Expanding Access to HIV/AIDS Treatment

Mission Report Indonesia

19-31 January 2004

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Acronyms

ART	antiretroviral treatment
ASA / FHI	Aksi Stop AIDS / Family Health International
ARV	antiretroviral
ANC	antenatal clinic
CDC	Department of Communicable Disease Control, Indonesia
DOTS	directly observed treatment, short-course
DTDC	Directorate of Disease Control
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IDU	injecting drug user
IEC	information, education and communication
KPAD	Provincial AIDS Prevention Committee (KPAD = Komisi Penanggulangan AIDS Daerah)
KPA	National AIDS Commission
MoH	Ministry of Health
MSF	Médecins Sans Frontières
MSM	men having sex with men
NGO	nongovernmental organization
NPO	National Programme Officer
OI	opportunistic infection
PLWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PTB	pulmonary tuberculosis
SW	sex worker
STI	sexually transmitted infection
T&C	testing and counselling
UNGASS	United Nations General Assembly Special Session
VCT	voluntary counselling and testing

1. Introduction

Recently, Indonesia has adopted an ambitious target of providing antiretroviral treatment (ART) to at least 10 000 people by the end of 2005. As of January 2004, of an estimated 15 000 people who were in need of ART, only 1300 persons were receiving the treatment. The intermediate target for 2005 is in line with the global WHO and UNAIDS "3 by 5" initiative. The initiative aims to provide three million people in developing countries (out of six million in need globally) access to ART by the end of 2005. The ultimate goal of the initiative is to provide universal access.

By declaring the national "3 by 5" target, Indonesia has joined forces with other countries towards reaching the global target. In December 2003, shortly after the launch of the global "3 by 5" initiative on the World AIDS Day, the Minister of Health requested assistance from WHO. From 19 to 31 January 2004, a team of WHO experts visited Indonesia to assess the country's readiness for rapid scale-up of ART, to identify the technical support that will be needed, and to recommend urgent action towards achieving the time-bound target.

2. Terms of reference

The team visited Indonesia with the following terms of reference:

- to consult the government and partners on issues, modalities and operational aspects of ART expansion in the context of the "3 by 5" initiative,
- to explore and identify potential roles of WHO and key partners in ART expansion, and
- to identify follow-up steps for future action.

3. Activities and methods

The consultation team (Annex 1) consisted of representatives from the Ministry of Health (MoH) and the World Health Organization (WHO).

The six most affected provinces (Jakarta, East Java, West Java, Bali, Riau, Papua) were visited. Discussions were held with key government officials at the provincial and district levels; hospitals, as well as current and potential ART service delivery points were visited; nongovernmental organization (NGO) projects (e.g. harm reduction projects) were reviewed; and key implementation partners from various sectors and constituencies were interviewed. Between 26 and 31 January, site visits, and discussions and interviews with central multisectoral authorities were conducted in Jakarta.

On 28 January, a workshop was organized in Jakarta by the Directorate of Disease Control (DTDC), facilitated by WHO. Group discussions were held on:

- Drug procurement / management
- Testing and counselling / entry points
- People living with HIV/AIDS (PLWHA) support groups / vulnerable population, and
- Clinical services / training / capacity building

4. HIV epidemic in Indonesia

Indonesia has an estimated population of 214 million inhabitants (UN Population Division projection-2001 estimates). Although the HIV epidemic is concentrated among certain high-risk groups, a national consultation in August 2002 estimated the total number of people living with HIV/AIDS (PLWHA) in the country to be between 90 000 and 130 000 (average of 110 000 persons).[1] According to this estimate, up to 15 000 persons are in need of ART.

Initially, HIV transmission occurred mostly among heterosexual partners. However, in the past six years HIV transmission in injecting drug users (IDUs) has shown an eightfold increase. In surveys among selected populations of IDUs, seroprevalence has reached as high as 90% in Jakarta and 53% in Denpasar, Bali. In female sex workers (SWs), the highest prevalence rate was observed in Merauke, Papua (26.5%).[2] The 2002 national consultation on HIV prevalence estimates ranged from 19.2% to 34.4% in IDUs and from 2.0% to 5.2% in SWs. Other highly affected groups were transgenders (Waria — from 9.3% to 14.3%) and prison inmates (from 8.6% to 15.4%). HIV prevalence in men having sex with men (MSM) group was estimated to have risen from 0.4% to 1.3%.[1]

Few HIV/AIDS cases are identified and reported at the national level due to limitations in the national HIV/AIDS surveillance system. As of December 2003, 2720 HIV-positive cases, 371 AIDS cases (Figure 1) and 479 AIDS-related deaths were reported to the Ministry of Health (MoH). Among the total number of AIDS cases, 78% were male. Heterosexual transmission accounted for 51%, IDU

[1] National Estimates of Adult HIV Infection. Indonesia 2002. Workshop report. Ministry of Health, Communicable Disease Control and Environmental Health. 2003.

[2] National HIV/AIDS Strategy 2003-2007. Office of the Coordinating Minister for People's Welfare/National AIDS Commission. 2003.

for 26% and MSM for 9% of all new AIDS cases in 2003. In recent years, injecting drug use has been more frequently identified as the mode of transmission (Figure 2).

