

Review of the
Health Sector Response to
HIV and AIDS in Indonesia
2007



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**World Health
Organization**

Regional Office for South-East Asia

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Acronyms and abbreviations

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral medicines
AusAID	Australian Agency for International Development
BSS	behavioural surveillance survey
CBO	community-based organization
CST	care, support and treatment
DC	Disease Control
EH	Environmental Health
ELISA	enzyme-linked immunosorbent assay
FHI	Family Health International
FSW	female sex worker
GDP	gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	hepatitis C virus
HBV	hepatitis B virus
HBsAg	hepatitis B surface antigen
HIV	human immunodeficiency virus
HSS	HIV serosurveillance
ISAC	Intensified Assistance and Collaboration
IBBS	integrated bio-behavioural surveillance
IDR	Indonesian Rupiah
IDU	injecting drug user
IEC	information, education and communication
IHPCP	Indonesia HIV/AIDS Prevention and Care Project

IMAI	Integrated Management of Adult and Adolescent Illness
MoH	Ministry of Health
MSM	men having sex with men
NAC	National AIDS Commission
NAP	National AIDS Programme
NGO	nongovernmental organization
OI	opportunistic infection
PLHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
STD	sexually transmitted disease
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
TRIPS	Agreement on Trade Related Aspects of Intellectual Property Rights
UNAIDS	United Nations Programme on HIV/AIDS
UNICEF	United Nations Children Fund
UNODC	United Nations Office on Drugs and Crime
VCT	voluntary counselling and testing
VDRL	Venereal Disease Research Laboratory

Executive summary

As part of the process of development of the National Strategic Plan on HIV/AIDS for 2007-2011, the Ministry of Health and the World Health Organization (WHO), in collaboration with a range of partners, organized, from 5 to 17 February 2007, a review of the health sector response to the HIV epidemic in Indonesia. The overall objective was to review progress in the national AIDS programme, especially in areas related to the health sector response, and recommend appropriate measures towards revision of interventions and strategies.

The review team comprised ten international experts, six representatives from civil society, networks of nongovernmental organizations (NGOs) and people living with HIV/AIDS (PLHA), five representatives from bilateral donors and 27 facilitators from the Sub-directorate HIV/AIDS and sexually transmitted infections (STI), Directorate General of Disease Control and Environmental Health (DC & EH), Ministry of Health, and WHO.

The methods used were desk review of formal and informal documentation, focus group discussions and semi-structured interviews. Members of the review team and facilitators were deployed to six areas as follows: Jakarta, Papua (Merauke, Wamena, Timika and Jayapura), Bali (Denpasar), West Kalimantan and East Java (Surabaya and Bayuwangi). The teams visited five provincial AIDS commissions, six district AIDS commissions, 22 hospitals, both at regional and district levels, 16 community health centres (Puskesmas), two prisons (West Kalimantan and Bali), nine PLHA groups, seven self-help groups of injecting drug users (IDUs), 13 brothels and four self-help groups of men who have sex with men (MSM) and the transgender.

Key findings

The HIV epidemic in Indonesia is among the fastest growing in Asia although the aggregate HIV prevalence among adults (15-49 years of age) is still low (0.16%). An estimated 193 000 people were living with HIV as of 2006. The epidemic remains concentrated, in most parts of the country, among groups at high risk: populations sharing injecting equipment and engaging in unprotected sex. It has reached high levels among populations at high risk,

such as IDUs, with 70.8% in Depok, Jakarta, and female sex workers (FSWs), with 22.8% in West Irian Jaya. Recent unpublished data suggest that Papua may be experiencing an emerging generalized epidemic with HIV prevalence several times the national average. Since the first AIDS case was reported in 1987 in Bali, HIV has affected all of Indonesia. Currently, 32 provinces and 169 districts have reported AIDS cases.

The national commitment to respond effectively to the epidemic is strong. An impressive expansion of the response to the epidemic has been seen in the last two to three years but major disparities exist: geographical, the nature and size of the epidemic, health systems capacity, and available resources. A number of sound strategies and interventions were in place to control the epidemic but, on the whole, coverage remains insufficient.

Policy, structures and programmes

Limited capacity in HIV programming of the provincial and district programme managers and implementers, as well as a lack of coordination within the structure of the new AIDS commission, have adversely affected the current response. Decentralization requires that local AIDS commissions be responsible and have the capacity for coordinating the multi-sectoral response at the local level. These institutions need to establish that they are transparent, credible, and responsive.

There is recent evidence of a generalized epidemic in Tanah Papua. The general perception is that the local health care system is not well developed. However, in some sites visited the services were indeed well developed. There is high-level recognition that the epidemic is different and that the response to it should be adapted to the situation in these provinces.

The health sector response involves a number of directorates in the Ministry of Health. Coordination of planning and implementation across the entire Ministry is needed in the multi-sectoral response to HIV.

Recently, there have been notable gains in the political and financial commitment to HIV prevention and control, marked by the commitment of the President to increasing overall funding for the HIV/AIDS response. However, the national AIDS programme remains highly donor dependent, raising concern about its sustainability. There were considerable financial and human resource gaps.

Second-generation surveillance has been implemented. Data are available and used at provincial and district levels to derive estimates for planning. However, integrated analysis combining multiple data sources is not conducted regularly and STI surveillance is inadequate.

Several parallel monitoring and evaluation systems are in place resulting in redundancy of data collection at facility level. Staff are over-burdened in fulfilling the various reporting requirements.

HIV prevention

Effective HIV prevention requires integration of the many different interventions considered below. It is important to bear in mind that at-risk groups may have multiple risk factors and the health sector offers multiple opportunities, integrating care, treatment, and prevention.

There was a notable lack of a consistently-supportive environment to scale up effective HIV prevention interventions among sex workers (SWs), IDUs, MSM and the transgender.

STI services do not always reach the most important target groups. Recent guidelines have not yet reached all health service facilities and the newly recommended required STI drugs are not yet in stock.

Condom use rates remain low among populations at high risk for HIV and STIs such as SWs. Condoms are not always available or promoted in health facilities. Peers, volunteers and outreach workers do not always carry condoms or promote their use.

Coverage of harm reduction is insufficient. Projected target number of IDUs has not been reached, and clean needles, syringes and condoms supplied to IDUs who were contacted were inadequate.

Prevention of mother-to child transmission (PMTCT) intervention is available only in a few pilot sites.

Blood safety is not universal, especially where the Indonesian Red Cross is not actively involved. The Red Cross operates in 185 of the 447 districts.

HIV testing and counselling

Commitment to scale up HIV testing and counselling services exists at all levels. Overall access and use remain low and few clients are self-referred. Provider-initiated HIV testing and counselling is the norm. Stigma and discrimination are major barriers for increasing access to, and coverage of, HIV testing and counselling services.

Care, support and treatment

Substantial achievements have been made since 2004 with respect to increasing availability and coverage of care, support and treatment services. However, the quality of clinical care, in particular with respect to diagnosis and treatment of opportunistic infections, is insufficient.

Though antiretroviral therapy (ART) is offered free of charge, other associated costs are sometimes prohibitive. In all regions visited, stockouts of antiretroviral drugs were reported. Provision of second-line therapy was rare. Paediatric formulations are not yet registered.

People living with and affected by HIV

In several areas visited, support groups for PLHA have been established and are involved in a full-range of prevention, care and support programmes. However, there was limited participation in policy and programme planning.

Key recommendations

- (1) Provision of technical support to local AIDS commissions is essential in order to help them prepare and launch costed local strategic plans that will ensure long-term sustainability of comprehensive prevention, care, support and treatment programmes. The support activity should be funded by domestic and external sources. Key activities of the local AIDS commissions should include budget advocacy as well as involvement of people living with and affected by HIV in policy making and planning.
- (2) Fundamentally different planning and implementation needs of Papua, due to the unique nature of the epidemic in the region and the limited financial, human and technical resources available locally, should be addressed.
- (3) Representation of all aspects of health care in HIV programming and improvement in the functioning of one working group directly under the guidance of the Minister of Health should be ensured.
- (4) Capacity for second-generation surveillance should be strengthened at all levels, particularly in the areas of data management, collective analysis of data from various sources, and regular dissemination of data.
- (5) Harmonization of existing reporting systems to establish ONE national monitoring and evaluation system, through efforts initiated by the National AIDS Commission and the Ministry of Health, should be facilitated. The responsibility for collecting, collating and analyzing the primary data on the health sector response should remain under the auspices of the Ministry of Health.
- (6) The 100% condom programme should be implemented and rapidly expanded, especially in economic hot-spots and where sex work is common.

- (7) Rapid establishment and scaling up of a comprehensive approach, including availability of methadone maintenance therapy, needle syringe and condom distribution in all provinces where injecting drug use is an important risk factor, should be given urgency.
- (8) Implementation of blood safety, including application of existing guidelines on testing blood and blood products for blood-borne infections and rational use, should be a national priority.
- (9) Access to, and coverage of, HIV testing and counselling services should be increased at all levels, paying special consideration to local conditions and needs.
- (10) Capacity, as well as mentoring and supervision of overall care, support and treatment, should be strengthened, especially for management of opportunistic infections (OI).
- (11) Necessary health products should be made available at all health facilities. Particular attention is needed to ensure the uninterrupted supply of antiretroviral medicines (ARVs), medicines for common opportunistic infections, and the introduction of second-line ARVs and paediatric formulations.
- (12) Capacity of people living with and affected by HIV to come together and form self-help groups and networks should be strengthened.

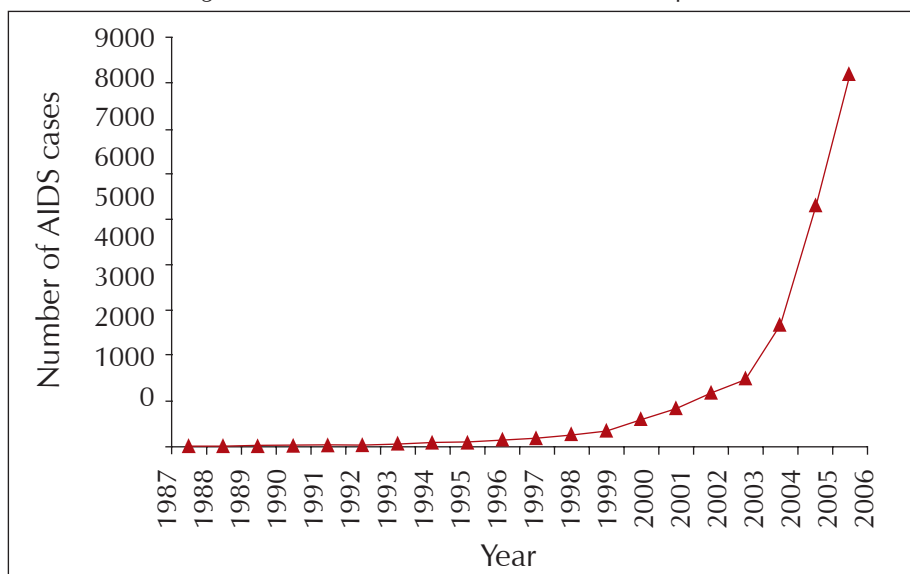
1. Introduction

Indonesia, located between continental Asia and Australia, comprises more than 17 000 islands. With a population of over 220 million, it is the fourth most populous country in the world. The gross domestic product (GDP) per capita is estimated at US\$ 1 280. In 2004, the World Bank estimated that 52% of the population lived on less than US\$2 per day.

Life expectancy at birth is 67 years.¹ The Central Bureau of Statistics estimated the infant mortality rate at 35 per 1000 live births in 2003. In 2002, the mortality rate in children under five (5) was at 46 per 1 000 live births. Maternal mortality, although in decline, remains high in Indonesia with WHO estimating it to be at 230 per 100 000 live births. Communicable diseases remain a large burden, even as the burden from non-communicable diseases is climbing. Indonesia, for example, ranks third in the world for the burden of tuberculosis (TB), with a prevalence of 262 per 100 000 (all cases), and TB mortality of 41 per 100 000 in 2005. Health spending per capita is estimated at US\$ 33 in 2004, representing 2.8% of the GDP. Government expenditure on health represents about 34% of total spending on health. The majority of private spending on health is out-of-pocket. Recent steps have been taken to ensure that the poor can access health facilities. With the implementation of a national social health insurance scheme, or *Askeskin*, the government will now pay the premiums for 60 million poor as of the beginning of 2005.

In 2001, Indonesia underwent a rapid process of decentralization, devolving budgetary and implementation authority for most health services, down to the district level. Previously it had been a vertical system, where the national level government set priorities and agendas, as well as determined funding. Now, the 440 districts in Indonesia have this authority. The 33 provinces coordinate districts and municipalities. While decentralization brings the opportunity for increased efficiency, flexibility and accountability, the ability of the central government to influence decisions about priority setting and funding is limited. The health system has been affected by the challenges of intergovernmental relationships in a decentralized system, with some functions, such as disease surveillance, becoming more difficult.

Figure 1: Cumulative number of AIDS cases reported



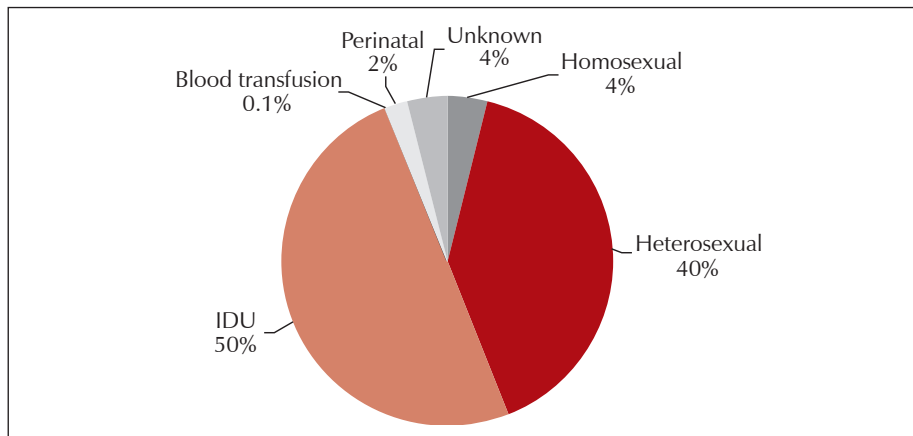
Source: Directorate General of DC and EH, Ministry of Health, Republic of Indonesia

Although the aggregate national HIV prevalence is still low (0.16%), the increase of reported cumulative AIDS cases in Indonesia is high, making it one of the fastest growing epidemics in Asia (**Figure 1**). What began as mainly an epidemic among injecting drug users (IDUs) in Jakarta, West Java and Bali, has now spread from IDUs to their non-injecting sex partners, prisoners, SWs and their clients. About 70.8% of IDUs in Depok, Jakarta, and up to 23% of sex workers in Papua have been infected as of 2006.

