDS and STI Services at Penitentiary Facilities, Prisons, and Correctional Centers, Directorate General of Disease Control and Environmental Sanitation of Ministry of Health and Directorate General of Community Correction of Ministry of Law and Human Rights of Republic of Indonesia</i>	The enactment of this Regulation displays the intensive commitment of the Ministry of Health and the Directorate General of Community Correction in the promotion of human rights through the improvement of life quality of inmates, prisoners, mentored individuals at correction centers, and the centers' clients as Indonesian citizens, on response to HIV and AIDS and STIs amongst high-risk people at Penitentiary Facilities, Prisons, and Correctional Centers.	
2013	<i>Regulation of Minister of Health of Republic of Indonesia No. 21 Year 2013 on HIV and AIDS Reponse</i>	The scope of this Ministerial Regulation covers the comprehensive and sustainable HIV and AIDS response, which consists of health promotion, prevention, diagnosis, treatment and rehabilitation for individuals, families, and communities.	
	<i>Circular Letter No. GK/Menkes/001/I/2013 on Services for Prevention from Mother to Child Transmission</i>	This Circular Letter of the Ministry of Health is addressed to all of Heads of Provincial and District/Municipality Health Offices and Hospital Directors across Indonesia to deliver improvement of early detection measures and PMTCT, which is to be implemented comprehensively and sustainably thus PMTCT can be implemented effectively, efficiently, and right on target.	
	<i>Circular Letter No. 129 Year 2013 on Implementation of Response to HIV and AIDS and STIs, Ministry of Health of Republic of Indonesia</i>	This Circular Letter of the Ministry of Health aims to strengthen health promotion efforts on prevention, expansion efforts on HIV counseling and testing, CST efforts in the implementation of treatment program as prevention.	

## Annex 4


### Capacity to develop strong leadership and governance

#### Bali

Local leadership figure affects how responsive local government is in the HIV and AIDS prevention and response. For example, during the leadership of the Deputy Governor, Alit Putra and the Deputy Governor, Kelakan as Chief Executive of Bali Provincial AIDS Commission (KPA P Bali), HIV- and reponse programs were regarded more dynamic. As it is today, under the leadership of Sudi Kerta (Deputy Governor) HIV and AIDS response programs are considered more pronounced. He is the only deputy governor who attended the AIDS conference (ICAAP) in Bangkok (2013). However in Bali, there has been a vacuum as in when HIV and AIDS programs were static, which was during the period of leadership of the Deputy Governor, Puspa Yoga.

Coordination mechanisms in Bali: Coordination of planning is carried out by Bappeda and KPA Secretariat following the local development planning mechanism. This planning process shall be synergized with the mechanism of national development planning as stipulated in the document of National Medium Term Development Plan (RPJMN) at national level and also the mechanism of local development plan (Musrenbang) at local level as set out in the Local Medium Term Development Plan (RPJMD) and the 2015 MDGs Local Action Plan in accordance with Governor Regulation No. 111 Year 2011. In addition to the formal coordination, this shall involve non-formal coordination engaging ethnic group leaders. According to the HIV and AIDS program managers for Bali Province there is the need for coordination of Tri Sula, which is the involvement of civil society, government and donors. Coordination with the General Assembly of Pakraman Village for HIV and AIDS response programs in the Pakraman Village.


**INNOVATIONS**



**Village based AIDS Commissions: 471 villanges (1802 people ) of 1413 Traditional Villanges (*Desa Pakraman*).**

12/27/2013

**6518 school students, 250 university students trained - KSPAN program**



Source: Bali Provincial KPA

## Annex 5

Local government's processes in addressing the APBD funding with donors operating in the region.

### **Funding for HIV dan AIDS Programs**

Ever since the beginning, the HIV and AIDS programs commenced with funding support of donor agencies, such as HCPI, IHPC of AusAID, HAPP program of USAID, ASA, FHI360, SUM II, the Global Fund, IPF and other donors. The local government welcomes these donor funds and coordinates the programs through KPAP and relevant technical agencies, such as the Provincial/District and hospitals.

East Java manages the division of working areas for donor agencies, as follow:

GF R 9	IFP	HCPI	FHI360
Municipality of Surabaya	District of Probolinggo	Municipality of Madiun	Municipality of Surabaya
Municipality of Sidoarjo	District of Nganjuk	District of Madiun	Municipality of Malang
District of Jombang	District of Madiun	District of Malang	District of Malang
Municipality of Kediri	District of Gersik	Municipality of Malang	
District of Kediri	District of Blitar	Municipality of Surabaya	
District of Tulung Agung	District of Mojokerto	District of Sidoarjo	
District of Malang	District of Batu		
Municipality of Malang			
District of Jember			
District of Banyuwangi			

Provincial and District Governments have started to budget funding for HIV and AIDS programs through the Provincial and District/Municipality budgets. In Bali, the funding through its local government has been fairly high in the last 3 years, as follow;

Provincial APBD for 2010 was IDR 1,160,940,500; for 2011 was IDR 943,000,000; for 2011 was IDR 794,587,000.