Figure 1: Increase in the number of new AIDS cases reported by year (Source: Department for Communicable Disease Control (CDC), Indonesia)

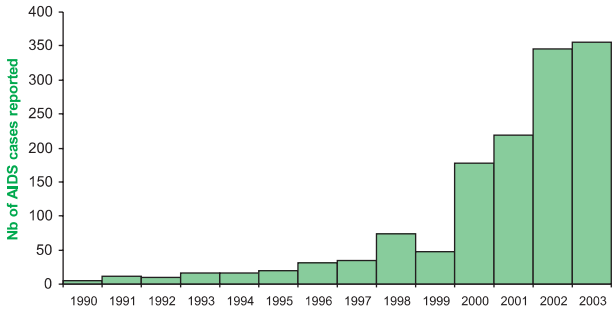
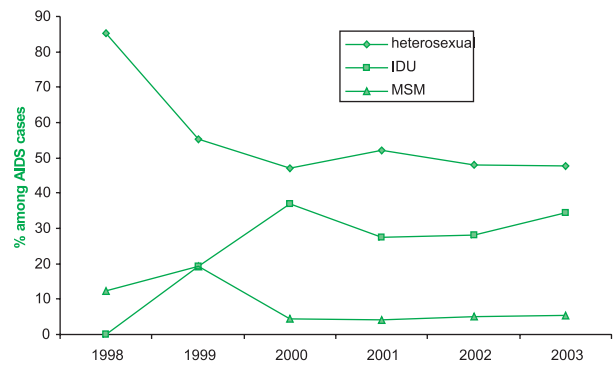


Figure 2: Distribution by mode of transmission of new AIDS cases by year (Source: Department for Communicable Disease Control (CDC), Indonesia)



5. Country situation

5.1. Policy, management and funding

5.1.1 Policy

Since 2001, a decentralized process has transferred the HIV/AIDS budget to the districts and municipal administrations.

A National AIDS Commission (Komisi Penanggulangan AIDS; KPA) was established in 1994, coordinated by the Ministry of Social Welfare. Provincial AIDS commissions were then established in every province (headed by the Vice-Governor) and district. However, not all of these commissions are fully functional at the district level.

The National HIV/AIDS Strategy identified seven programme priorities for 2003-2007: [2]

1. HIV/AIDS prevention
2. Care, treatment and support for PLWHA
3. HIV/AIDS and sexually transmitted infections (STI) surveillance
4. Operational studies and research
5. Enabling environments
6. Multistakeholder coordination, and
7. Sustainable response

The Government of Indonesia is in the process of finalizing a national policy for ART. This policy stipulates that the national targets for providing ART are 5000 persons in 2004 and 10 000 persons in 2005. Six of the 30 provinces have been identified as priority areas and 25 hospitals have been designated as service delivery points for ART. The central government planned to subsidize antiretroviral (ARV) regimen worth up to 200 000 rupiah (US$ 24) per patient per month for 4000 patients in 2004. The total ARV cost per patient/month for the proposed first-line regimen (zidovudine, lamivudine, nevirapine) from a local producer is 380 000 rupiah (US$ 45) per month. Thus each patient would need to obtain funds to cover the difference of 180 000 rupiah (US$ 21) per month for the purchase of ARVs alone (not including testing and counselling, care, laboratory monitoring and other treatment costs), unless additional subsidy is made available. At the provincial level, there are varying degrees of commitment to provide additional subsidies. Currently, Papua is the only province complementing the central government subsidies by provincial resources to provide free services (including testing and counselling, care and treatment) to all PLWHAs requiring ART.

5.1.2 Management

At the central level, the MoH has taken the initiative to develop an HIV/AIDS care and treatment plan (including ART) as a core element of the comprehensive national HIV/AIDS response. Various MoH directorates and other units, such as CDC, Medical Services, Pharmaceutical Services, Community Health Services and Laboratory Services, are actively involved in the initiative. The government has introduced active partnerships with nongovernmental organizations (NGOs), PLWHA networks, bi- and multi-lateral assistance agencies, and funding agencies such as the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) in the area of care and treatment. No formal management and coordination mechanisms, however, have been established to date.

Operational plans have not yet been developed at the central and provincial levels.

5.1.3. Funding

A detailed costing of activities needed to identify individuals requiring treatment and to consequently provide comprehensive care and treatment has not been done to date. It appears that available resources from various sources, both internal and external, will be inadequate to meet the demands (Table 1). Internally, the MoH earmarked 10 billion rupiahs (around US$ 1.2 million) at the central level to subsidize the cost of ARVs for 2004, whereas the provincial governments had to locate additional resources at varying levels. Subsidies from related services, such as HIV testing and counselling, drugs for the treatment of opportunistic infections and laboratory services will be highly dependant on future commitment and allocations from local governments. Externally, Indonesia has been granted US$ 6.9 million from the GFATM for HIV/AIDS in total, of which only a small fraction has been allocated for ART (only 100 persons). While a number of bilateral donors are supporting activities related to HIV/AIDS, none of these donors is supporting ART. A number of NGOs provide support for care and treatment, of which only Médecins Sans Frontières (MSF) directly funds ART.

Table 1: Resources allocated to HIV/AIDS (in US dollars)[3]

	2003 (source UNGASS)	2004 budget
Government budget	5 369 138	6 000 000 (1.2 million for ART)
GFTAM (first round)	936 403	5 988 568 (for 2 years)
International donors	16 400 000	9 000 000 (Aksi Stop AIDS / Family Health International [ASA/FHI])
UN agencies		5 600 000

5.2. Identification of HIV-positive persons in need of treatment

The availability of testing and counselling (T&C) services as well as the cost charged to the clients varies from province to province. Access to T&C is limited and stigmatization remains an obstacle to its use. A recent assessment on T&C services, conducted by the MoH with the support of

[3] Country report - Indonesia. National AIDS Programme Managers' Meeting, Dehli, India (19-21 November 2003).

Aksi Stop AIDS / Family Health International (ASA), showed that mostly symptomatic patients are referred for T&C by physicians. The practices of T&C are not standardized. Family Health International (FHI) has conducted training for counsellors in 10 provinces but counselling is seldom available. T&C services in STI, tuberculosis (TB), antenatal care (ANC) and drug dependence services are not in place or well developed.