Since the first AIDS case was reported in 1987 in Bali, HIV has affected all of Indonesia. Currently, 32 provinces and 169 districts out of a total of 33 provinces and 440 districts respectively have reported AIDS cases. Injecting drug use accounts 50% of AIDS cases reported out of a cumulative number of 8194 AIDS cases reported up to December 2006 (**Figure 2**).²

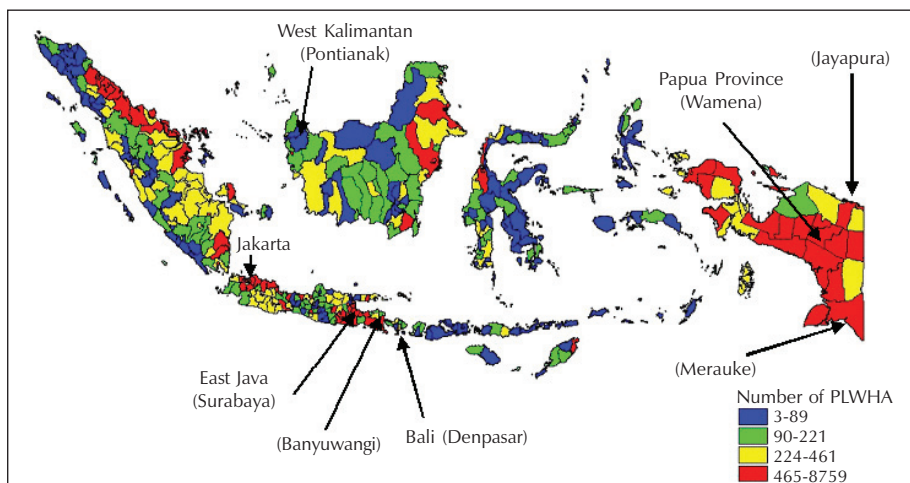
In 2006, an estimated 193 000 (ranging from 169 000 to 216 000) people were living with HIV and AIDS (PLHA). In most parts of the country, the epidemic remains concentrated among groups at high risk characterized by sharing injecting equipment and engaging in unprotected sex. Data from behavioural surveillance show that there are two major categories of high-risk behaviours that account for the majority of HIV infections: sharing of contaminated injecting equipment among IDUs, and low condom use during sex among female, male and transgender sex workers and their clients as well as among men having sex with men. Also there are considerable overlapping risk behaviours between the groups (**Figure 3**).

Figure 2: Proportion of AIDS cases reported by transmission category (2006)



Source: Directorate General of DC and EH, Ministry of Health, Republic of Indonesia

Figure 3: Estimated number of people living with HIV/AIDS by district (2006)

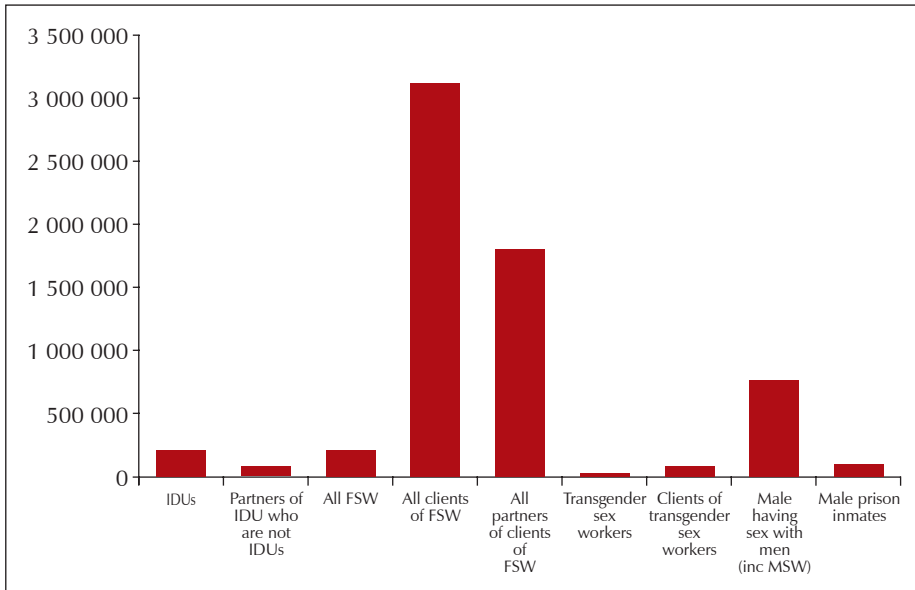


Source: Directorate General of DC and EH, Ministry of Health, Republic of Indonesia

There is a vast variation in the HIV burden by geographical area. In the provinces of Bali, Java, Sumatra, West Kalimantan and South Sulawesi needle sharing among IDUs is the predominant mode of HIV transmission. However, sex work is found across the country with an estimated 3.1 million male clients (**Figure 4**). While other provinces have concentrated epidemics, Papua seems to be experiencing an emerging generalized epidemic with HIV prevalence several times the national average. A first population-based integrated bio-behavioural surveillance (IBBS) conducted in 2006 in Papua found HIV prevalence several times the national average. The reported AIDS cases per 100 000 population in the Papua province is 20 times higher than that of the national average of two cases per 100 000 population. From 1998 to 2005,

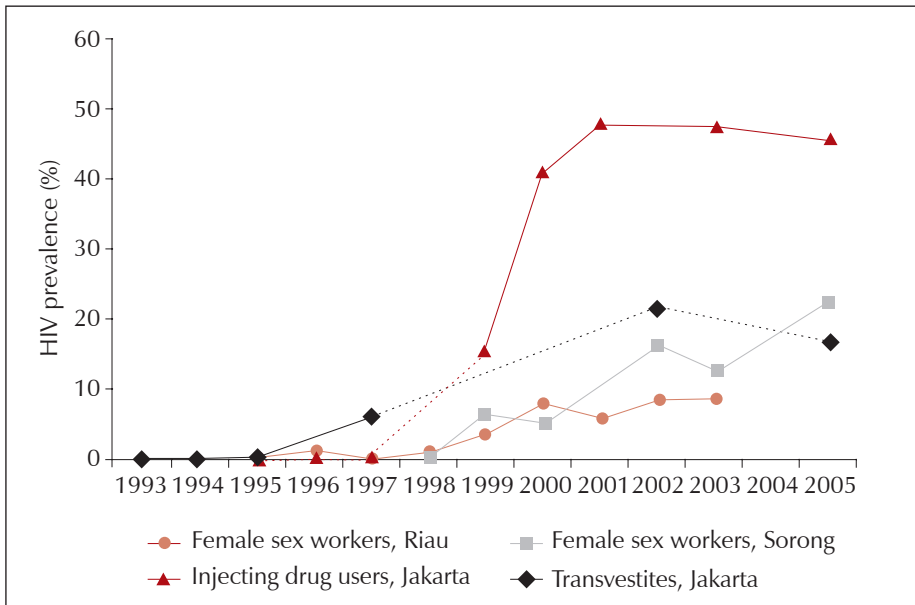
HIV prevalence among sex workers increased from approximately 1% to 23% in Sorong (Figure 5).

Figure 4: HIV-vulnerable population size



Source: Directorate General of DC and EH, Ministry of Health, Republic of Indonesia

Figure 5: HIV prevalence among populations with high-risk behaviours (1993-2005)



Source: Directorate General of DC and EH, Ministry of Health, Republic of Indonesia

The high rates of sexually transmitted infections (STIs) among sex workers (SWs) in Papua also enhance transmission of HIV. The Minister of Health established the National AIDS Committee in 1987. A Short-Term Plan and a Medium-Term Plan were implemented from 1988 to 1994 with assistance from the WHO Global Programme on AIDS. Presidential Decree No. 36/1994 expedited the establishment of the National AIDS Commission (NAC), a multi-sectoral body. According to the decree, the NAC was chaired by the Coordinating Minister for People's Welfare, with the Minister of Health as one of the Vice-Chairs. It also stipulated the formation of AIDS Commissions at provincial, district and municipality levels.

The NAC formulated the first National AIDS Strategy and a Five-Year Programme Plan for AIDS Prevention and Control (1995-2000) as part of the 6th National Development Plan. Due to the economic crisis, the plan did not receive the necessary budget from the government but attracted foreign donors. The Minister of Health Indonesia signed the Declaration of Commitment of the UN General Assembly Special Session on HIV/AIDS in June 2001. Subsequently the National HIV/AIDS Strategy, National AIDS Commission (2003 – 2007)³ and the National Strategic Plan on HIV/AIDS Control, Ministry of Health (2003 – 2007)⁴ were developed. With the changing pattern of the HIV epidemic and increasing awareness on HIV many new activities have started during recent years.

2. Methods

The current review, jointly organised by the Ministry of Health Indonesia and the World Health Organization, was conducted from 5th to 17th February 2007 as part of the process of development of the National Strategic Plan on HIV/AIDS for 2007-2011.

The objectives of the current review were to:

- review relevancy and adequacy of the National Strategic Plan on HIV/AIDS (2003 – 2007) and existing policies related to health sector responses to HIV/AIDS;
- review national targets, identify achievements and gaps, and update these in the light of the developing epidemic;
- assess progress and efficiency of HIV prevention, care and treatment activities;
- identify constraints in programme implementation;
- review appropriate budget allocation for prevention, care, support and treatment;
- provide recommendations for future plans and the way forward for program planning, implementation and collaboration among partners, and
- review all commitments (government, major NGOs, donors, and private sector) to support implementation of the National AIDS Strategy related to health sector responses to HIV/AIDS

The review team comprised ten international experts, six representatives from civil society, networks of nongovernmental organizations (NGOs) and PLHA, five representatives from bilateral donors and 27 facilitators from the Sub-directorate HIV/AIDS and STI, Directorate General of Disease Control and Environmental Health (DC & EH), Ministry of Health and WHO.

The review covered five thematic areas: (i) policy, structures and programmes, (ii) strategic information, (iii) prevention of HIV and STIs, (iv) HIV testing and counselling, and (v) care, support and treatment.

The methods used were desk review of formal and informal documentation compiled by the various sub-directorates in the Ministry of Health, the NAC, NGOs and donors, staff from country offices of WHO, United Nations Programme on HIV/AIDS (UNAIDS), United Nations Office of Drug and Crime (UNODC), and the United National Development Programme (UNDP).

Members of the review team and facilitators were deployed to six areas (see **Figure 3**: district estimates): Jakarta, Papua (Merauke, Wamena, Timika and Jayapura), Bali (Denpasar), West Kalimantan and East Java (Surabaya and Bayuwangi). The six teams visited five provincial AIDS commissions, six district AIDS commissions, 22 hospitals, 16 community health centres (Puskesmas), two prisons (West Kalimantan and Bali), nine groups of PLHAs, seven self-help groups of IDUs, 13 brothels and four self-help groups of MSM/transgenders. All teams collected and analyzed information on the five thematic areas using a semi-structured questionnaire developed in the initial phase of the review and reviewed programme data.

This report summarizes the findings of the joint review and presents the main conclusions and recommendations. Additionally, province-specific findings and recommendations were given and can be obtained on request from the Sub-directorate of HIV/AIDS and STI, Ministry of Health Indonesia and the WHO Indonesia Country Office.

3. Policy, structures and programmes

Prerequisites for an effective HIV/AIDS control programme are strong political commitment and adequate structures and effective management of the overall programme with formulation of sound policies and strategies.

3.1 Legislation, policies and strategies

There is clear evidence of increased governmental commitment to the national response at all levels over the past three years. The most important evidence is the restructuring of the NAC through a Presidential regulation in July 2006.⁵ The NAC, being chaired by the Coordinating Minister of People's Welfare and two vice-chairpersons, the Minister of Health and the Minister of Home Affairs, has now the authority from the highest level of the Government of Indonesia to take on its leadership role. The membership of the NAC was enlarged to 23, including 18 ministries and agencies, and five (5) nongovernmental organizations. The NAC has appointed a secretary and recruited a number of professional staff in its secretariat. AIDS commission offices are being established in all of Indonesia's 33 provinces and in 100 priority districts.

As a result of the increased commitment, so far there have been rapid increases in the number of voluntary counselling and testing (VCT) service sites and people tested, increases in the number of opiate users taking methadone substitution therapy, in the number of needle syringe programmes started and the number of people with HIV taking antiretroviral medicines (ARVs). However, the number of service delivery sites is not sufficient and the quality of programmes is not assured. There continues to be a need for more commitment to translating policies to action.

Legislation and a number of policies and strategies on the prevention and control of HIV have been formulated. The translation of national legislations, policies and strategies, however, need to be expedited by the provincial and district governors to result in effective implementation.

The National HIV/AIDS Strategy, National AIDS Commission (2003 – 2007) and the National Strategic Plan on HIV/AIDS Control (2003 – 2007), under the Ministry of Health, were developed in 2003.^{3,4} Interventions targeting vulnerable groups such as IDUs, MSM, transgender (*waria*), female SWs, migrants, children, pregnant women, and prisoners are specified in both strategic plans. However, estimates of well-defined vulnerable populations, present coverage, and targets were not articulated.

Based on these strategies, the “*Sentani* Commitment to combat HIV/AIDS in Indonesia”, a formal policy declaration, was formulated in 2004.⁶ It included the Coordinating Minister for People’s Welfare, six Ministers (Health, Social Welfare, Religion, Education, Home Affairs, and the National Family Planning Board) as well as the governors of the most affected provinces (Bali, DKI Jakarta, East and West Java, Riau, and Papua).⁷ This action specified policies to prevent HIV through promoting condom use in risky sexual activities and a comprehensive harm reduction approach to IDUs, provision of ART, reduction of stigmatization and discrimination of PLHA, establishment and empowerment of provincial and district AIDS committees and development of laws and regulations conducive to HIV/AIDS programmes and accelerating overall efforts in response to HIV/AIDS.

In 2003, the National AIDS Commission and the National Narcotics Board signed a Memorandum of Understanding (MOU) with the Coordinating Minister of Social Welfare and Chief of the National Police on harm reduction.⁸ A draft law on harm reduction remains to be proposed to the national legislature and by planning for a comprehensive prevention and care programme including prisons.

In June 2005, the Ministry of Justice published the National Strategy for Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centres for the period of 2005 to 2009. It is a formal policy document that provides the legal basis for the establishment of services for the control of HIV/AIDS and drugs within correction and detention institutions in Indonesia.^{8,9} There are preliminary national plans to increase the number of prison staff who will be trained to work on HIV issues.

In general, the review teams noted that the national legislations, the *Sentani* Commitment, national policies and strategies were not consistently implemented across areas visited.