Based on the funding allocation above, it seems that HIV and AIDS programs under the current approach cannot be implemented without donor assistance. The local government has not been able to provide the full funding so there has only been grant or social assistance funds that are far from sufficient, and also grant or social assistance funds cannot be provided for an organisation on a continuous basis. Therefore the local governments through Provincial KPA, District/Municipality KPA, encouraged the relevant SKPD to allocate funding for HIV and AIDS programs in each of their institutions.

## Annex 6

### Significant role of civil society in AIDS response program at local level

#### Role of Civil Society

The existence of civil society in the HIV and AIDS response programs is very important. The civil society response starts off with identifying cases, conducting outreach and assistance, to undertaking policy advocacy. In Bali, there is Yayasan Citra Indonesia Usadha/ YCUI outreaching homosexual customers and communities. While Yayasan Kerthi Praj/ YKP commenced in 1992 and has been conducting operational researches on Female Sex Worker/ FSWs in the area of Sanur and YKP has now been equipped with a fairly complete clinical services, Amrita Clinic. In the university circle, there is UPLEK UNUD (Prof Muninjaya) that has been conducting activities in HIV and AIDS response with funding from the Ford Foundation; School Based Education program in collaboration with the University of Michigan and outreach program for truck drivers in support of USAID funding in the 2000s. PKBI has also been active around that time, working with a number of Tour Guides to educate HIV and AIDS through production of 'Healthy while Traveling' book in 1992.

In East Java, the academic draft of PERDA on HIV and AIDS has been produced by Masyarakat Peduli AIDS, a collaboration of activists, academics, NGOs and the groups of people with risk of HIV transmission.

The active NGOs ever since the beginning of the discovery of AIDS cases in East Java are Hotline Surabaya (PMTS), PKBI East Java (PMTS), Gaya Nusantara (Gay), Perwakos (Transgender), Embun, Bina Hati (HR), ORBIT, Sadar Hati (HR in Malang), Igama, Wamarapa and Paramitra (PMPTS), Suara Kediri, Bambu Nusantara, Madiun, and Lembaga Mahameru, plus the key population organisations such as GWL-INA, OPSI, IPPI, and JOTHI East Java.

The ability of these NGOs to deliver such programs is highly due to donor assistance and cooperation with local governments. Thus the issue of program sustainability post donor assistance remains a discussion at the NGOs circle.

## Annex 7

### Access to drugs and preventive materials

#### Availability of Drugs and Preventive Materials

The availability of drugs and medical logistics determines the success of treatment, care and support for PLWHA. Preventive materials such as condoms and pelicans, sterile syringes were available in the sampling areas. These materials were disseminated by the Central Government through KPAP and distributed through the Provincial/Districts to Hospitals, Puskesmas and clinics providing Reagent services for HIV and STIs testing, ARV drugs, TBC drugs, STIs drugs and OI drugs are available in supporting hospitals and some local government hospital, PKM and Clinics.

During the team's field visits the ARVs, condoms and sterile syringes were available. The consistency on the use of condoms and pelicans in particular, remains a problem. Sterile syringes are easily accessible in a few places, but the convenience of accessing them also remains a problem. ARVs are available at the supporting and referral hospitals.

Treatment Program as Preventive measure still needs to be well prepared, either in term of the patients and the provision of services, as this would also involve the availability of ARVs in the future.

The availability of health insurance in the areas of East Java, Bali and South Sulawesi helps people to get treatment on opportunistic infections of PLWHA.

## Annex 8

### Replication of Services

#### Replication of Puskesmas Services in Malang District

Malang District has had a local regulation PERDA No. 14 Year 2008 on HIV and AIDS Response, which consists of 11 Chapters and 31 Articles that became the basis of each step of activities carried out by KPA, either the respective Local Offices/Agencies or NGOs in Malang District.

HIV and AIDS prevention and response are administered by the Government, society, and NGOs under a partnership basis. Malang District Government through the Provincial/District has administered a replication of STIs service and prevention, that is the service of VCT clinic into 4 services (PKM Sbr.Pucung, PKM Gondanglegi, PKM Pujon, RSD Kanjuruhan) and 4 STIs clinic into 6 services (PKM Sbr. Pucung, PKM Gondanglegi, PKM Pujon, PKM Sitarjo, PKM Lawang, and PKM Tumpang). These STIs/HIV prevention services are carried out by the following puskesmas and hospitals:

- 1) Puskesmas Gondanglegi provides health services for IDUs and FSWs through Methadone Maintenance Treatment/ MMT (*Program Terapi Rumatan Metadon/PTRM*) and Sterile Syringe Service (*Layanan Jarum dan Alat Suntik Steril/ LJASS*), STIs examination and treatment, Prevention from Mother to Child Transmission, VCT service, Care, Support and Treatment for PLWHA, and provision of mobile clinic to support STI/VCT clinic at Puskesmas Sitarjo.
- 2) Puskesmas Sumberpucung  
Provides services for direct and indirect FSWs through the following main activities: Reproductive Health Services, STIs Examination and Treatment, VCT dan CST services and PMTCT, and operation of mobile clinic to support STIs/VCT clinic at Puskesmas.
- 3) Puskesmas Pujon  
Provides STIs examination service and VCT service for FSWs key population in Pujon area.
- 4) Puskesmas Lawang  
Provides STIs examination/treatment service, VCT service for high risk groups/massage parlors and communities in Lawang, Singasari areas.
- 5) Puskesmas Tumpang  
Provides STIs examination/treatment service and sterile syringe service for high risk groups in Tumpang areas.
- 6) Puskesmas Sitarjo  
Provides STIs examination and treatment for high risk key population groups (FSWs) in Sumbermanjingwetan area, this area is potential to such increase of FSWs particularly during the fishermen season (area of Sendangbiru harbor).
- 7) RS Kanjuruhan  
Provides CST service, VCT service, PMTCT for all high risk key population and other patient in risk, and operation of mobile clinic.

## **Medan**

**Services:** Law No. 35 on HIV response guidelines issued by the Ministry of Health in 1992 is the basis of the service providers, including VCT and facilitation. The implementation on the ground needs to be in cooperation with various parties thus an agreement is absolutely necessary. In Medan, for example, there are also some of MOUs which were developed to facilitate program implementation. Such agreement must be complemented by the availability of operational funding. For example is the MOU between NGOs and RS Pirngadi. Transportation allowance is provided by the hospital to the NGOs that collect and bring in used syringes in a safety box to be extinguished at the RS Pirngadi.

The provincial areas of North Sumatra and Medan – condoms and syringes are disseminated from Provincial KPA and District/Municipality KPA to subsequently be distributed to NGOs, Puskesmas, and outlets as well as hotspots. As for ARVs, they are disseminated from the Provincial/District and then distributed to referral hospitals or Puskesmas.

## Annex 9

### Human resources for HIV and AIDS programs

#### Human Resources for HIV and AIDS Programs

HIV and AIDS program requires qualified and diverse human resources, ranging from medical personnel, paramedics, HIV and AIDS counselors, case managers, and field officers and accompanying persons. Information obtained from field visits imply that as long as donor funding is available, programs in terms of human resources are considered as quite comprehensive. A number of training and capacity building are carried out with support of donor funding. Operational funds including human resources incentive are derived from donors. This would become a whole of problem once donors are no longer available.

There are government's efforts to provide funding for human resources however these are very limited. The local financial system is performance-based thus the provision of honorarium or other incentives are made in accordance with the applicable regulations, making it difficult for the government to provide full funding for specialized staff such as human resources within HIV and AIDS programs, when there are such the funding would be accounted for honorarium for resource persons.

Another issue that arises is the rotation system or displacement of civil servants within the local government. Positions at certain levels are often rotated thus advocacy to policy makers level has to always take place. Quoting the Secretary of East Java Provincial AIDS Commission, there is a need for continuous advocacy to government officials and decision makers as determinants of local government programs, to keep them informed and concerned with HIV and AIDS programs.

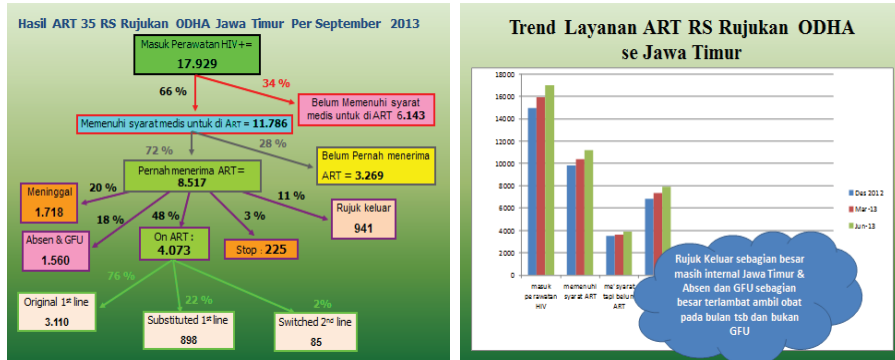
## Annex 10

### Provision of effective and quality health services

#### Provision of Services for PLWHA

The availability of affordable services, in terms of distance, funding and the availability of qualified health personnel are very important in the treatment, care and support for PLWHA. Some local government efforts in providing services for PLWHA have been delivered. ART services, for example, at the beginning of the HIV and AIDS cases were discovered, ART services were available at supporting hospitals that were generally located in the provincial capital, such as one in East Java at the RS Dr. Soetomo Hospital Surabaya, which has been subsequently developed into some of the municipality/district hospitals. At the time of this research, there are 35 referral hospitals for PLWHA in East Java.

The East Java Local Government and its municipality/district governments continue to improve and provide services for PLWHA, starting from supporting hospitals, referral hospitals and also conducting mobile clinics to expand the coverage of services for PLWHA. In addition, the health department and local level AIDS Commissions are also active in the monitoring and evaluation of services for PLWHA within their respective work areas. ART referrals for PLWHA and the trend of services are described in the figure below.



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