High-risk populations are mainly approached during outreach strategies through local NGOs. In each provincial capital, a drug demand reduction programme is available at the mental health hospital. These services, however, are not consistently proposing the use of T&C services.

A prevention of mother-to-child transmission (PMTCT) pilot project has been implemented at two sites.

- In Jakarta, the project is supported by Pellita Ilmu. As of November 2003, 520 pregnant women were tested and 2.8% were found HIV positive. This group of women is not representative of the general population as most of them are from high-risk groups.
- In Merauke District in Papua Province, the District Public Office Project targets four health centres and depending traditional birth attendants. In 2002, 200 pregnant women accepted the test and none were found positive. In 2003, the project was poorly functional and no women got tested.

Indonesia ranks third in the South-East Asia Region regarding TB burden. The annual incidence of smear-positive pulmonary TB (PTB) is estimated to be 115/100 000 population and of all forms of TB 256/100 000. Thus, around 250 000 new cases of smear-positive PTB are occurring each year.[4] No survey was conducted on HIV seroprevalence in TB patients. Indonesia has a directly observed treatment, short-course (DOTS) network in more than 7500 health centres with an estimated 98% coverage. However, about one third of the country's TB patients seek care through the private sector. Smear examination and TB treatment are free of charge (but not chest X-ray). In July 2002, a workshop was conducted to orient the integration of HIV and TB activities.[5] Four provinces were assessed, namely Jakarta, West Java, East Java and Bali. For Jakarta, an action plan was developed and started in three sites with the support of a WHO grant. A guideline for

[4] DRAFT. Global Tuberculosis Control. WHO report 2004.

[5] Workshop on situational analysis of TB-HIV co-infections in 4 Provinces in Indonesia. Bandung, 7-10 October 2003

integrating medical care for HIV/TB was developed. Bali would soon establish a pilot programme.

The expansion and strengthening of T&C services has been recognized by the MoH and partners as a priority to identify those in need of ART. The MoH is currently finalizing national guidelines for T&C. Training modules and materials for T&C have been developed. The central level plans to conduct training in four priority provinces, namely Papua, Jakarta, Bali and Riau. The provinces have identified the sites to implement T&C, and nurses and doctors will be trained as counsellors.

5.3. Building capacity for providing antiretroviral treatment (ART)

Currently, the capacity to respond to national ART scale-up (including T&C, case management, adherence counselling, laboratory monitoring, treatment support) is inadequate to achieve the "3 by 5" goal and there is no systematic approach to institutional and human resources capacity building across the health sector for this purpose. Of the estimated 1300 patients who have started ART in Indonesia (Table 2), 90% are bearing the full cost of treatment and care from personal finances. No data are available regarding ART prescribed in the private sector but branded ARVs are seldom available with private pharmacists and, if available, they are available mostly in Jakarta. CD4-count equipment is available only in Jakarta and Bali.[6]

Table 2: List of services offering ART in Indonesia as of January 2003

Facility	Province	Estimated no. of patients starting ART
RS Cipto Mangun Kusumo (Pokdisus)	Jakarta	Up to 1000
RS Dharmais	Jakarta	40
RS PI	Jakarta	10
RS Hasan Sadikin	West Java	47
RS Sutomo	East Java	53
RS Sanglah	Bali	30
RS Jayapura	Papua	6
RS Merauke	Papua	14

[6] Results of the survey on laboratory equipment for HIV/AIDS. Japan International Cooperation Agency. November 2003.

Local initiatives for ART have been launched throughout the country, due to the commitment and will power of the local authorities and physicians taking care of PLWHA. Pokdisus (the Working Group on AIDS from the Faculty of Medicine) has conducted training in T&C, ART management for doctors and nurses and HIV/AIDS care and support for treatment supporters. Zidovudine, lamivudine and nevirapine are being used as first-line regimen.

The MoH is finalizing national guidelines for ART and case management. Zidovudine, lamivudine and nevirapine will remain the recommended first-line regimen. Training modules for ART and case-management have been developed, and the MoH has begun conducting training courses for nurses and doctors in the six priority provinces.

Treatment models including adherence counselling have been developed at the central level, taking into account the experiences of local initiatives. Twenty-five hospitals in the six priority provinces have been identified as ART services delivery points.

5.4. Ensuring access, adherence and responses to the needs of vulnerable populations

HIV epidemics in many of the provinces are concentrated among IDUs and SWs, with some populations experiencing extremely high prevalence rates (e.g. HIV prevalence exceeding 90% in some IDU populations). Real access to HIV treatment services for IDUs and SWs is significantly limited by stigma and discrimination as well as ignorance of health care providers. The marginalization and criminalization of these populations pose major obstacles for accessing HIV testing, counselling and treatment.

The coverage of HIV/AIDS programmes targeting IDUs and SWs is extremely low. Promising small-scale programmes exist for IDUs (including methadone maintenance, peer outreach, risk-reduction counselling, HIV testing and counselling, condom distribution) and PLWHA support groups, but the coverage is inadequate to impact the overall epidemic. Currently, no services are available for prison inmates.

Presently, most services for vulnerable populations are being provided by community-based and nongovernmental organizations (CBOs/NGOs), with significant support from international donors. There will be increasing demands on these organizations to provide HIV/AIDS

treatment and care as their clients become ill. Whereas a number of programmes provide high quality and multicomponent services, often their capacity to provide HIV/AIDS treatment, including ART, is severely limited.

Many CBOs/NGOs are very well placed to provide monitoring of, and support to, PLWHA on treatment, through mechanisms such as case management, adherence monitoring, buddy systems, home visits and home-based care. Referral systems between CBOs/NGOs and government facilities, however, are not adequate.

Experiences from other countries demonstrate that adherence to ART is greatly improved for those on drug dependence treatment, particularly for opioid dependent individuals on methadone maintenance.