Local legislations have been enacted in most sites visited. For example, East Java has had a legislation and implementation guideline in place for three years with specific recommendations on condom promotion in brothels and harm-reduction activities among IDUs. However, this legislation, as well as the implementation guideline, was not adopted by municipal and district authorities.

Jakarta had no overall local legislation or *perda* on HIV/AIDS as the legislators have not yet passed proposed legislation and an election is due in the summer of 2007. East Jakarta has a local decree meant to enable

outreach among vulnerable populations but outreach workers are still harassed by police. Similar observations were reported to the review team from other provinces visited.¹⁰

An agreement signed in 2005, between the governor of the major city in West Kalimantan and the head of districts, stipulated how to fight drug addiction and control the spread of HIV. An agreement to establish an HIV related referral system in prison was signed in December 2006 by key stakeholders led by the local AIDS commission and the provincial department of health. Staff and support workers from outside prisons had started working on HIV prevention activities inside prisons in West Kalimantan. There were similar activities reported from prisons in Bali and Jakarta.

According to informants, there was little reinforcement and almost no monitoring of implementation of HIV-related legislations in most provinces. For example, in West Kalimantan police do not support needle and syringe programmes in any location. They stated they required a directive from the national level before they could accept harm-reduction activities at the provincial level. Similar observations that local police do not support needle syringe programmes were made in other provinces visited.

Informants from the Indonesian Medical Association reported that local moral norms in some geographic areas limit doctors in providing care to female SWs, as required. This happens despite the fact that doctors who break the legislation are supposed to be fined. There is as yet no national legislation to protect the rights of PLHAs.

Recommendations

- The Secretariat of the National AIDS Commission and local AIDS commissions should build a sense of ownership. They should build capacity of programmes across sectors so that ministries and local offices of line ministries may start incorporating HIV services into their own planning systems.
- The local AIDS commissions should build and generate confidence that they are transparent, credible, responsive and capable of developing leadership capacity.
- Mechanisms should be developed to monitor the implementation of legislation and policies.

3.2 Coordination and partnerships

Multi-sectoral coordination

HIV/AIDS efforts are led by local Governors at the provincial level and by the Regent or Mayor at municipal/ district level, as well as by Head of the Sub-

district. They are coordinated by the local AIDS commission with active participation from respective health offices, other government offices, nongovernmental organizations, religious and educational institutions, and other stakeholders.

The provincial and municipal/district governments establish and put into action a provincial and municipal/ district AIDS commission and allocate resources, especially human and financial resources, for HIV activities. Each related department/ agency is required to draw up an action plan that is consistent with the provincial or district/ municipal AIDS strategy.

The local AIDS commissions are currently facing many challenges. They often do not have sufficient financial resources to recruit staff in their secretariats and do not understand their roles. Informants were concerned about the technical capacity of the AIDS commissions to lead the local multi-sectoral response to HIV. For example, it was noted in East Java that the local HIV responses were predominantly driven by active health sector officials.

Ministry of Health

Within the Ministry of Health, the Directorate General of Disease Control (DC) is the main Directorate responsible for planning, monitoring and supervising the health sector interventions for HIV and STIs. There are five other Directorates with shared responsibilities such as Medical Care and Community Health (see **Annex 2**). The DC can facilitate collaboration and coordination but has no authority to lead the response within the Ministry of Health. There is currently no central mechanism to oversee the role of the entire Ministry of Health in the response to HIV (see **Annex 1**).

The Ministry of Health has established technical working groups on surveillance, harm reduction, prevention and control of STIs, HIV drug resistance surveillance and monitoring, VCT, prevention of mother-to-child transmission (PMTCT) and TB/HIV. The working groups often do not have work plans and there is irregular attendance at meetings. With frequent duty change, some participants drop out so there is little continuity. It was suggested that there be better planning for the working groups and that they become more inclusive.

Numerous NGOs have been working in the HIV response but coordination varies considerably across institutions and is often weak. NGOs and community-based organizations (CBOs) play a key role in implementing HIV prevention in Indonesia by reaching people and groups with specific needs – i.e., youth, faith-based groups, women, professionals, high-risk groups, and PLHA that are often not easily reached by the government. Their activities include outreach, training, mentoring for people living with HIV, giving support, and counselling. NGOs and CBOs also play a part in motivating PLHA to establish self-help groups to provide mutual support and enable them to

become more involved in HIV prevention. Although the Ministry of Health cannot directly use the Government budget to fund the activities of local NGOs, members of affected communities including PLHA are involved in the response as regular and volunteer staff of local organizations. Outreach workers commonly are members of these communities. They join in governance of the response through their participation and their work positions. One service provider for transgender in Jakarta has three full time transgender staff and one local NGO had of half its staff being former IDUs. This situation is also seen in other provinces.

Civil society

There is only limited civil society participation in national and local leadership of the AIDS response. Large local NGOs are often involved at central and provincial level meetings of the National AIDS Commission and the various working groups. Key informants from associations of MSM, transgender, SWs, IDUs and PLHA mentioned that they were invited to some AIDS Commission meetings at national level and rarely at provincial level but they were not actively involved in programme planning and implementation. Key informants reported that members of vulnerable communities were participating in some Ministry of Health working groups.

Private sector

There is a limited but growing involvement of the private sector in the response to HIV in Indonesia. Companies usually give donations for World AIDS Day and make small but strategic donations to smaller implementing agencies. They tend to donate to their own companies or geographical areas. There has been an increase in private sector involvement through workplace programmes for HIV prevention.

The private health sector is often an entry point to care but the role of the private sector in the provision of HIV care has not expanded significantly. The review could not visit private sector health facilities. The Ministry of Health has not included the private sector in the training on HIV clinical management, treatment and monitoring.

Recommendations

- The National AIDS Commission including the Ministry of Health should more actively involve and empower the civil society including PLHAs in programme planning, control and response to HIV.
- The capacity of the Ministry of Health to coordinate and implement all elements of a comprehensive health sector response including peer support should be strengthened through establishing one overarching working group under the Minister of Health.

- Government –through NAC— should cooperate with private sector (corporate sector) to establish independent and sustainable funding source for HIV prevention, care and treatment programmes and should also involve medical associations and private practitioners in the programme planning.

3.3 Planning

An overall multi-sectoral national strategic plan in response to the HIV epidemic is in preparation by the national AIDS commission in collaboration with different ministries including the Ministry of Health. An operational plan with planned budget is in the process of being prepared in early 2007.

Proposed key targets for the year 2010 in the draft national strategic plan are as follows:

- (1) Comprehensive prevention programmes reach 80% of most-at-risk populations.
- (2) Behaviour change occurs in at least 60% of people in the most-at-risk populations.
- (3) 80% of all eligible people with HIV receive antiretroviral therapy, care and support services.
- (4) Civil society participates actively: prevents — and fights against — stigmatization and discrimination, making the emergence of an enabling environment possible.
- (5) By 2008, domestic and international resources reach the estimated needs. 60% of pregnant women have access to antiretroviral prophylaxis.
- (6) A set percentage (to be defined) of orphans and vulnerable children receive support packages.
- (7) A set number or percentage (to be defined) of new infections decrease over the baseline of 2638 recorded new infections in 2005.

A similar process involving many partners inside and outside the health sector is underway to formulate a comprehensive health sector response. A participatory process is considered as important and vital. Promulgation of the new health sector plan through the Ministry of Health and other ministries should guide partners in their work.

The Sub-directorate of HIV/AIDS meets annually with provincial health administrations and develops work plans with budgets. The provinces develop their plans based on inputs received from each district.

Most institutions met by the review team had strategic plans, annual work plans or both. Examples of organizations that had undergone strategic planning processes were the Red Cross, the police, the Indonesian Medical Association, the combined armed forces, the Indonesian Nurses Association, the association of doctors involved in HIV care, and the Ministry of Women's Empowerment. Among the NGOs met by the team, almost all had written strategic plans and work plans.

Estimates of well-defined vulnerable populations, current coverage, and targets were rarely articulated in the work plans. Data from estimations on risk-populations were not available or consulted.

The Ministry of Health has recognized that the HIV epidemic and health systems infrastructure in Papua are different from the rest of the country. This underscores the importance of tailoring and adapting the response to the epidemic to fit the different situations in the provinces.

Recommendations

- The working groups under the Minister of Health should facilitate the preparation of a promulgated and costed national strategic plan on scaling-up HIV prevention, care and treatment for 2008 – 2012, involving key partners within and from outside the Ministry of Health, provincial and district level stakeholders. The plan should include estimates of well-defined vulnerable populations, present coverage, targets and indicators and consider long-term sustainability.
- Technical support to local AIDS commissions should be provided to prepare and promulgate costed local strategic plans for 2008 – 2012 with the goal of long-term sustainability of comprehensive prevention and care activities, funded by domestic and external sources.
- The fundamentally different planning and implementation needs of Papua should be effectively addressed, due to the unique nature of the epidemic and the limited local financial, human and technical resources. Increasing coverage of prevention, care, support and treatment interventions in Papua should be prioritized, in view of the rapidly-expanding generalized epidemic.

3.4 Budget and financing

Financial resource allocations are in general adequate for activities currently undertaken but not sufficient enough to scale up activities to the level required to make an impact on the HIV epidemic.

There has been an increasing financial commitment to national HIV/AIDS control programmes in recent years. The review team developed a summary table of the overall budget for HIV activities in the country (**Table-1**). While MoH budgets are increasing moderately, budgets for other government agencies are expanding more rapidly. It is uncertain whether the projected increase in the MoH budget for 2007 will be realised. Based on the estimates by the National AIDS Commission of projected funding needs for 2007 - 2010, only 21% of projected resources are likely to be available for the four-years period which is the proportion committed by the Government of Indonesia.

Though there has been notable expansion in the financial commitment to HIV/AIDS control following the President's decree on HIV/AIDS, the HIV/AIDS programme remains highly donor dependent, raising concern about the sustainability of the programme.

Table 1: *Estimated budget by sources of funding for HIV/AIDS control programmes*

Source of funding	Actual expenditures (\$US)			Planned budget 2007
	2004	2005	2006 [§]	
DOMESTIC SOURCE: National source (Ministry of Health)	7 479 062	7 664 731	7 850 400	9 891 304
DOMESTIC SOURCE: Other national government agencies/ministries	1 287 927	5 335 269	7 149 600	7 108 696
DOMESTIC SOURCE: Regional and local governments*	800 000	1 600 000	2 000 000	2 500 000
SUBTOTAL: Domestic sources	9 566 989	14 600 000	17 000 000	19 500 000
EXTERNAL SOURCE: GFATM Round 1*	2 139 213	2 139 214	882 181	882 181
EXTERNAL SOURCE: GFATM Round 4	0	8 123 856	14 270 074	18 502 317
EXTERNAL SOURCE: Bilateral donors**	13 560 000	31 760 000	31 760 000	31 760 000
EXTERNAL SOURCE: Other multilateral donors**	6 915 675	7 665 625	7 665 625	7 665 625
EXTERNAL SOURCE: Int'l NGOs**	391 657	460 000	460 000	460 000
SUBTOTAL: External sources	23 006 545	50 148 695	55 037 880	59 270 123
TOTAL: ALL SOURCES	32 573 534	64 748 695	72 037 880	78 770 123

* Estimates from NAC

** Estimates from various sources

§ Cells in blue are estimates based on time series

The HIV/AIDS implementation rate for the MoH in 2006 (expenditures over allocations) was 79%

All ministries outside the health sector dealing with HIV/AIDS noted that they needed increased financial resources and that they also had unmet human resource and technical resource needs. Civil society informants told the review team that in general they had sufficient resources. NGO staff at the district level noted that they have not seen enough Ministry of Health financial support or technical inputs. The team also heard reports of late release of programme funds from local AIDS commissions.

Commitment from donors, notably the Global Fund, has allowed the start-up of many new activities in Papua and West Kalimantan. There has not been a simultaneous commitment from national or local governments to assure that funding for these activities is sustainable.

The evaluation team rarely came across the view that the costs and prices for HIV prevention services were a barrier to their use. HIV testing through VCT services was provided free or at low cost. On the other hand, user-fees may be a significant barrier to access care services. The most important of these is the high cost of CD4 testing. While antiretroviral medications are fully subsidised, some associated costs such as CD4 counts may have to be paid, impeding access to the programme. Instances of people with late stage HIV disease who were unable to afford the cost of a CD4 test, which is a prerequisite for starting ART in Indonesia, were reported.

Recent steps have been taken to ensure that the poor can access health facilities through the implementation of a national social health insurance scheme. The government began paying the premiums for 60 million poor at the beginning of 2005. However, informants in all sites visited reported that access to health insurance cards for the poor was limited as the procedures for applications were complex. Many people who are sick, especially active IDUs and people with advanced HIV disease, need help in obtaining these cards. It was also reported that migrants, people without identification cards and prisoners might not be able to access these cards. Some NGOs in East Java reported that they provided support to people in need to access these cards.

The Minister of Health has decided to allocate specific health funds for HIV/AIDS in Tanah Papua. As a result, the provincial budget allocation for HIV has doubled in 2005/2006. However, given the remoteness of Papua, costs for health sector activities are much higher than elsewhere, as all supplies must be brought in and travel costs for health workers are high. An increase in the provincial health budget allocation was also seen in East Java.

Recommendations

- Advocacy for increasing local resources to parliament, national planning bureau, local parliament and local planning bureaus should be increased.

- A financial analysis of how needs will be met should be included in the current budget projections, identifying commitment from funding parties, including overseas donors and philanthropic groups.
- Sustainability of activities in the absence of external funds should be planned. This is of particular importance for people taking ARVs in order to avoid treatment interruption and prevent emergence of HIV-drug resistance.
- Health insurance mechanisms should be strengthened so that migrants have access to health insurance to cover HIV prevention and care services. This should also apply to prisoners and to people without identification cards who are often the most vulnerable and poor sections of society.
- The national government – through NAC — should negotiate with insurance companies so they are willing to accept PLHA as their customers.

3.5 Human rights

There were numerous reports from a range of informants on issues related to human rights in health. The most common were reports of discrimination by some health workers in government health care facilities against members of vulnerable communities and PLHAs. These included both hospitals and *puskesmas*. Health care workers reported these instances of discrimination by other health care workers. Members of the affected communities also reported them directly to the review team.

Health care providers' discrimination against IDUs, the poor, *waria*, people without national identification cards, migrants, and PLHAs were all noted. Specific instances included unwarranted disclosure of a patient's serostatus, being asked to stop narcotic use before initiating ART, and police detaining IDUs for legally carrying needles and syringes as part of harm reduction services. Arrests of drug users by police have taken place in front of a methadone clinic.

Although most data are disaggregated by sex, there is only a limited recognition of the gender dimensions of the HIV epidemic. The women's empowerment ministry is promoting reproductive rights including the right to refuse sex without a condom. Although some officials working in the field of addiction recognize that women who use drugs have limited access to health services and hence want to build a women's rehabilitation centre, some health workers do not seem to recognize this fact. *Warias* may be refused inpatient care, as there is ambiguity about whether they are accommodated in male or female wards.

Availability of PMTCT services is very limited in Indonesia. The children born to parents who tested positive experience discrimination. The team heard of a child who was not allowed to go to school.

Two to three million people a year that apply for overseas jobs undergo testing organized by the Ministry of Labour. This is a requirement set by countries importing Indonesian labourers. There is no policy or practice for internal migration.

The Ministry of Law and Justice has new recruitment regulations, which require candidates to be tested for HIV; all those who test positive will be dismissed. Those in the armed forces who test positive are moved to lighter duties.

Recommendations

- A gender and human rights review of the draft national strategic plan should be conducted in order to assure that the needs of both men and women are addressed. The strategy must include a human rights complaints mechanism.
- The health sector should develop evidence-based programme to decrease discrimination in the health sector. Religious leaders and women's organizations should be mobilised in response to discrimination. The Ministry of Health should take the lead in training all health care workers on how to reduce stigma and discrimination. This objective should be integrated into the ongoing provincial level training on care, support and ART.
- Legislation and policies at national and local levels (e.g., district, hospital) should be formulated to prohibit doctors or nurses from violating codes of conduct by refusing treatment to certain patients.
- Policy for HIV testing and counselling for migrants should be debated and discussed. The policy should include informed consent and access to HIV prevention, care and treatment services as part of overall HIV testing policies and strategies.

3.6 Human resources

It was a consistent finding in all areas visited that human resource capacity needs to be strengthened. There will be a national health sector training needs assessment completed in 2007 and then training plans will be developed for hospitals and health centres. It is unclear whether the training needs assessment will address overall human resources in health as training is only the first step in building capacity. It is difficult to determine exact human resource needs at the peripheral level but human resources were consistently said to be limited at the district level.

The capacity for data compilation, management and analysis varies across provinces and districts. The human resource capacity for supervision from central level is limited. The quality of information is seldom monitored. Additional information collected at local level is rarely analyzed.

Funding by GFATM in the last two years accelerated the increase in human resource capacity in one province and at national level through the Intensified Assistance and Collaboration (ISAC). Outreach support workers are paid through this funding. Sustainability of GFATM resources for funding outreach workers is an issue that has not yet been resolved.

NGOs frequently mentioned that human resources are the main constraint to scaling up.

Recommendation

- The number of trained human resources in AIDS programme management, programme implementation, including service delivery at all levels of the programmes, and services in the Government and NGO sectors should be increased.

3.7 Access to HIV related health products

Intellectual property rights

As a member of the World Trade Organization, Indonesia follows the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). Kimia Farma manufactures several ARVs. A few of these ARVs are under patent in Indonesia. Indonesia has issued compulsory licenses (Presidential decree 083/2004) for lamivudine with Biochem Pharma Incorporation and for nevirapine with Boehringer Ingelheim. They have been issued in 5 October 2004 and will last until the end of the patent term (i.e. 8 and 7 years respectively) and specify that a compensation of 0.5% of the net selling value will be paid to the patent holder.

Procurement and supply management

There are two main sources of procurement for HIV related health products: the Government of Indonesia and GFATM.

First line ARVs are manufactured or imported by Kimia Farma and distributed directly to hospitals. For other health products, there is an annual tender among local pharmaceutical companies and the company awarded the contract is in charge of procurement and distribution directly to the district level. The Sub-directorate of HIV/AIDS and STI, Directorate General of DC and EH, monitors the performance of the company and penalties for non-performance can apply. The tender process takes about six months every year.

Requests for antiretroviral medications from hospitals are first sent to Sub-directorate HIV/AIDS and STI; it was reported that it could take up to one month for the order to be sent to Kimia Farma. Kimia Farma regular crosschecks the quantities of orders with the hospitals by phone to check consistency between the hospital order and the Sub-directorate order. Hospital staff noted that they were not informed about potential delays and did not have a designated focal person at the central level that could inform them on the progress of the delivery process.

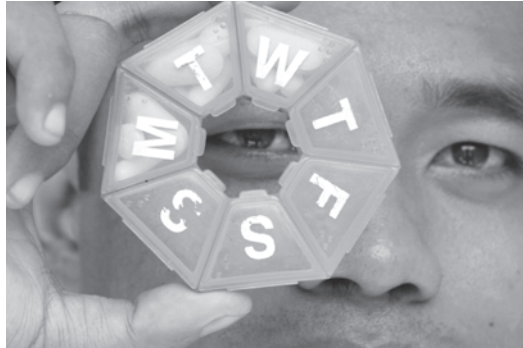


Photo: G. Hampton.
Pill box used for antiretroviral medicines

HIV-related health products including second line ARVs are purchased using GFATM money through an agreement with UNICEF. In the beginning, there were long delays in procurement but recently a new agreement has been signed between UNICEF and the government and the delays have been shortened. The GFATM supports ARVs in 17 out of 33 provinces. There is an informal agreement that the drugs can be deviated to other provinces when stock outs occur.

Because the government is procuring the ARVs that are manufactured in the country and the GFATM is purchasing them internationally, some patients follow single-tablet regimens and some follow fixed-dose combination regimens.

There is also small a third supply of ARVs, from the National Narcotics Board, to selected prisons. The Narcotic Board directly purchases its ARVs from Kimia Farma and works independently from the system of the Ministry of Health. The Narcotic Control Board does not follow the Ministry of Health ART monitoring system and does not report to the Ministry of Health.

It was reported to the review members that stock-out of ARVs had occurred in almost all provinces in 2006. Kimia Farma is currently only working at twenty per cent of its manufacturing capacity for ARVs and would have capacity to deliver a buffer stock to the peripheral level. For the GFATM-financed products stock levels are very low and the central storage is too small to store all the current products already.

Kimia Farma is building a new plant expected to be completed by end of July 2007 to manufacture ARVs and will be able to begin production of fixed dose combinations and paediatric formulations. Before being authorised to manufacture and distribute fixed dose combinations and paediatric formulations, registration needs to be undertaken with the Food and Drug Control Office. This process can take up to one year.

In many hospitals, the laboratory technician reported difficulties to get supplies of reagents making the effective availability of necessary laboratory exams and thus diagnosis of HIV, OI and monitoring of treatment problematic.

Box 1: Action points to strengthen stock and distribution management system

- Harmonize the drugs and regimens used by referring only to generic names and using a single drug or fixed dose combination for all patients.
- Harmonize the reporting forms for all health products by filling only one report at the facility level and the batch number will allow stockists to know from which programme the product is coming.
- Implement a training programme for the staff on stock management and calculation of the needs and forecasts.
- Formalize the communication and exchange of information between the central and the peripheral levels in both directions.
- Establish intermediate stores with appropriate buffer stock in several locations throughout the country from which the facilities can receive their regular supply.
- Set up a system to follow-up the orders from the facilities.

Recommendations

- The stock and distribution management system throughout the whole supply chain (**Box 1**) should be strengthened.
- Pediatric ARV formulations and fixed-dose combinations should be registered.
- The process of WHO pre-qualification of the ARV products manufactured by Kimia Farma should begin. Kimia Farma should initiate this through the WHO Office in Jakarta.
- Government co-funding should be ensured so that an uninterrupted supply of health products, in particular of ARVs, will continue when the time-limited GFATM funds will be finished.

3.8 Laboratory capacity

The fact that laboratory exams related to HIV are not subsidized for the patients and are not covered by insurance schemes limits the regular follow-up of

patients. The review team noted that health laboratories were often not equipped for the diagnosis of opportunistic infections and monitoring of ART.

Many STI laboratories reported difficulties obtaining a consistent supply of reagents for diagnosis of STIs. Trained laboratory technicians are too few in some sites, and the training was considered inadequate. Though some of STI clinics claim to diagnose STIs by aetiological approach, the tests used were not sensitive enough for diagnosis.

The MoH has developed the National Policy for HIV testing strategies which include HIV testing for screening of blood for transfusion, surveillance and diagnosis of infection. In 25 hospitals three HIV rapid tests are used for the diagnosis of HIV infection and the test kits are from the Directorate General of DC/MoH. In some hospitals two rapid tests and one ELISA test are used for diagnosis of HIV infection.

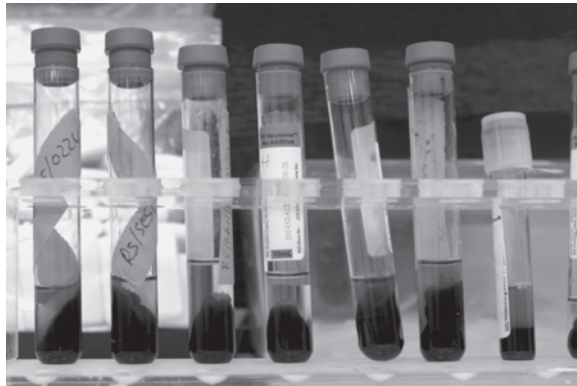


Photo: G. Hampton.
Human blood samples

The Ministry of Health has established an external quality assessment programme for HIV, HBsAg, hepatitis C (HCV) and syphilis testing, but not all laboratories participated in this programme. MoH issued internal quality control guidelines.

Recommendations

- Common HIV-related laboratory exams should be provided free of charge to patients (as it is for ARVs).
- A quality assurance system for all laboratory examinations, starting with strengthening the external quality assurance system for HIV testing and STI diagnosis, should be implemented. This should include the appropriate selection and assessment HIV and STI test kits.

4. Strategic information

The Government of Indonesia has recognized the importance of improving the scope and quality of information to inform decision-making about HIV prevention, care and treatment programmes. After the first AIDS case was reported in Bali in 1987, the MoH conducted cross-sectional HIV serosurveys from 1988 to 1990 in two provinces and, by 1996, in 13 provinces. First behavioural surveys were conducted in 1996 and 1998 in Manado, Jakarta and Surabaya. In 2001, the government endorsed the principles of second-generation surveillance for HIV as recommended by the World Health Organization and UNAIDS and, in 2002, the Ministry of Health began a process that led to estimates of the number of people living with HIV and at risk of contracting HIV.¹¹

Under Government Regulation 25 of year 2000 that relates to the autonomy of districts, the epidemiologic surveillance of HIV prevention and control measures is authorised by the central level under the Directorate General of DC & EH. All surveillance activities are implemented under this government regulation.

4.1 Second generation surveillance for HIV

The establishment and implementation of a second generation surveillance system for HIV is led by the Sub-directorate of HIV/AIDS and STI. The Sub-directorate is responsible for the collection and analysis of biological data and the Central Bureau of Statistics for behavioural data. Their respective offices at the provincial and district levels are responsible for data collection.

HIV and AIDS case reporting

Indonesia has established a system of AIDS case reporting for all public-sector facilities. AIDS case reporting is based on the Bangui definition (major and minor signs). This case report form includes sociodemographic information, transmission category, and method of HIV testing and is stripped of patient identifiers.

As of December 2006, a cumulative number of 8 194 AIDS cases been reported. Among AIDS cases:

- 6706 (82%) were reported during the last 3 years,
- 82% of these were male, and
- 55% were 20-29 years old.

In addition, a limited number of VCTs sites have reported new positive HIV test results. HIV case reports are analyzed separately from AIDS case reports.

HIV case reporting started few years ago. As of December 2006, the cumulative number of HIV cases reported at the central level was 5230.

HIV serosurveillance

In 2005, the Ministry of Health designated 49 core sentinel sites in 20 provinces for following sentinel populations: female SW (27 sites), IDUs (5 sites), prisoners (6 sites), MSM (2 sites), transgender (2 sites), male STI patients (4 sites), pregnant women (2 sites) and sailors (1 site). National guidelines for serosurveillance are used and include unlinked anonymous testing with informed consent.

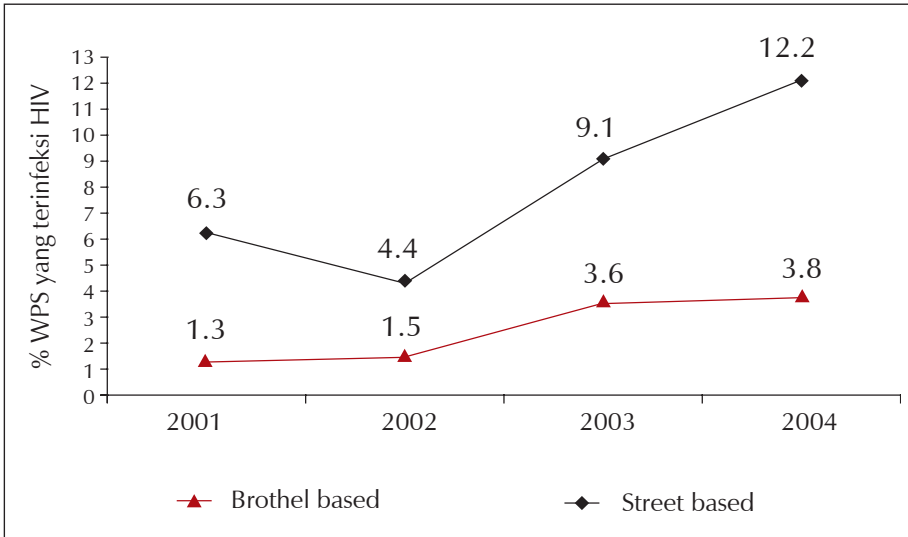
Provincial health offices are responsible for the implementation of HIV serosurveillance (HSS) under the supervision of the central level. The HSS was funded from the regular central budget until 2005. In 2006 several provincial health offices could not complete the sero-surveillance data collection due to shortage of supplies, in particularly reagents for HIV testing. In addition to the national HSS, provinces have been conducting supplementary cross-sectional surveys relevant to specific information needs supported by the local government and bilateral donors. For example in Surabaya local analysis of cross-sectional surveillance data revealed the HIV prevalence among street-based sex workers is three times higher than among brothel-based sex workers (**Figure 6**).

There is no system to report information and results from ad hoc sero surveys, conducted at the local level using local funds, to the Sub-directorate of AIDS and STD. As a result, information from these additional surveys is often not captured at the central level database and not utilized.