The recent signing of a Memorandum of Understanding (MoU) between the National AIDS Commission and the Narcotics Control Bureau provides opportunities for scaling up effective HIV/AIDS prevention and care programmes for IDUs.

In summary, throughout the country, a range of promising but small-scale projects targeting vulnerable populations (particularly IDUs and SWs) exist. Most projects focus on HIVAIDS prevention with limited emphasis on care and treatment. These projects, however, would be good models as entry points for care and ART.

5.5. Providing drugs and diagnostics

The nationally supported treatment regimen includes only one of the WHO's recommended first-line regimens, i.e. zidovudine plus lamivudine plus nevirapine, and does not include other recommended first-line ARVs, such as stavudine and efavirenz. Therefore, no alternative treatment exists for those who may not tolerate the zidovudine plus lamivudine plus nevirapine regimen.

Zidovudine, lamivudine and nevirapine are included on the essential drugs list in Indonesia. Most ARVs have been registered in Indonesia, but they are not widely available, especially not outside Jakarta. Few generic ARVs are registered.

Since no national supply system for ARVs exists, ad hoc supply systems were set up. These ad hoc systems supply unregistered generic ARVs, which

are imported, using a 'special access permit'. The ad hoc systems, however, are not sustainable, and there are first signs that they are struggling to cope with the growing demand.

Meanwhile, the MoH has realized the need for a more structured national supply system. A considerable amount of preparatory work to set up a formal ARV supply system is in progress.

Essentially, the envisaged supply system will rely on the local production of three ARVs (zidovudine, lamivudine and nevirapine) by Kimia Farma and is already approved by the Food and Drugs Control. The cost of the triple regimen is 380 000 rupiah/month (US$ 45). This is, however, significantly higher than the best obtainable price in the international market. Kimia Farma's nationwide distribution system will be used for supplying hospitals that have been appointed for providing ART.

The MoH identified funds to subsidize the treatment of 4000 people in 2004. As a result of this subsidy, the actual cost of the triple regimen to the patient was 180 000 rupiah/month (US$ 21).

5.6. Monitoring and evaluation, surveillance and research

Activities in Indonesia are mainly focused on the surveillance of the HIV epidemic. HIV sentinel surveillance has been established since 1993, targeting mainly female SWs. Thirteen of the 30 provinces now report surveillance data. In some provinces, unlinked anonymous surveys are also conducted among pregnant women attending ANCs and prisoners. Ad hoc surveys are conducted for IDUs, clients of SWs, MSM and STI clinic attendees. More recently, second-generation surveillance has been established in 13 provinces. These target SWs and their clients, youths and professional corps (military and police).

Few data are available in the general population and pregnant women are not being systematically surveyed. The HIV/AIDS mandatory reporting system is limited in part due to poor access to T&C services.

A standard monitoring system for T&C, care and treatment is not in place and local monitoring does not coordinate between the various services. As a consequence, global activities regarding T&C, care and treatment are difficult to assess.

6. Province-by-province situation

	Papua	Jakarta	Bali	Riau	West Java	East Java
Total population	3 000 000		3 350 000	5 300 000	38	35 000 000
Local estimates, PLWHA ≈equivalent HIV prevention in adults	9000-13 000 ≈0.5-0.9%	25 000-27 000	1500-2500	40 000 ≈1.5%	11 000	11 500 ≈0.07%
AIDS cases reported Cumulative (and in 2003)	470 (88)	347	205	69 (26)	NA	(54)
T&C-No. of districts with T&C	2 out of 28 (Jayapura/Merauke)	5	3 out of 9	0	NA	NA
Population accessing HIV testing for diagnosis*	TB, STI, inpatients Community, only in Merauke	TB, STI, IDU, PMTCT Inpatients (no counselling)	IDU, inpatients	Inpatients (no counselling)	IDU, inpatients	IDU, inpatients
No. of persons tested for diagnosis in 2003 (and tested positive)	Jayapura: 232 (49) Merauke: data not available	not applicable	95 (35) in IDUs	10 (4) in Pekambaru	(25)	230 (107)
Cost charged for HIV testing	Free	150 000 rupiah	100 000 rupiah	100 000 rupiah	60 to 80 000 rupiah	120 000 rupiah
HIV/AIDS medical care Services available and no. of HIV-positive patients	◆ Pneumology in RS Jayapura (2-4 hospitals/month) ◆ RS Merauke (cohort of 40 patients)	◆ RSCM ◆ RS Dharmais ◆ RSPI (64 inpatients in 2003)	◆ RS Sanglah	◆ Internal medicine in RS Pekambaru (4 inpatients in 3 years)	◆ RS Hakan Sardkin ◆ 3 private clinics	◆ NA
No. of doctors in charge of ART	1 in Jayapura 4 (2 MSF) Merauke	2 in RSCM, 2 in RSPI, 2 in Dharmais, 1 Duren Sawit	3 in Sanglah	0	1 in Hakan Sardikin	NA
Supportive organization for care	MSF/WVI in Merauke	Pokdisus, Pelita Ilmu, Y Mitra, Kiosk Atma Jaya	Y. Pratikerja, Y Hati Hati, Yakeba	none	Rumah Cemara Bahtera	NA

	Papua	Jakarta	Bali	Riau	West Java	East Java
Cotrimoxazole primary prophylaxis	Only in Merauke	no	no	no	no	no
No. of patients who started ART	Jayapura 6 Merauke: 14	Up to 1000	10	0	47 53	
CD4-count	no (plan for Dynabeads* in February 2004 in Merauke)	2 Facscan, 1 Facscount	1 Facscount (Prodia)	no	no no	
Cost charged for medical care	All free	Charged (MSF subsidizes for 40 patients)	Charged	Charged	Charged	Charged
PLWHA organization	◆ Jayapura: JSG (23 members) ◆ Merauke: in process	◆ Pelita+, Spiritia	◆ Pelita+	◆ none	◆ NA	◆ NA

* **inpatients:** counselling seldom available NA= not available

7. Recommendations

7.1. Policy, management and funding

Policy

- The government's ultimate goal should be to provide universal access to antiretroviral treatment (ART). The national policy should emphasize the need to ensure equal access, unhampered by individual economic constraints. This may require a re-consideration of the current plan to subsidize only a fixed percentage (about 50%) of the recipients. Free access should be guaranteed to the most economically disadvantaged persons while cost-sharing schemes should be implemented for those who can afford to contribute at varying capacities.