Behavioural surveillance

The first national behavioural surveillance survey was conducted in 2002-2003 in 16 survey sites. The survey was repeated in 2004/2005 in a total of 49 sites in 16 locations (regencies/ municipalities) among following populations: direct and indirect female SW (18 sites), male with the greatest potential to engage in commercial sex acts such as sailors, truck drivers/helpers, port

Figure 6: HIV prevalence among street based and brothel based sex workers in Surabaya



labourers, motorcycle taxi drivers, civil servants and factory employees (17 sites), as well as IDUs (5 sites), transgender (4 sites), MSM (3 sites), and high-school students (2 sites).^{12, 13}

Among IDUs in Jakarta, Bandung and Surabaya, needle sharing remained high at 62% in 2002 and 51% in 2004, while condom use at last sex was low, 23% and 32%, respectively. The use of condoms at last sex among female SW increased from 46% in 2002 to 56% in 2004, but remained low for some of their clients, varying from 24% to 33% for drivers and sailors. The rate was higher for civil servants (53%) and employees. Significant behaviour changes were noted among transgender and MSM in Jakarta and Surabaya where condom use at last sex increased from 41% to 76% among *warias* and from 29% to 53% among MSM from 2002 to 2004.

The central level expressed interest to expand integrated bio-behavioural surveillance (IBBS) in other surveillance sites. Recent unpublished data from IBBS conducted in 2006 suggest that Papua may be experiencing an emerging generalized epidemic with HIV prevalence several times the national average.

The emphasis placed on surveillance (biological and behavioural) among those at highest risk for HIV infection was not considered sufficient by the review team. The surveillance focuses on sentinel populations such as female SW. However, the current core sites for both HIV sero surveillance and behaviour surveillance include only five sites for IDUs despite the fact that this is the main affected population in at least seven provinces. This also applies to other groups at high risk for contracting HIV such as MSM and transgender.

The existing surveillance systems are not equipped to capture a change of epidemic level from concentrated to generalized. For example, in Papua there is only one HIV sentinel site among pregnant women in Timika; in other provinces visited, no sentinel surveillance among pregnant women attending antenatal care was conducted at all. The last sero surveillance survey was conducted in two antenatal care sites in 2005 and since then has stopped.

STI surveillance

There is no national STI reporting system (syndromic or etiologic) in place. Some health centres visited had developed data collection and case report forms based on syndromic and etiologic diagnosis. The format varied from facility to facility. There was also no formal local STI reporting system in any of the provinces visited.

Routine VDRL screening of pregnant women attending antenatal care and reporting of positive results have not been established. There is limited capacity of health laboratories in health centres and district hospitals for VDRL testing.

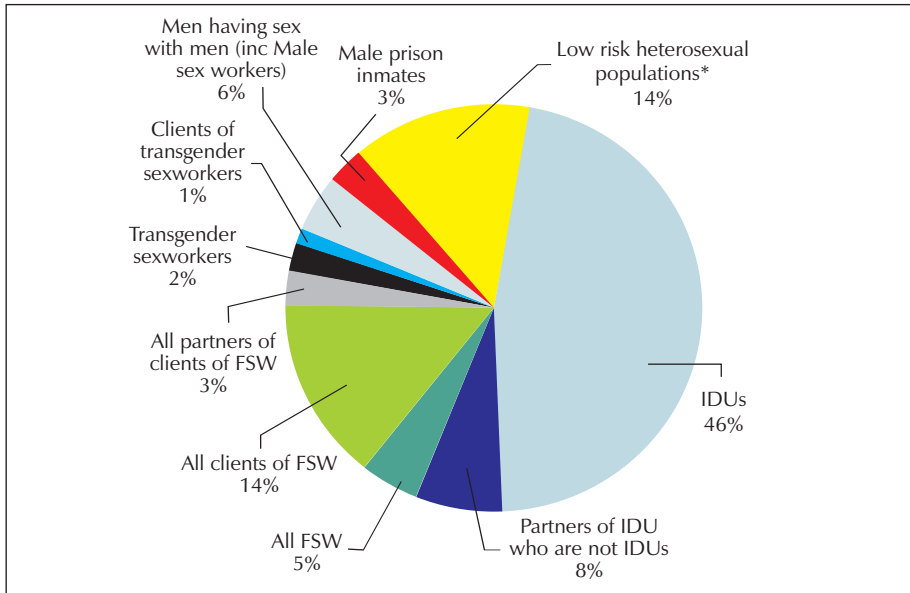
The review team observed that the provincial health offices conducted cross-sectional VDRL surveys at local level among female SWs. Family Health International (FHI) and the local government support these surveys. In addition, antibiotic susceptibility studies have been conducted in selected sites in 2002 and 2004. For example, the provincial health office of East Java reported biannual VDRL and HIV sero surveys among sex workers in all establishments in East Java and selected other groups at risk in 29 sites in 2002, 34 sites in 2003 and 40 sites in 2004. These sites include the core sentinel sites. These additional data are not reported to the Sub-directorate of AIDS & STD.

Estimations

National estimates of people living with HIV were conducted in 2002, 2004 and 2006. 2006 estimates were based on district data. More than 75% of the districts participated in the third round of deriving national estimates. The national estimates were discussed during the annual surveillance evaluation meeting and during a consensus meeting with intersectoral partners and NGOs (**Figure 7**).

There is no system in place to monitor the HIV trends among registered TB cases. A TB-HIV surveillance protocol has been field tested in Yogyakarta where the prevalence of both TB and HIV are low (TB/HIV 2%, MoH/Gajamada University 2005). Data presented to the review team by the Merauke district health office showed that the HIV prevalence among TB patients was as high as 5% in Papua.

Figure 7: Estimated proportion of people living with HIV/AIDS, by population



* Data from Irian Jaya Barat and Papua New Guinea only
 Source: Directorate General of DC & EH, Ministry of Health, Republic of Indonesia

Data collection, analysis and dissemination

Protocols and guidelines for sentinel serosurveillance and behavioural surveillance were available at the provincial and central level. Reporting forms were also available at health facilities and health offices.

The Sub-directorate of AIDS and STI is producing a quarterly report based on AIDS case reporting and shared with national and international stakeholders. This report is complemented with additional information when available, such as results of HSS or other national estimates. The BSS report is produced and shared after each round. The Ministry of Health is organizing annual meetings for national HIV surveillance to provide a forum to share and discuss latest surveillance data.

Comparative analysis (data triangulation) and utilization of data for planning are not regularly done. Analysis of trends over time, across geographical areas and of determinants of the progression of the epidemic, are not routinely done.

Capacity of data compilation, management and analysis varies across provinces and districts. The human resource capacity for supervision at the central level is limited. The quality of information is not validated. Additional information collected at the local level is rarely analyzed and disseminated.

Recommendations

- The number of surveillance sites should be increased among populations at high risk for HIV transmission, such as IDUs and MSM/ transgender as well as populations at low risk such as pregnant women in antenatal care in particular in areas with indications for transition into a generalized epidemic such as Papua.
- Collective analysis of data from various sources should be conducted at the central level to better understand the HIV epidemic trends and geographical variations.
- Capacity for second-generation surveillance should be strengthened at all levels, particularly for data management, validation and analysis and regular dissemination.
- Participation of provinces and districts in the planning process of second generation surveillance (selection of target population and sites) should be strengthened to better cover the local data needs.
- HIV cross-sectional surveys should be initiated among TB patients in selected sites where prevalence of TB and HIV are high.
- Reporting on OIs using the WHO case definitions of HIV for surveillance and revised clinical staging and immunological classification of HIV-related disease in adults and children should commence.
- STI surveillance should be strengthened with standardized case definition, guidelines and reporting forms for the determining the disease burden, monitoring of the impact of the condom use programmes and for detecting risk behaviour for HIV transmission.

4.2 Monitoring and evaluation

In 2006, the National AIDS Commission released national guidelines on monitoring and evaluation and reporting of HIV/AIDS.¹⁴ This national guideline describes the key indicators, recording and reporting system and flow of data and is being implemented in 100 pilot districts. Data reported from health facilities are from STI, VCT, PMTCT and ART services. This information is sent directly from the health facilities to the district and provincial AIDS commission branches to the national AIDS commission. The respective health offices and the chief of the monitoring section of the Sub-directorate reported to the review team that they were not aware of this type of reporting and data flow.

The review team observed that there were at least four monitoring and evaluation systems in place, namely the MoH system, the monitoring for the joint donor database, the monitoring for the GFATM projects and the aforementioned system proposed by the NAC. One staff from the Sub-

directorate of HIV/AIDS and STI is also responsible of the monitoring of the GFATM Round 1 and 4 funded projects. This is resulting in redundancy of data collection at facility level. Staff are over burdened in fulfilling the various reporting requirements. For example during the visit to Surabaya, it was observed in VCT services that the staff had to complete six different forms (FHI pre-test form, FHI post-test form, NGO pre- and post-test form, hospital pre-and post test form, and district health offices form, laboratory request form, NAC VCT form). The review team reviewed the electronic facility-based VCT report form which required reporting of individual client information to the NAC, instead of aggregate data.

Indicators used in the different M&E systems are not harmonized and also the frequency of reporting varies (the same indicators might be reported using different time periods).

ART monitoring tools were adapted from WHO guidelines by the national experts and the Ministry of Health in February 2005. The data collection forms, including patient card, pre-ART registration, ART registration, HIV care and ART follow-up forms, drug procurement report, drug stock report, monthly report, cohort report – are provided by the Sub-directorate of AIDS and STI to all referral hospitals.

Among 103 hospitals providing ART, 85 (83%) have been trained on monitoring and 54 of them (64%) are reporting regularly.

ARVs funded by the Government are now distributed to 103 hospitals which have been asked to report regularly to the central level following the national ART monitoring system. However, data for the previous four months were available from fewer than 20 hospitals. The ART monitoring system does not yet produce all the indicators recommended at international levels (cohort indicators, TB/HIV). It also does not address specific indicators relevant for the country (e.g. number and proportion of IDUs accessing ART and on dual treatment ART and methadone) though all this information is collected in the ART patient record. ART monitoring (including CD4 counts) is limited to quantitative data with a limited number of indicators; laboratory monitoring or data on side effects are missing.

The reporting on prevention of HIV and STI transmission and the coverage of associated services is done through the joint donor database.

Decentralization has resulted in limited compilation, validation, analysis, report generation and utilization of available data (reported by health facilities and NGOs) at all levels (district, province, central).

Coverage information on prevention and care services are not adequately addressed either because of a lack of a defined denominator or the failure to use a common agreed denominator, particularly at municipal/ district and facility levels.

There are only limited mechanisms in place for feed back on data between the different levels. The review teams observed that data sharing mechanisms were more common (in frequency and structures) between district and provincial health offices than with the sub-directorate on AIDS & STDs.

Recommendations

- Ensuring that the national monitoring and evaluation system is more responsive to the information needs at different levels is urgent.
- Existing reporting systems should be harmonized to set up ONE national monitoring and evaluation system, through the efforts of the National AIDS Commission and the Ministry of Health.
- The responsibility of collecting and using primary data on the health sector response should be kept under the auspices of the Ministry of Health.
- Regular evaluation of the AIDS control programme should be conducted at all levels, in partnerships with stakeholders, and the work plans should be adjusted accordingly.
- A focal person should be assigned as responsible for strategic information (data-collection, validation, compilation, analysis, reporting) in health offices in priority districts and provinces. Sufficient resources (financial, training, transport for supervision of sites) should be allocated for the offices' proper functioning.

4.3 HIV drug resistance surveillance

Considerable concerns about the risk of emerging HIV drug resistance and an urgent need to strengthen services for the prevention of resistance were voiced. Rates of patients who are lost to follow up and interrupt ART amount to 13%.

The Ministry of Health has initiated HIV drug-resistance threshold surveillance which indicates the resistance in recently transmitted HIV infections following the WHO protocol. The survey started in 2006 in Jakarta targeting newly diagnosed HIV-positive persons among IDUs. The sample size has almost been reached (conducted in collaboration with St Vincent Laboratory in Sydney) and first results will be available during 2007. A plan to strengthen the laboratory capacity in Jakarta for measuring HIV drug resistance has been developed, as well as plans to begin monitoring emerging drug resistance by examining levels of resistance in patients on ART as part of national surveillance in 2007.

Recommendations

- Threshold surveillance should be expanded beyond Jakarta.
- Efforts should be strengthened on the prevention of HIV drug resistance.
- HIV Drug resistance monitoring should be established as part of surveillance depending on results of the threshold surveys.

4.4 Operational research

A number of stakeholders have conducted operational research related to HIV. This has contributed to building capacity of local research institutes and universities. Current research questions were related to HIV epidemiology. Only few studies were related to access, coverage, utilization and quality of interventions. The second National AIDS Conference, held in Surabaya in February 2007, was a great opportunity for sharing information on operational research. However, a gap exists between sharing and using research results and programme planning.

Recommendations

- Capacity to plan and conduct quality operational research should be built to inform decision making relevant to the planning and implementation of public health interventions.
- Universities and medical professional organizations should be mobilized for the development of operational research questions and protocols, coordination, resources mobilization, sharing and utilization of information.

5. Prevention of HIV and sexually transmitted infections

The National Strategic Plan for the Prevention of HIV/AIDS in Indonesia (2003-2007) and the National HIV/AIDS Strategy 2003-2007 prepared by the National AIDS Commission have appropriately identified HIV prevention as one of the priority areas.^{15, 16} The HIV prevention programme is aiming to reduce the vulnerability of the general populations by preventing transmission from the most affected populations. For most of Indonesia facing an epidemic that is concentrated in IDUs and SWs, this strategy is well chosen. Its



Photo: G. Hampton.
Young Indonesian women

success will depend on the intensity and coverage of the interventions chosen. In areas where the epidemic has generalized, as it appears to have done in Papua, this approach is still crucial. Other interventions must be scaled up for the general population, including young people in and out of school, harbour workers and other mobile men, street children and other vulnerable populations.

The national guidelines 2003-2007 have recommended the following activities for HIV prevention:

- Reducing vulnerability of specific population
- Promoting safer sexual behaviour
- Promoting and distributing condoms
- Prevention and treatment of STIs
- Provision of safe blood transfusion
- Promotion of safer drug injection behaviour

While these strategies are all important for an effective response, how these strategies are brought to bear for HIV prevention among the most-at-risk populations is not specified. Effective HIV prevention requires integration of the many different interventions as most-at-risk groups may have multiple risk factors. The health sector offers multiple opportunities for effective prevention integrated with care, support and treatment.

Under the current strategic plans, substantial commitment to HIV prevention has been evidenced and good progress has been made in recent years. Despite this, emphasis on prevention remains inadequate and is often eclipsed in the health sector by attention to care and treatment, even where caseloads are small. Decentralization has also limited the amount of assistance and direction available at the provincial and district level, where the capacity with some aspects of prevention are often more limited.

5.1 Information, education and communication

The reach of information, education and communication (IEC) has increased substantially in recent years. Though greater awareness of HIV/AIDS is a key element of the strategic plan, many members of the most-at-risk populations interviewed displayed serious gaps in their awareness and knowledge. IEC materials were available in most health care facilities and through NGOs providing HIV prevention and other services. In many cases, however, IEC materials are not prominently displayed.

Although a wide variety of IEC methods are used across the country, the availability of different methods at the local level was limited. The ineffective use of IEC at the local level was further exacerbated by varying local conditions. Multiple languages and low-literacy levels complicate the use of IEC materials. Logistics are also a problem. In some cases, IEC materials are not reaching their target group due to high transportation costs. This was especially true in the remote highlands of Papua.

The content of IEC is often not appropriate for the needs of those most at risk. Outreach workers, volunteers, peer educators and health authorities conducting community outreach were often focusing predominantly on bringing people to clinics for testing and treatment. Field-based behaviour change communication activities are extremely limited or non-existent. In addition, peer outreach workers and counsellors in health care facilities were often not taking advantage of the opportunities to provide behaviour change communication. The quarterly checks for HIV among SWs, for example, are key opportunities for additional counselling and reinforcement of prevention messages. These opportunities were often lost.

Recommendations

- Attention to IEC should be increased in general. Low levels of information and awareness about HIV/AIDS and prevention were found in some areas.
- Promotion of evidence-informed behaviour change communication, particularly at community level and by peer-outreach workers and counsellors in health care facilities as a tool for promoting and maintaining safe behaviours, is essential.
- The quality and appropriateness of IEC for the intended target audiences such as SWs and drug users should be monitored.

5.2 Sexually transmitted infection prevention and treatment

The STI control program is implemented at district and city levels through the STI clinics operated by the Government and NGOs. While clinics are intended to service all STI patients, many in fact provide services almost exclusively to SWs, in the form of monthly STI checks.

The STI prevalence among sex workers is high, especially gonorrhoea and chlamydia. A study of sex workers in ten cities in 2005, by the Ministry of Health/FHI, found the following results¹⁷:

chlamydia	44%
gonorrhoea	28%
trichomoniasis	15%
syphilis	9%

Little is known about STI prevalence among the general population.

GFATM-supported STI clinics have been established in 61 health care institutions in 19 of the provinces of Indonesia. Similarly, FHI, one of the key partners of the national STI control programme, is providing assistance to local NGOs and puskesmas to operate 24 STI clinics in seven provinces. Another supporting partner includes Indonesia HIV Prevention and Control Programme (IHPCP) which is funded by the Australian Agency for International Development (AusAID). In addition, some STI clinics run exclusively by local NGOs also exist. State-level hospitals and medical colleges are also providing STI management. Private physicians also treat STI cases. STI clinics may be linked with community outreach programmes. Self-medication is also common.

Coverage and quality of STI services have increased substantially in recent years. Significant gains have also been made in increasing STI treatment literacy of the affected population in some sites visited. STI clinics are providing

treatment, screening, laboratory support, counselling and IEC services, along with distribution of free condoms, to clients. Clinics are using both syndromic and etiologic approaches in treating the STIs. In some cases, treatment is not given in clinics purporting to use syndromic management until confirmation is received from the laboratory. In these cases crucial time is lost.

A number of insufficiencies were found. STI services that do exist primarily provide regular monthly screening to women involved in sex work. Little attempt to inform others about symptoms of STIs and to encourage timely health seeking behaviour was found. Few men or women, other than those directly involved in sex work, seek treatment from STI clinics. Men are particularly underrepresented in the patient population of STI clinics. Transgender population services are extremely limited. The opportunity to provide and reinforce prevention messages in STI services is often missed.

The opportunity to treat partners of STI patients is also missed, as partner notification is not always pursued. Some clinics do provide outreach for partner notification and other prevention activities but the quality of these is variable.

Responding to persistently high STI-prevalence among SWs, national consultations were held in 2005 and 2006. These resulted in recommendations to enhance STI services for SWs with effective drugs and three rounds of periodic presumptive treatment, initially in four cities (Surabaya, Semarang, Banyuwangi and Denpasar). The outcome of this intervention will be measured in the second half of 2007. The periodic presumptive treatment is part of a package of services for SWs, including STI screening, STI and condom counselling, provision of high quality condoms, lubricants and STI brochure. However, the review team visiting sites in Surabaya noted that sex workers were only provided three to ten condoms for a period of three months.

In 2006, National STI treatment guidelines were revised responding to reports of high level ciprofloxacin resistance in some areas.¹⁸

At the local level, adherence to the drug regimens of the national STI treatment guidelines is variable. The revised national STI treatment guidelines are not uniformly distributed to STI clinics across the country and the drugs newly recommended in those guidelines are not yet supplied to most of the clinics. Referral linkages with the other services, particularly with VCT, are highly variable.

Recommendations

- STI services should be made more community friendly by strengthening peer education, outreach programmes and engagement of key community stakeholders.

- Recent STI guidelines should be followed and the required drugs should be available in all health service facilities.
- The number of STI clinics and coverage areas of the clinics in the provinces with strategic linkages to HIV testing and counselling, care, support and treatment as well as TB diagnostic services, should be increased.
- The condom promotion programme should be strengthened to make it an integral part of the comprehensive STI control activities. This should include increasing visibility of condom use messages in the STI clinics.
- Overall coverage of the high-risk groups, with special attention on SW, MSM, *warias* or transgenders, and clients of the SWs, should be improved. They should be brought under comprehensive STI control programme. STI control activities should reinforce the 100% condom programme.
- The networks of venerologists and general physicians who treat STI cases in private practices should be strengthened to improve access.
- IEC should be undertaken in local languages to inform populations about STI risks and symptoms and to encourage timely health-seeking behaviours.

5.3 Condom promotion

The government has recommended condom promotion in high-risk sexual activity as the principle component of the national strategy. In the past, the piloting of 100% condom programme in several locations (Riau, Papua, Jakarta, and Bali) was supported by WHO. However, the 100% condom programme as implemented in Cambodia, Myanmar and Thailand and elsewhere in Asia has not yet been promoted on a large scale in Indonesia.



Photo: G. Hampton.
Condoms and IEC materials

Though the 100% condom programme is often referred to when questions about condom use in general are raised, the programme is usually limited to distribution of condoms in entertainment establishments as noted by the review teams. Increasing condom use in other at risk groups than SWs should be addressed through other means, such as IEC, behaviour change communication and condom social marketing.

The programme also recognizes the benefits of dual protection of condoms, preventing against both STI/HIV and unintended pregnancy when used correctly and consistently. The condom promotion programme is supported by local legislation and regulation but there is no enforcement of the legislation as noted with 100% condom programmes as implemented elsewhere in Asia.¹⁹

The review team saw evidence of condom promotion in most sex work settings visited. Often signs from the Sutra social marketing campaign were prominently displayed in brothels (*localisasis*) and most *localisasis* visited could produce a supply of condoms when asked. In Surabaya, with one of the largest entertainment areas in South-East Asia, the review team was informed by the SWs interviewed that they had never seen the condom boxes before the visit of the review team. All SWs knew the importance of condoms and reported frequent, though rarely consistent, condom use. Objections and resistance from clients were usually cited as the reason for non-use.

The observations of the review team corroborate the data reported by FHI. However, the data varied in the provinces visited by the review team. The percentage of female sex workers reporting consistent condom use in the last week ranged from only 8% among brothel-based workers in West Java to 65% among indirect sex workers in North Sumatra. The percentage reporting condom use during the most recent sex act with a client was higher, ranging from 23% among brothel-based sex workers in West Java to 90% or more among indirect sex workers in North Sumatra and Central Java. Use of condoms by male sex workers in sex work appears to be more frequent. The quality of the condoms *Artika* distributed by the government is also a problem. These were not satisfactory for sex workers and the injecting drug users interviewed. The *Sutra* condom, available through social marketing, is of higher quality and much preferred. Promotion and supply of lubricant is extremely limited. This is essential for MSM and transgenders.

While these figures fall short of the target (achieving 50% of the Government's condom use programme), they do show progress, along with the need for further strengthening. Additional strategies to reach and influence clients of SWs are clearly needed, as the primary resistance to correct and consistent condom use originated with these men. Also brothel owners and pimps need to consistently promote condom use in brothels and among street-based sex workers (**Box 2**).

Box 2: Action points to implement the 100% Condom Programme

- Build capacity of the local AIDS commissions in all provinces to form condom core groups to agree and oversee implementation of 100% condom programme and enforce local legislations on condom use.
- Local authorities, owners of sex businesses, and pimps take responsibility for promoting and maintaining an enabling environment.
- Create an enabling environment to empower sex workers in all sex establishments to refuse sex services if customers do not want to use condoms, so that customers will not be in control of the sex services with regard to condom use.
- Map sex establishments.
- Reach out to sex workers.
- Empower sex workers to use condoms.
- Adopt locally relevant strategies to reach clients of sex workers.
- Provide free quality condoms.
- Strengthen and increase access to STI services for sex workers.
- Reinforce police training curriculum with modules on 100% condom programme and HIV/AIDS.

For those not involved in sex trade, promotion of condom use is less apparent. Condoms are not always available or promoted in health service facilities. Peers, volunteers and outreach workers do not always carry condoms or promote their use. Additional prevention opportunities are missed by this failure to promote and provide condoms. Increasing condom use in sex work will be facilitated by more generally promoting condom use for high-risk sexual encounters, as many of those receiving the message about condom use will have been and may continue to be clients of sex workers.

Key steps to increasing condom use include orientation of establishment owners and pimps, reaching out to sex workers, provision of free quality condoms, access to STI services.

Recommendations

- The 100% condom programme should be adapted to local conditions and rapidly expanded, especially in economic hot spots and where sex work is common.

- Social marketing programmes for condom use for populations not involved in the sex trade should be introduced. All health service facilities should provide and promote condoms.
- Systems for condom quality control and supply management should be strengthened.
- It should be ensured that outreach workers always carry condoms and promote their use to those at risk.
- Collaboration with social marketing agencies to reach populations in greatest need of HIV-risk reduction with high-quality condoms should be considered essential.

5.4 Harm reduction



Photo: G. Hampton.
Dispensing of methadone

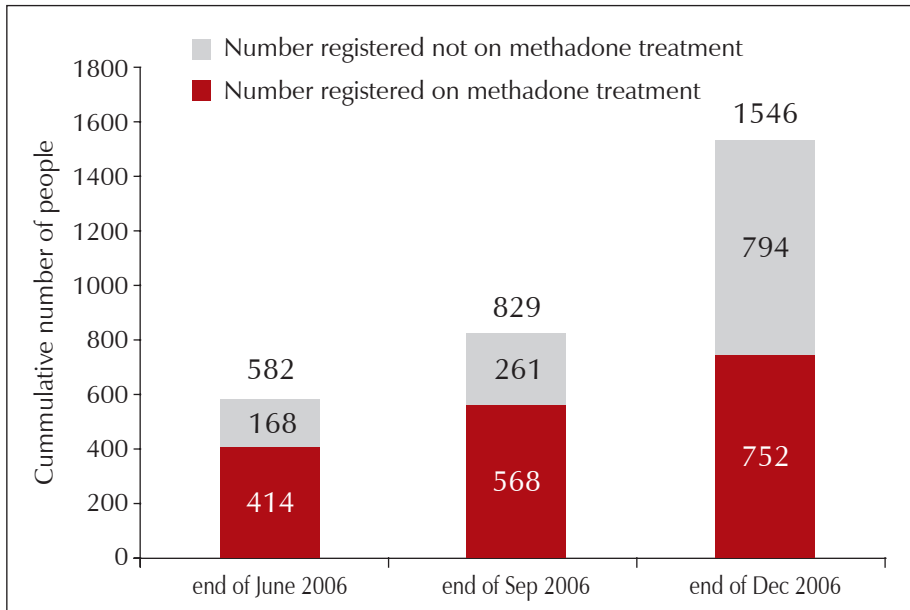
Harm reduction has gained political acceptance and programmes are implemented to a varying degree across a number of provinces. In many sites, there is involvement with networks of NGOs working in harm reduction, drug-user associations and drug users themselves. The quality and comprehensive nature of service provision for drug users varies widely. Some areas have only minimal IEC activities while others have commenced methadone maintenance and needle syringe programmes. Young drug users are often not reached. Coverage of interventions in prisons remains low. Overall though, the harm reduction response is accelerating.

Indonesia has adopted the WHO definition of harm reduction. There are a number of constraints limiting effectiveness. These include limited inter-sectoral collaboration, particularly with police, relating to the mandate of each sector (public health versus public order); in a number of cases, provincial and district level offices not prioritizing harm reduction; the national narcotic board not endorsing needle and syringe programmes; and in some cases drug users and those on methadone are unable to commence ART. Clean needles and syringes are not routinely available. In some areas, police presence reduces access by drug users to methadone clinics. Those areas providing methadone and needle syringe programmes have only limited coverage.

Methadone maintenance treatment was available in three treatment sites in two provinces in 2003. In 2006, an additional two provinces began providing methadone maintenance treatment, bringing the total number of sites where

methadone is available to twelve. At the end of 2006, 752 active patients were reported in methadone maintenance (**Figure 8**). While the availability of services increased, the coverage is still limited compared to the estimated need. The estimated total number of IDUs in Jakarta alone is more than 30 000. Across the country, the estimated total exceeds 190 000. Of these, it is estimated that almost half are already infected with HIV. Clearly, a need for rapid expansion of methadone maintenance and ART exists.

Figure 8: Cumulative number of clients registered for methadone treatment



Source: Directorate General of DC & EH, Ministry of Health, Republic of Indonesia

Equally, a need for expansion of other key elements of a comprehensive harm-reduction approach exists. Needle syringe programmes are in operation, though coverage is still limited. Programmes currently exist in four provinces and, of the 57 currently operating, more than half are in Jakarta. Coverage of injecting drug users, as reported in the FHI data, is increasing but still low. Measured as the number of commodities supplied to IDUs and, therefore, the number of needle-sharing opportunities avoided or potentially risky acts averted, coverage appears to be even lower, with active IDUs receiving on average in a year only enough needles and syringes to protect themselves for less than a month. Coverage of the number of programmes in operation, the number of IDUs in those programmes, both methadone maintenance treatment and needle syringe programmes, and the quantity of needles and syringes provided should be rapidly increased (**Box 3**).

Box 3: Action points to establish and scale up a comprehensive approach towards harm reduction

- Assure a supportive policy and legislative environment.
- Establish community outreach, with a focus on peer approaches.
- Introduce behaviour change communication, including risk-reduction information.
- Provide access to clean needles and syringes as well as to means of their safe disposal.
- Make available drug dependence treatment, particularly methadone maintenance therapy.
- Assure methadone maintenance prescribing is consistent with National guidelines.
- Encourage HIV testing and counselling (voluntary and confidential).
- Prevent sexual transmission through distribution of condoms and prevention and treatment of STIs.
- Introduce HIV/AIDS treatment and care, including ART.
- Provide primary health care, including hepatitis B vaccination, vein and abscess/ulcer care, overdose management.
- Reinforce police training curriculum with modules on harm reduction and HIV/AIDS.