Management and Planning

- To facilitate timely and efficient management of the national treatment and care programme, the following mechanisms should be established:
  - a national HIV/AIDS treatment and care advisory committee (consisting of MoH staff from the relevant departments and external experts representing various constituencies, including the NGO sector).
  - a focal point for the HIV/AIDS treatment and care programme, to ensure strong leadership and effective coordination. This focal point, to be located in the most appropriate department of the MoH responsible for clinical service provision, should be responsible for management and coordination across the MoH, and with provincial focal points, as well as with other relevant partner organizations, such as the NGO sector, and multi- and bi-lateral partners.
  - a provincial level focal person should be responsible for managing care and treatment activities at the provincial level, and for coordinating with the central and district levels, as well as with partners at the local level.
- A strategic and operational scale-up plan should be developed as a priority. This plan should be elaborated in consultation with key actors in the six priority provinces, the 22 ART delivery service units, and other partners (including NGOs, PLWHA). The plan should clearly lay out key actions required to meet the national "3 by 5" target, the costs related to it, the resources currently available, and those still to be generated. One key component should be a capacity building plan.

Financing

- A detailed costing of activities and testing, treatment and care services should be made as part of the operational planning. A mapping of existing resources and funding gaps should be identified. Consequently,

a resource mobilization strategy should be developed to ensure that the funding gaps are addressed adequately.

- The GFATM Country Coordination Mechanism of Indonesia should develop a proposal to be submitted to the 4th Round of the GFATM. This proposal should aim to fill the funding gap related to treatment and care.

7.2. Identification of HIV-positive persons in need of treatment

- The national guidelines for testing and counseling (T&C) should be finalized to ensure standard and good medical practices. Training materials should be reviewed to ensure compliance with these guidelines.
- Training of counsellors should be conducted in all of the six priority provinces.
- Organizations providing outreach to vulnerable populations, including IDUs, sex workers, warias and MSMs, should be supported to develop capacity for HIV T&C. This support activity should include: (i) development of clear organizational policies and guidelines, (ii) training of staff, (iii) simplifying HIV testing methods (e.g. rapid tests), (iv) developing HIV counselling capacity, (v) introducing systems for guaranteeing patient confidentiality and (vi) introducing well-developed referral mechanisms for HIV/AIDS assessment and treatment.
- STI services, TB services, inpatients wards, ANC care services, and drug dependence services should be considered as entry points for ART and should offer T&C services.
- With T&C in ANC care services, PMTCT programmes should be implemented for reducing vertical transmission.
- T&C should offer a standard package of preventive services (information, education and communication (IEC) materials and condom promotion, for example), which should be integrated into the existing services and provide referral to other services when needed. The quality of these services should be regularly assessed.
- T&C services should be closely linked to PLWHA support networks.
- To encourage the use of T&C services, an aggressive social marketing campaign specifically targeting vulnerable populations should be initiated.

7.3. Building the capacity to deliver ART

- As an essential component of the overall operational plan for ART scale-up, a capacity building plan should be developed for the six

priority provinces. Taking each local context into account, the plan should indicate the resources available (NGOs, private partnerships, for example) and the form of their coordination. The plan should also clearly describe (i) the organizational model of the care and referral system involving different services (entry points, T&C, ART delivery services, supportive organizations), (ii) the process to address the need for staff training in the future, (iii) the operation of the laboratory networking and monitoring system, (iv) the roles and responsibilities of the key agencies/ persons involved, and (v) the funding process.

- National ART and case-management guidelines are urgently needed for standardizing and ensuring good medical practice. These guidelines should be developed by the proposed national HIV/AIDS treatment and care advisory committee (see 7.1).
- The ART guidelines should include additional therapeutic options (such as stavudine and efavirenz) in the first-line regimen. Cotrimoxazole, for primary and secondary prophylaxis, should be part of the case-management guidelines.
- As few CD4-counts are expected to be performed at each site, a referral laboratory network for CD4 counts should be established either nationally, or provincially, or for a cluster of sites. This will mean that there will be no need to implement the technology at every site. Description of the laboratory network, the methods of shipment and of conservation of samples (fixative) should be part of the operational plan. Ideally, one CD4-count machine should be made available in each of the six provinces, and possibly more as the demand increases.
- Experiences should be shared among the various ART service delivery points. An electronic forum for sharing progress reports should be introduced.
- The medical staff in each province should engage in more advocacy for HIV/AIDS prevention and treatment. All doctors and nurses (including those in the private sector) should receive a package of basic information on HIV/AIDS care, including T&C, ARV and other available services. This will help them develop their commitment to the National ARV Plan.

7.4. Ensuring access, adherence and responses to the needs of vulnerable populations

- Government policy should be based on equitable access to ART for all those in need, including vulnerable populations such as IDUs, SWs, MSM and prisoners.