It is a common mistake in HIV prevention to assume that IDUs have only drug-associated HIV risks. Sexual-risk behaviour by IDUs in the community is often not addressed. Data from FHI show that the proportion of IDUs who reported condom use during their most recent paid sex ranged from 25% in East Java to 44% in West Java. IDUs reported consistent condom use even more rarely with non-commercial sex partners, ranging from only 3% in central Jakarta to 12% in West Java. Given the estimated HIV prevalence among IDUs, the potential for HIV transmission posed by the unprotected sexual behaviour of IDUs is high.

Prisoners are a high-risk population, many having entered prison for drug-related crimes. Although IEC has been undertaken in 95 prisons and methadone maintenance treatment has been established in four prisons, the coverage is insufficient and condoms are rarely available. ART and prophylaxis of opportunistic infections are also rarely provided. The sustainability of the programmes that do exist is also a cause for concern. Post-release programmes are an essential component of harm reduction in other countries and are vital in assuring continued

connection to needed programmes once a prisoner is released. It appears that such programmes are limited at best. No effective programmes for prevention of sexual transmission of HIV are available in prisons.

Recommendations

- Implementation of Regulation No. 02/Per/Menko/Kesra/1/2007 of Coordinating Ministry of the People's Welfare should be reinforced at all levels and the Harm Reduction Working Group involving all stakeholders should be strengthened.
- A comprehensive approach, including methadone maintenance therapy, needle syringe and condom distribution in all provinces where injecting drug use is an important risk factor, especially in closed settings, should be rapidly established and scaled up.
- Coverage both in terms of the number of IDUs covered, including young drug users who are not presently reached and particularly in terms of the commodities supplied to those who are contacted, should be assured.
- Criteria for initiating ART should be limited to WHO criteria only; additional conditions such as drug use and being in closed settings should not preclude treatment.
- Sexual risk-behaviours of drug users should be addressed.
- Post-release programmes, linking prisoners to the community and community health centres (*puskesmas*), should be developed.
- Investment should be made in human resources to work with drug users, increasing the number and quality of trained personnel.

5.5 Prevention of mother-to-child transmission

PMTCT is not yet available in health care settings in districts with high HIV prevalence. Efforts to scale up PMTCT are underway. A working group on PMTCT with broad membership has been formed. Despite this, the Directorate of Maternal and Child Health requested greater involvement in HIV planning. National level guidelines exist and have been adopted in most districts. Implementation, however, seems inconsistent.



Photo: G. Hampton.
Woman and child

In some cases, all pregnant women are offered testing and counselling with high levels of acceptance. In other cases, testing and counselling seems to be selectively offered, and acceptance is much lower.

The focus in PMTCT programmes is largely on the provision of ARVs to HIV-infected pregnant women. The prevention of unintended pregnancies among women living with HIV is not yet a prominent feature, and neither is primary prevention of HIV infection among women. Different antiretroviral regimens are used in different places, and infant feeding support varies depending on the existence of external funding. Where services are in place, the number of infected pregnant women detected and provided ARVs remains very low.

Recommendations

- Scaling up of comprehensive PMTCT in all areas of high HIV prevalence, particularly in Tanah Papua, should be prioritized.
- PMTCT efforts should be integrated into general reproductive health services with more active links between antenatal clinics, voluntary counselling and testing and family planning services.
- Participation of Maternal and Child Health and Community Health services, especially Mother's Health, in PMTCT programmes, should be increased.
- Encouragement of participation, forging of strong links with family planning (BKKBN) and encouragement of similar links at the local level are strongly recommended.
- Coverage should be increased through the participation of hospitals which provide AIDS treatment services. Links to NGO-based VCT and health centre -based PMTCT activities should be made.
- Awareness, demand and acceptance of PMTCT through community IEC should be increased.

5.6 Blood safety and universal precautions

Blood product safety

Blood product safety is covered in the national plan, though currently only about half of the districts have a blood transfusion services. The Indonesian Red Cross currently operates 187 blood transfusion services across the country, in addition to the central transfusion unit in Jakarta. These services are located in 185 of the 447 districts. One quarter of these services are located in hospitals. The blood transfusion services of the Indonesian Red

Cross are partly subsidized by the Government. The Indonesian Red Cross plans to provide universal screening in all its blood banks but lacks the financial resources. Screening coverage is universal for hepatitis B and syphilis but is only 70% for hepatitis C among the 1.3 million blood donations last year.

Testing of blood is supported through various means. In 2006, the Directorate General of DC & EH provided 1 500 000 routine reagent and ELISA HIV test kits, 220 000 tests for Hepatitis C Virus (HCV), 1 000 000 VDRL tests, and a small quantity of Hepatitis B (HBsAg) test kits. WHO is supporting about 8% of the estimated requirement for HCV tests in 2006 and 2007. The remaining reagents required for ensuring blood safety are meant to be provided directly by the blood transfusion service of the Indonesian Red Cross, with the support of local government budgets.

In addition to the Indonesian Red Cross Blood Transfusion Service, another 44 public hospitals under the auspices of the MoH operate blood transfusion services. These are funded by local government budget and they purchase reagents for blood screening through other channels.

It is recognized that some level of paid donations and replacement donation still occurs. This was the case in one of the areas visited by the review team where, unfortunately, HIV prevalence is significantly higher than the national average. The issue in this case was logistical, the inability to obtain a reliable supply of reagents, not a failure to realize the importance.

Recommendations

- The practice of blood safety as a national priority should be implemented, including application of existing guidelines on testing of blood and blood products for blood-borne infections and rational use, to assure that current guidelines are made available in all blood transfusion services and health facilities.
- Guidelines on rational use of blood should be developed to limit demand on blood services.
- Safe blood programmes should be instituted in all districts.
- Paid donations which sometimes occur, particularly in the form of replacement donation where no next of kin can be found, should be eliminated. Awareness of the civic importance of blood donation should be enhanced, so community blood drives can be increased. Community and religious leaders play an important role and should be included.
- Internationally recommended guidelines for recruitment of voluntary donors, including risk assessment, should be implemented.

Universal precautions

Universal precautions are recognized as an important issue. Guidelines exist and efforts are being made to implement these. Training has been conducted. However, more training is need-ed, especially for key staff in health facilities. Funding for the necessary commodities for universal precautions is not sufficient. In almost all cases outside the cities, waste management was through burial. No other means were available.



Photo: G. Hampton.

Universal precaution kits for health care providers

Guidelines for post-exposure prophylaxis for accidental occupational exposures are included in the universal precaution guidelines. There is no written policy to support post-exposure ARVs, but the practice now is to provide free laboratory tests and ARV in case of accidental occupational exposure.

Recommendations

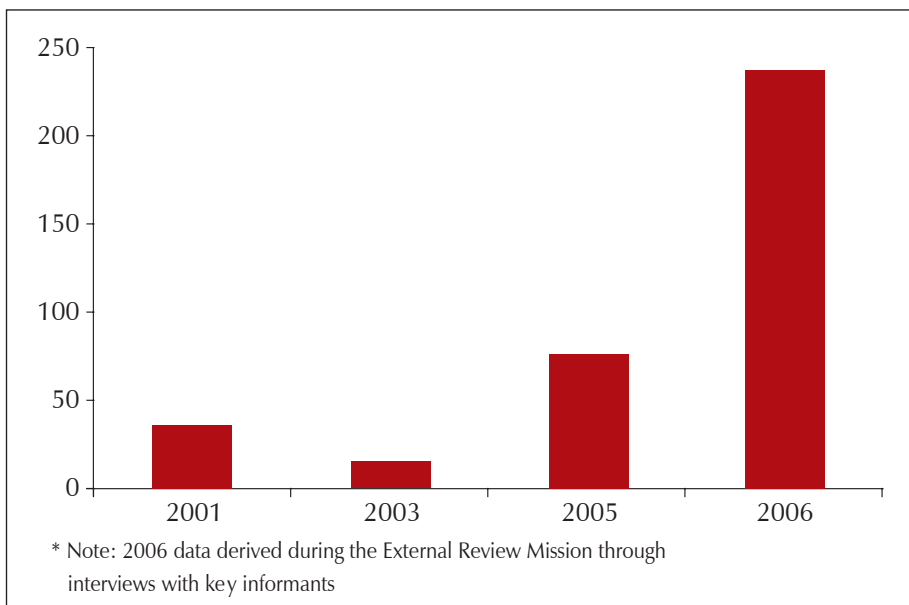
- Funding for universal precaution supplies and training should be increased.
- Frequency of training in, and reinforcement of, universal precautions should be increased.
- Better systems for waste management, particularly incineration, should be adopted.

6. HIV testing and counselling

Among the six provinces covered under the review, West Kalimantan began HIV testing and counselling as early as 1993. In Jakarta, the Pokdisus HIV working group established the service at Cipto Mangunkusomo Hospital in 1995. In the past five years VCT services have expanded considerably across the country with the support from USAID (FHI-ASA), GFATM and AusAID (IHPCP).

HIV testing and counselling services are now available in approximately 236 sites in nearly 100 out of 440 districts, and in 19 out of 33 provinces (**Figure 9**). A national guideline on VCT was formulated in 2005, and HIV testing and counselling was included in the National Strategic Plan 2003-2007.

Figure 9: Number of public/NGO testing and counselling sites in Indonesia (2001-2006)



Source: USAID, UNAIDS, WHO, UNICEF, Policy Project. June 2004. Coverage of selected services for HIV/AIDS prevention, care and support in low and middle-income countries in 2003, 2004 and 2005. 2006 data derived during the review mission through interviews with key informants.

Although HIV testing and counselling has been one of the key priorities in the HIV response, overall coverage and utilization remains low and few clients self-refer to testing and counselling. As of December 2006, only 4% (n= 8,197) out of estimated 193 030 people living with HIV were aware of their HIV positive serostatus. Utilization of testing and counselling by individuals at high risk of HIV (IDU and SW) is particularly low.

HIV testing and counselling services are mostly delivered through a provider-initiated approach in health care facilities as well as through mobile VCT teams in some areas, and in STI clinics in sex work establishments, and by some NGOs. It is often provided free of charge, otherwise a minimal cost (registration fees of IDR 1000 and IDR 50 000 for counselling and testing) can be covered by ASKESKIN, the national health insurance for the poor. However, as noted earlier, not all persons at risk can get cards because they have no identity cards. As per the national scale-up plan one testing and counselling service is to be made available in a health centre in every district.

A considerable cadre of counsellors has been built through training of trainers. However, the majority of trainers are yet to train other health care staff and lay counsellors. While counsellor meetings and supervision are in place in many areas refresher training is not. The majority of counsellors are health care workers or lay counsellors and few PLHAs have been trained or engaged in counselling.

The review team observed that HIV testing and counselling services were mostly promoted with the objective of diagnosing and treating PLHAs. Often, testing and counselling is offered to already symptomatic individuals at advanced stages of AIDS, resulting in late diagnosis of HIV disease and delayed treatment.

In general, referral networks are well established between testing and counselling services and TB, STI and antenatal clinics and with linkage to ART programmes and ongoing support by counsellors and case managers. The potential of NGO support groups in provision of ongoing psychosocial support remains limited. The majority of testing and counselling services visited were voluntary, respecting informed consent and confidentiality in accordance with the guidelines. Maintaining confidentiality of patient records, however, was not uniform.

The review team noted that provision of testing and counselling services is constrained by limited number of services available and accessibility due to cost of transport and communication challenges due to language variation in particular in remote areas such as Papua. The high level of stigma and discrimination associated with HIV and low motivation for learning HIV status due to low personal risk perception, fear of rejection by family or community and other such factors also impedes service uptake.

Provider-initiated HIV counselling and testing should always be part of a comprehensive package of HIV prevention, care, support and treatment.

Given the rapid growth of the HIV epidemic and emerging generalized epidemics, testing and counselling programs must be fully costed and funded, with sufficient human resources in place. Monitoring of the quality of training and of overall testing and counselling services must be strengthened. Equally important is counsellor support mechanisms to prevent burnout.

Recommendations

- Access to, and coverage of, HIV testing and counselling services should be increased at all levels, after considering local conditions and needs.
- Client-initiated VCT should be strengthened in the national scale-up plan and balanced with provider-initiated HIV testing and counselling services.
- HIV testing and counselling should be offered as part of a comprehensive package of prevention, care, support and treatment interventions with a good referral system between services within health facilities and between facilities.
- Utilization of testing and counselling services by IDUs, SW and their clients, MSM and transgender should be increased through outreach and referral to care and treatment.
- HIV testing and counselling to all TB patients should be routinely offered in districts where HIV prevalence is higher and in all STI clinics.
- HIV testing and counselling to pregnant women should be routinely offered during antenatal care in districts where HIV prevalence is greater than 1%, informed consent should be ensured and confidentiality respected.
- PLHA should be trained and engaged in provision of testing and counselling services, including supportive counselling and adherence counselling.

7. Care, support and treatment

Provision of care, support and treatment for PLHAs is among the priority areas of the National HIV/AIDS Strategy, National AIDS Commission (2003 – 2007) and the National Strategic Plan on HIV/AIDS, Ministry of Health (2003 – 2007).^{3, 4}

In keeping with the strategies, the government has supported (i) provision of free ARV and other drugs for the treatment of opportunistic infections (OIs), and (ii) training of health-care providers in HIV/AIDS clinical management and counselling, in hospitals of provinces with high HIV prevalence. The targets have been to provide free ARVs to 12 000 people considered eligible by the end of December 2006 and another 14 000 by the end of December 2007. The strategies included strengthening of HIV care and treatment centres as well as laboratory services.

7.1 Availability of services

In 2004, the Ministry of Health identified (Decree no. 781/Minister of Health/SK/VII/2004) 25 hospitals as ‘ART referral hospitals’ and, by the end of 2006, increased the number to 75 hospitals. Currently there are 103 sites that provide ART. These hospitals can provide ART to satellite sites such as health centres and treatment sites in prisons. The staff in these satellites have been trained to receive ART from the referral hospitals.

The HIV care, support and treatment programme started in four provinces with high numbers of reported HIV and AIDS cases and has since expanded to 32 other provinces. Seventeen provinces are supported with funds from GFATM where ARVs and drugs for OI treatment as well as standard laboratory investigations are provided free of charge. The project description states that CD4 should be covered by the GFATM funds. In the remaining provinces, only ARVs are provided free of charge.

HIV care is integrated into the existing public health care system in government facilities in Jakarta as well as in some other provinces and districts. The costs of services such as consultation and hospitalization depend on the local district policy. The cost of care for most poor people may be covered by *Askeskin*, the national social insurance scheme (see page 1).