- Comprehensive HIV/AIDS prevention services for IDUs, particularly methadone maintenance, peer outreach, condom programming and needle-syringe programmes, should be urgently scaled up.
- The capacity of government drug dependence treatment services, including methadone maintenance, detoxification and rehabilitation programmes, should be strengthened to deliver ART.
- Where ART access for IDUs and sex workers through government facilities are poor, alternative ART delivery systems, including building capacity of NGOs to deliver ART, should be considered.
- STI treatment and condom programming should complement ART, particularly for sex workers.
- Effective two-way referral systems should be established between NGOs/CBOs and health services providing ART to ensure that access to ART is optimized, and that community monitoring and support are guaranteed. (There should be back and forth referral between health services, CBO/NGO, community case management personnel, community support groups, and adherence monitoring and support services.)
- Continuity of ART should be guaranteed for individuals who are detained or incarcerated. This requires close collaboration between public health services and prison health services.
- Funds should be allocated to develop the involvement and capacity of PLWHA networks and of the community in adherence support.

7.5. Providing drugs and diagnostics

- Recent WHO guidelines have highlighted the need for five ARVs for first-line treatment. Therefore, the national supply of first-line ARVs should be expanded to include efavirenz and stavudine. This could, at least initially, be done via a "special access permit" issued by the National Agency for Drug and Food Control.
- The supply system should be operational as soon as possible. For it to function smoothly, it will be necessary to develop clear and simple procedures, assign clear responsibilities and ensure coordination. This will include making provisions for a buffer stock (probably by Kimia Farma) and the development of procedures for quality control and assurance (by the national agency for food and drug control and its regional branches).
- To ensure timely production and delivery of critical drugs, forecasts on the number of treatments per location should be communicated to Kimia Farma, at least two months in advance.

- Efforts should be made to further reduce the price of triple regimen; this should include tax exemption for ARVs, raw materials and packaging material.
- Kimia Farma should prepare and apply for WHO prequalification, since many donors, including the GFATM, will impose prequalification by WHO as a condition for providing funds for the procurement of ARVs.
- Preparations for the supply of second-line treatment drugs, pediatric formulations and drugs for opportunistic infections, which are not easily accessible (e.g. cotrimoxazole for primary prophylaxis and fluconazole) should be initiated.
- The provision of rapid tests for diagnosis should be discussed further between the concerned parties. Once a decision is reached, forecasting of the needs and communication of those forecasts to suppliers will be essential to ensure timely availability.

7.6. Monitoring and evaluation, surveillance and research

- A monitoring system covering T&C and medical services should be developed by the proposed national HIV/AIDS treatment and care advisory committee (see 7.1 above). Internationally recognized standard indicators and methods should be used.
- ARV drug-resistance monitoring should be done on a population basis. A national reference laboratory for HIV drug-resistance testing should be established in Jakarta.
- National HIV/AIDS surveillance, including behavioural surveillance, should be strengthened in accordance with second-generation surveillance.

8. Key priority actions

Management (within one month):

a. Coordination teams should be set up at the national level and in the six priority provinces. These teams will be responsible for the implementation process, on-going support and monitoring and evaluation.

b. The National HIV/AIDS Treatment and Care Advisory Committee, responsible for developing national guidelines on T&C, ART and case management, should be set up.

Financing (within one month)

a. A proposal should be submitted to the GFATM 4th Round.

b. Additional resources should be identified.

Capacity building (within three months)

a. A national workshop, with representatives from the six priority provinces and from the 22 ART service delivery units, should be held to establish the strategic and operational scale-up plan, and the capacity-building plan (within the first month).

b. Training in T&C, ART, and case-management should be provided in the six priority provinces.

c. A referral system should be organized between T&C, ART and care delivery services, laboratory network and support network.

d. Laboratory facilities for HIV testing and CD4-count, and ART laboratory monitoring in selected facilities should be upgraded.

Procurement and supply (within three months)

a. The ARV procurement system and drug supply monitoring should be set up.

b. The drug procurement system for opportunistic infections treatment and prophylaxis should be strengthened.

c. The laboratory supply system for HIV testing, CD4-count and ART laboratory monitoring should be set up.

9. Technical support requirement from WHO

9.1. Support to the government and partners

WHO participation in the proposed National HIV/AIDS Treatment and Care Advisory Committee and provision of technical support to the coordination unit at the central and provincial levels will include the following:

- Technical assistance in the development of the strategic and operational scale-up plan, including human resources capacity building and costing
- Assistance to the government in establishing a communication strategy for promoting the "3 by 5" initiative, including fact sheets, posters and patient information leaflets
- Technical assistance in the development of the GFATM 4th Round proposal
- Technical assistance in reviewing and implementing (including training) national guidelines (T&C, ART, case-management)
- Assistance for the adaptation and translation of WHO tools and guidelines relating to implementation of the "3 by 5" initiative (ART Toolkit)
- Technical assistance for strengthening laboratory services including training of laboratory technicians (HIV testing methods, CD4-count

technology, ART laboratory monitoring), setting standards and implementing quality assurance practices in the six priority provinces

- Assistance for the adaptation and translation of WHO tools and guidelines for HIV/AIDS prevention, treatment and care for vulnerable populations (including toolkits on IDU, drug substitution therapy, condom programme, SW, and MSM)
- Technical assistance for the establishment of an efficient and secure ART procurement and management system
- Technical assistance to national drug producers for application for WHO prequalification
- Provision of advice on international pricing, procurement and prequalified ARV drugs, opportunistic infections drugs and diagnostics
- Technical assistance for developing a national monitoring and evaluation plan for ART scale-up
- Technical assistance for establishing an ARV drug resistance surveillance system
- Support the development of operational research on ART adherence, particularly in vulnerable populations

9.2. Strengthening of the WHO country office

The WHO country office should resemble the following organizational structure:

- "3 by 5" country team leader (international)
- "3 by 5" medical officer in Papua Province (international)
- "3 by 5" liaison officer (National Programme Officer; NPO)
- "3 by 5" monitoring and evaluation officer (NPO)
- "3 by 5" officer (support procurement, capacity building) (NPO)
- Six provincial HIV/AIDS treatment and care advisors for the six provinces (NPOs)

10. Annexes

10.1. Participants of the Mission Team

Dr Saiful Jazan
Chief STD/HIV/AIDS
DTDC, MoH

Dr Fonny Silfanus
Deputy Chief STD/HIV/AIDS
DTDC, MoH

Dr Amaya Maw Naing
HIV/AIDS Medical Officer
WHO Indonesia

Dr Bing Wibisono
HIV/AIDS National Professional Officer
WHO Indonesia

Ms Karin Timmermans
Technical Officer EDM
WHO Indonesia

Dr Gottfried Hirnschall
Deputy Director
Department of HIV/AIDS
WHO Geneva

Dr Andrew Ball
Manager, Country Support
Department of HIV/AIDS
WHO Geneva

Dr Anupong Chitwarakorn
Senior Expert in HIV/AIDS, MoH Thailand
WHO SEARO

Dr Jean-Michel Tassie
Consultant
WHO SEARO

10.2. Participants in group discussions

Dr Haikin Rachmat, Director, Directly Transmitted Disease Control, Directorate General for Communicable Disease Control & Environmental Health (DG DTDC - CDC & EH)

Dr Farid W. Husain, National AIDS Commission

Dr Georg Petersen, WHO Representative

Dr Sjaffi Ahmad, Secretary Director General, DTDC, CDC, EH (as above)

Dr Yusharmen, DTDC, CDC, EH

Dr Rosmini Day
Chief, Sub-directorate TB, DTDC, CDC, EH (as above)

Dr Dahlia Artati, DTDC, CDC, EH

Dr Sigit Priohutomo, Head of Surveillance and Evaluation, Sub-directorate AIDS, DTDC, CDC, EH (as above)

Dr Sri Hermiyanti, Director Medical Care

Dr Yusmansyah, Medical Care

Dr Ahmad Hardiman, Director, Sub-directorate Specialistic Medical Services, DG for Medical Care

Dr Guntur Bambang, Director, Directorate of Health Laboratories, DG for Medical Care

Dr Rarit Gemphri, Directorate for Medical Care

Dr Eka Viora, Directorate for Community and Family Health,

Dr Husniah Rubiana, Directorate for Pharmaceutical Care

Dr Bahron Arifin, Directorate for Pharmaceutical Care

Dr Susanti Herlambang, Director, Department Social Welfare, Directorate General for Social Welfare

Soejoto Sriyuwono, Department of Law & Justice

Dr Tuning Nina, Food and Drug Control

Dr Linda Sitanggang, Food and Drug Control

Dr Aida Yatmi, Jakarta Provincial Medical Office

Dr Budyo Prasetyawan, Badan Narcotic Nasional (BNN / National Narcotic Board)

Dr Santoso Soeroso, Director, Rumah Sakit Penyakit Infeski (Infectious Disease Hospital)

Dr Zubairi Djoerban, Head of Pokdisus-Cipto Mangukusumo Hospital

Dr Syamsuridjal Djauzi, Director, RS Dharmais

Dr K. Maria P., Naval Hospital (Rumah Sakit Pusat Angkatan Darat)

Dr Suganda, RS Sukanto

Gunawan Pranoto, Director - Kimia Farma Pharmaceuticals

Dr Yuyun Soedarmono, Director - Palang Merah Indonesia (Indonesian Red Cross)

Dr Wiadnyana, Adviser to the Principle Recipient, GF AIDS

Jane Wilson, UN Country Coordinator, UNAIDS

Nick Goodwin, UNAIDS

Noon Pooroe Aomo, Focal Point for AIDS, UNICEF

Julia Loedin, Focal Point for AIDS, UNDP

Dr Ratna Kurniawati, Focal Point for AIDS, USAID

Dr Steve Wignall, Country Director, ASA-FHI/USAID

Dr Hendra Widjaja, Care, Support and Treatment Focal person, ASA-FHI/USAID

Sabine Rens, Medical Coordinator - MSF B

Helene Lorinquer, MSF B

Dr Nurlan Silitonga, Team Leader-Care, Support and Treatment, Indonesia HIV Prevention and Care Project, AusAID

Dr M. Toha Muhaimin, Yayasan Pelita Ilmu (NGO)

Chris Green, Spiritia (NGO)

Frika, Spiritia

Cecep Junaidi, Yayasan Mitra (NGO)

Firman, Yayasan Pelita Plus - Positive Support Group

Adi Sasongko, Yayasan Kusuma Buana (NGO)

Ade Jamjam Prasasti, Kios Atma Jaya (NGO)

Sam Nugraha, PITA - Support Group

Barraclough, Management Support for Health (MSH-USAID)

Yos E. Mudyono, MSH

10.3. "3 by 5" consultation agenda

TENTATIVE AGENDA for Country Mission						
Date	Day	Time	Activity	Venue	Focal persons	
14-jan-04	Wednesday	11.00hrs	Meeting with NGO Positive Network for Coordination Grp	WHO	Dr Saiful Yazan -CDC Nick Goodwin -UNAIDS Sam -PITA Chris Green -Spiritia	
		12.00hrs	Arrival Dr Tassie		TG 433 -pick up by Buana	
		13.00hrs	Meeting with NGO & INGO on	WHO	Helene -MSF Katri - MSF Rx related issues Chris Green - Spiritia, Dr Steve Wignall - ASA/FHI USAID, Karin - WHO, Dr Tassie - WHO, Amaya -WHO	
15-jan-04	Thursday	10.00hrs	Preparatory meeting w/ key partners (MoH, Projects,ASA, IHPCP, MSF)	CDC -MoH		
		17.00hrs	Depart for Riau		Dr Saiful Jazan, Dr Jean-Michel Tassie Dr Amaya Maw-Naing	
			Depart for Bandung		Dr Fonny - CDC -MoH Dr Bing	
16-jan-04	Friday	8.00hrs onwards	Riau discussions & site visits			
17-jan-04	Saturday		Return from Riau			
18-jan-04	**Sunday**		**FREE DAY**			
19-jan-04	Monday	10.00hrs	Join MoH Facilitators' Training Meeting in Bogor to discuss on clinicalmanagement & training plan	Bogor	Dr Saiful Jazan, Dr Jean-Michel Tassie Dr Amaya Maw-Naing	

Date	Day	Time	Activity	Venue	Focal persons	
20-jan-04	Tuesday	19.30hrs	Depart for Merauke		Dr Saiful Jazan, Dr Jean-Michel Tassie Dr Amaya Maw-Naing	
21-jan-04	Wednesday		Arrive in Merauke			
22-jan-04	Thursday		Depart for Jayapura			
23-jan-04	Friday		Jayapura			
24-jan-04	Saturday		Return to Jakarta			
25-jan-04	**Sunday**		**arrival of External Team**			
26-jan-04	Monday	08.30 - 12.30hrs	◆ Country Brief ◆ Debriefing from Missions to provinces/districts & synthesis of key issues for engagement and action in provinces with externalmission team	WHO	Dr Saiful Jazan, Dr Bing Wibisono, Dr Jean-Michel Tassie, Dr Amaya Maw-Naing Dr Anupong Chitwarakorn Dr Andrew Ball, Dr Gottfried Hirnschall Ms Karin Timmermans	
			Discussion with TB Team	WHO		
		14.00 - 14.30hrs	Briefing w/ UNTG, Donors on WHO 3 by 5 Strategy integration with Donors' meeting	WHO meeting room	Dr Saiful Jazan Dr Gottfired / Andrew Ball	
		15.00hrs onwards	Preparation of Group Discussions	WHO	Dr Bing Wibisono, Dr Jean-Michel Tassie Dr Andrew Ball	
		21.00 hrs	Depart for Bali		Dr Saiful Jazan, Dr Amaya Maw-Naing Dr Gottried Hirnschall	
27-jan-04	Tuesday	09.00 - 11.00hrs	Selected local visits in Jakarta - Methadone RSKO		**Grp I :** Andrew Ball, Jane Wilson Ibu Ratna IHPCP - Dr Bambang Eka ASA - Gambit & Wayne	Project Summary Paper needed

Date	Day	Time	Activity	Venue	Focal persons	
		12.00 - 14.00hrs	Outreach programme - Tebet Pelita Ilmu		**Grp I :** Andrew Ball, Jane Wilson, Ibu Ratna IHPCP - Dr. Bambang Eka ASA - Gambit & Wayne	Project Summary Paper needed
		16.00 - 18.00hrs	Atmajaya Drug Outreach		**Grp I :** Andrew Ball Jane Wilson Ibu Ratna IHPCP - Dr. Bambang Eka ASA - Gambit & Wayne	
		09.00 - 11.00hrs	RSPI		**Grp II :** Dr Anupong, Dr Bing ASA -Gambit & Wayne MSF Dr Tassie	Project Summary Paper needed
		16.00 - 18.00hrs	**Waria Clinic**			
		09.00 - 18.00hrs	BALI SITE ASSESSMENT		**Grp III :** Dr Saiful Jazan, Dr Amaya Maw-Naing, Dr Gottried	
28-jan-04	Wednesday	09.00 - 11.00hrs	RSCM, Pokdisus			
		12.00 - 13.00hrs	Meetings on specific technical issues - Lunch Briefing	CDC - MoH	Dr Haikin, Dr. Saiful, Dr Gottfired, Andrew Ball	
		13.00 - 14.00hrs	**Group Discussions**			
			- Drug Procurement & management	WHO MoH, CDC POM, MSF Yanfar	Ibu Karin	
			-VCT		WHO, MoH, Pelita Ilmu, Pokdisus, Atma jaya, IHPCP, ASA, Dr Ratna Mardiati, Y Mitra, DHL & UNICEF, MSF, UNICEF	Dr Tassie

Date	Day	Time	Activity	Venue	Focal persons	
			- PLWHA support groups		PITA, Pelita Ilmu, Pelita Plus, Spiritia, NAC, ASA, IHPCP, UNAIDS	Dr Gottfried
			- Clinical Services, training		WHO MoH -CDC, MedCare RSCM - UI RSPI MSF	Dr Anupong
		14.00 - 16.00hrs	Debriefing / 30 mins per group			
		16.00 - 16.30hrs	Discussions & Recommendations			
		18.00 onwards	Dinner Meeting with NGOs in Drug Outreach		NAC, MoH, ASA, IHPCP, WHO	
29-jan-04	Thursday	09.00 - 16.00 hrs	Preparation of Mission Report and recommendations	CDC - MoH	Dr Saiful Jazan, Dr Andrew Ball Dr Gottfried Hirnschall, Dr Anupong Dr Jean-Michel Tassie, Dr Bing Dr Jane Wilson	
30-jan-04	Friday	09.30 - 11.00hrs	Debriefing with country partners/stakeholders •MoH, NAC, NGOs, Donors, Private Sectors, UN team	MoH	Dr Haikin Rachmat MoH Dr Saiful Dr Gottfried Hirnschall Dr Andrew Ball	
		11.30 - 12.00hrs	PRESS CONFERENCE / PRESS RELEASE			
		Afternoon	Finalization of mission report	CDC or WHO		
31-jan-04	Saturday		Departure of Mission Team			

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