7.2 Capacity building

The Ministry of Health has made major investments in building capacity for HIV care, support and treatment during the past few years. They have introduced the concept of HIV teams. The training of HIV teams included two counsellors, one specialist doctor, one medical doctor, one nurse, one case manager, two laboratory technicians, one M&E staff were conducted for 153 hospitals in 78 out of 440 districts (33 provinces). Training content covered VCT, management of patients with HIV/AIDS, laboratory diagnosis and monitoring of HIV infection, HIV care and ART monitoring, universal precaution and post-exposure prophylaxis. The training has not included the management of opportunistic infections. Trainings were mainly classroom lectures based on knowledge transfer rather than skills building activities such as bedside training.

Seven regional training centres were identified to deliver trainings on care, support and treatment in DKI Jakarta, Riau, Pontianak, Makassar (2), Malang, and Denpasar. Each centre has one training coordinator, and is supported by master trainers from national and provincial levels and 35 were trained as trainers for this programme. The regional training centres are under the responsibility of MoH (collaboration between Directorate General of DC & EH and the Directorate PPSDM, Center for Education & Training of Human Resources for Health (see **Annex 1**)). Very little training has been conducted at regional training centres following the training of trainers in July 2006 and coordination between RTCs and national counterpart for financing of trainings is reported to be weak.

International NGOs such as FHI, IHPCP and Burnet Institute are supporting capacity building in care, support and treatment. IHPCP has continuously provided international experts support to three ART referral hospitals (Jakarta 2, Makassar 1).

Pilot projects adapting an approach developed by WHO, the integrated management of adult and adolescent illness (IMAI), at first and secondary level health facilities, started in nine districts in three provinces (Papua, East Java and West Java). Eighteen first and second level facilities were trained on the WHO IMAI guidelines on chronic care (focusing on ART) and palliative care. The training on acute care, which covers the diagnosis and management of opportunistic infections, has not yet commenced. These training sessions were complemented by workshops with provincial and district health office and hospitals to set up referral systems and initiate supportive supervision of health centres by ART referral hospitals. In addition, an HIV-experienced consultant is providing active mentoring to some of the trained health centres. IMAI training sessions, in addition to those targeting pilot provinces, have also been conducted by the national level. However, the number of

experienced trainers familiar with the special adult learning approach that is interactive and involves expert patient trainers is still small. Training delivery was rather ad hoc, not following a strategic approach of building comprehensive systems and questions have been raised about the quality of trainings. Experience from pilot sites suggested the strong need for follow up of trainings by mentoring of trained sites, which has not been a component of recent trainings.

Referral mechanisms between health centres, district hospitals and provincial hospitals are not well established. Efforts are underway to identify competencies and infrastructural needs for each level and establish referrals, not only within the health sector, but also involving the community. Community based professional care with home visits is limited.

Hospitals that have undergone one set of training on HIV care, support and treatment, VCT, laboratory, monitoring and evaluation were appointed ART referral hospitals by the Directorate of Clinical Services and receive ART from Directorate General of DC & EH, Sub-Directorate HIV (see **Annex 1**). However, this does not necessarily seem to include concomitant delivery of all drugs for treatment of opportunistic infection.

While enormous training efforts have been undertaken, high-mortality data in patients who started ART (see **Section 7.3**) suggest insufficient recognition and treatment of opportunistic infections during the critical period when patients access services late in the course of their infection.

Recommendations

- A long-term, costed, strategic training plan should be developed to increase capacity building for all level facilities in a phased-in manner, focusing on building comprehensive systems in priority areas. The number of trained personnel per hospital should be constantly increased.
- Training materials and training delivery should be reviewed and quality and impact should be evaluated.
- Ongoing practical training components, such as bedside teaching and mentoring, should be established.
- Current in-service training should be complemented by long-term sustainable training efforts, such as integration of HIV into pre-service training curricula for nurses, doctors, laboratory technicians, pharmacists, etc., in collaboration with the Medical Council and the Medical Associations.

- Capacity, mentoring and supervision of overall clinical care and of treatment, especially for prophylaxis and opportunistic infections, should be strengthened. The clinical management of HIV infection and opportunistic infections and curricula for pre-service training need to be developed.

7.3 Performance of the HIV care and antiretroviral therapy programme

The Sub-directorate of AIDS and STI, with the support of WHO, closely mentors (including supervisory visits and database validation) the 25 ARV referral hospitals.

A national dissemination workshop of the results of ART monitoring in the 25 ARV referral hospitals was conducted in October 2006. Statistics from June 2005 to June 2006 from the 25 referral hospitals were presented as below.

- Data analyzed from 25 out of 40 hospitals providing ART as of June 2006
 - Patients ever started ART: 6042
 - Male: 5007
 - Female: 906
 - Children: 129
 - ART outcomes
 - Retained on treatment: 3497 (58%)
 - Death: 1292 (22%)
 - Lost to follow-up: 758 (13%)
 - Transferred out to another program: 313 (5%)
 - Treatment interruption: 112 (2%)
 - Median gain in CD4
 - At 6 months: + 84 cells/mm³ (IQR:+30 to +145)
 - At 12 months: + 132 cells/mm³ (IQR:+74 to +221)
 - Median gain in weight
 - At 6 months: + 3 kg (IQR:+1 to +6)
 - At 12 months: + 4 kg (IQR:+1 to +10)

The functional status of patients after six months on ART was graded as: bed-ridden (15,1% to 1,6%), ambulatory (58,2% to 8,2%) and working (26,7% to 90,2%). Only 60%, out of 6042 of patients who ever started therapy, were still on treatment at 12 months of therapy. All facilities visited reported a mortality rate around 22% during the first weeks of therapy due to apparent

OIs. ART monitoring (including CD4 counts) is limited to quantitative data with a limited number of indicators; laboratory monitoring or data on side effects are missing.

In one tertiary level facility visited in West Kalimantan, the most common regimen used was AZT/3TC/NVP (65%) followed by D4T/3TC/NVP (17%), followed by AZT/3TC/EFV (11%). All teams reported similar observations. In West Kalimantan, medical doctors reported that regimen change was necessary in around one quarter of cases due to side effects.

In most facilities visited, adherence was measured by pill count and self-report and rated as high (>95%), and almost all patients are currently on treatment.

Second line antiretroviral drugs are only available in few referral hospitals. Paediatric ARVs and ARV for PMTCT are not yet supported. Second line ART supply problems are prominent. ARVs are available in the private sector.

The most common side effects reported to the review team were anaemia, gastrointestinal symptoms and liver dysfunction.

Recommendations

- Treatment adherence counselling and follow up should be established as a standard procedure of HIV care to prevent drug resistance.
- HIV- related morbidity and mortality should be assessed in selected ART centres to study the causes.

7.4 Management of opportunistic infections

Because of varying human resources, diagnostic capacity and hospital-community linkages, access to appropriate medications and the quality of opportunistic-infection management were variable across sites. OIs are responsible for the vast majority of HIV- related morbidity and mortality in Indonesia. In West Kalimantan, the most common causes of deaths reported by medical doctors were TB, suspected toxoplasmosis and septicaemia, secondary to pressure sores. This scenario was repeated in other sites.

All health facilities reported that *pneumocystis jiroveci* pneumonia was not treated or rarely diagnosed. The same comment applied to cryptococcal meningitis. Essential examinations (lumbar puncture) and tests (Cerebral spinal fluid examination for bacteria and fungi) to determine the aetiology of meningitis are not commonly conducted potentially resulting in high mortality from undiagnosed treatable conditions. Blood cultures are generally not available at district hospital level and rarely performed elsewhere. Lack of this service inhibits the diagnosis of septicemia.

From visits to the sites it was estimated that less than 50% of eligible patients were taking cotrimoxazole. For example, at one site in West Kalimantan only 23 (49%), out of the current 47 patients on ART, were taking cotrimoxazole. At a number of ART sites in Jakarta, cotrimoxazole was almost never given without a CD4 test, yet this test was not always affordable to patients at IDR 100000.

Medicines to prevent and treat OIs are often not available, though the drugs are listed in the WHO model list for essential medicines. For example, Amphotericin B for the treatment of disseminated fungal infections is not available and must be procured through GFATM funds. The standard treatment for cerebral toxoplasmosis (sulfadiazine plus pyrimthamin) is not available; instead Fansidar is offered in some health facilities. Injectable formulations of common medicines to treat OIs in somnolent patients are usually lacking. No antibiotics for treatment of staphylococci infections related to injecting problems in drug users were available.

Patients are not routinely screened for TB prior to ART initiation. In addition, TB patients are not routinely offered HIV testing and counselling. Links between TB and HIV treatment clinics were generally not strong though there were examples where links between VCT and TB DOTS service were well-coordinated, such as in Sanglah Hospital in Bali.

Recommendations

- Prevention, diagnosis and treatment of OI should be improved to reduce mortality.
- Strong links to TB programme, as TB is the most common OI, should be established. Active screening of all HIV patients for TB should be included in standard diagnostic work up of HIV infected patients.
- It must be ensured that all PLHA with TB or other symptoms of WHO stage 3 and 4 (CD 4 < 200 or TLC < 1200) have access to cotrimoxazole prophylaxis.
- Routine screening of all patients commencing ART should be considered for active TB and liver function tests. Selection of ART management should be based on the results.

7.5 Paediatric treatment

Although ART is provided to children at selected sites in Indonesia, paediatric formulation and single preparation of ARV such as zidovudine are not available. Paediatric treatment is not subsidized by the Government. Uptake of paediatric treatment is low. Paediatric treatment is complicated by the need for adequate nutrition and OI prophylaxis. Children orphaned due to AIDS, including children

abandoned and left behind at hospitals by relatives, were reported during the review. There is significant stigma for families with HIV- positive children. As a result care is often left to non family members.

Guidelines for children have not yet been adopted and, therefore, no paediatric formulation is available in the country. Children are treated with adult tablets that are crushed in the hospital pharmacy and the dose is adapted to the weight of the child.

Recommendations

- Provision of paediatric formulation of ARV and nutritional supplements should be considered with immediate effect.
- Estimation should be made of needs for paediatric formulations based on findings from upcoming estimation of children infected and affected by HIV and AIDS. Availability of paediatric formulations for HIV-infected children in need should be ensured.
- Protection and care of children orphaned or abandoned due to HIV should be ensured in line with international recommendations through the coordination between the Ministry of Health and the Ministry of Social Welfare.

7.6 Treatment literacy and adherence support

Knowledge of treatment among people living with HIV was variable, with some being actively involved in treatment adherence peer support, as in Surabaya. Few had knowledge about OI symptoms. In Surabaya, however, most PLHAs engaged in peer support knew about cotrimoxazole prophylaxis. This was also the case in West Kalimantan.

There is no treatment literacy training for PLHAs and also no training on treatment adherence support. Common reasons reported for the discontinuation of ART were side effects, feeling better or worse, switching to traditional healers, relapse to drug use, high ancillary costs associated with ART, advanced AIDS and limited knowledge of doctors in providing ART and treatment for OIs.

Recommendation

- Building of HIV and OI treatment literacy among PLHA is essential.

7.7 Continuum of care and integrating prevention

There is no continuum of care from home and community to health facility offering a comprehensive package of services. The key focus of the national

care, support and treatment programme has been on the provision of ART. Nursing skills for the severely ill and bed ridden HIV patients are also limited.

HIV prevention, VCT and care, support and treatment need to be linked to optimize effectiveness. Across Indonesia there is a general lack of prevention, care, support and treatment integration. In many cases, prevention, care, support and treatment are seen as separate programmes. For example, condoms were not routinely available at ART sites even for PLHA. ART and MMT are generally not integrated, though sometimes they co-exist (Bali). HIV prevention is not always emphasized among those engaged in care, support and treatment services.

Recommendations

- There should be a continuum of care from home/community to health facility offering a range of comprehensive care, support and treatment services with good linkages to prevention activities. These services should include management of TB/HIV co-infection and of other common opportunistic infections. Condoms should be made available to all patients on or considering HIV treatment and in methadone clinics.
- Providing ART at methadone maintenance clinics should be considered.

Free condoms and education on condom use should be provided in all health facilities.

7.8 Papua

Papua is considered separately here for its unique socioeconomic and cultural context. Papua is ethnically diverse. Poverty is widespread due to a lack of non-agricultural economy. In many areas large numbers of different tribes live in remote locations. Inland communities are only provided supplies by air, significantly increasing the cost of all goods and services. Health service infrastructure is poor. In Wamena, the team noted general services being understaffed. For example, of the 21 health centres and 2 district hospitals, only those in Wamena city are currently operating. It is difficult to attract full-time staff who are not on 'rotation', despite financial incentives.

Despite multiple obstacles, substantial achievements with respect to expanding the availability of services for HIV patients have been made in some areas since 2004/2005. While in 2002 only three main hospitals were providing services, this number has increased to 154 by the end of 2006. In various places, the service teams are fully functional and provide outpatient services, inpatient services, VCT, psychosocial support and other relevant services.

All ART centres have received training of at least one team of HIV-care providers consisting of a nurse, two doctors, a case manager, two counselors, a pharmacist and a person responsible for monitoring and evaluation. The team visiting Timika and Jayapura noted that although GFATM supports ART, availability of OI treatment other than TB remains variable. In addition, although ART has been available for around two years, uptake has been low. For example, only 38 people had ever initiated ART at Mitra Hospital. The main impediment is poor access due to the distance between highlands and the hospital (around seven days' walk).

Outreach teams or community-based support groups in a few places support hospital services. In Merauke, 32 of the 60 patients on ART joined a support group, along with 24 supportive family members. Despite this example, the rate of disclosure of HIV status to family members remains low due to the stigmas associated with HIV.

In summary, Papua has a number of unique issues which necessitate a tailored response. The service infrastructure is underdeveloped to support comprehensive HIV CST, though there are some examples, such as in Merauke, where comprehensive HIV CST is functioning.

Recommendation

- Basic health infrastructure in Papua should be strengthened. Developing a continuum of care for people living with HIV should be given priority so that HIV CST can be implemented in remote areas.

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Annex I: Basic indicators

For consistency reasons the data in the table below are taken from official UN publications.

Demographic data	Year	Estimate	Source
Total population (thousands)	2005	222, 781	UN Population Division
Population aged 15-49 (thousands)	2005	124, 214	UN Population Division
Female population aged 15-49 (thousands)	2005	21, 259	UN Population Division
Annual population growth rate (%)	1995-2004	1.2	UN Population Division
% of population in urban areas	2005	47.9	UN Population Division
Crude birth rate (births per 1000 pop.)	2005	20.2	UN Population Division
Crude death rate (deaths per 1000 pop.)	2005	7.3	UN Population Division
Maternal mortality rate (per 100 000 live births)	2000	230	World Health Report 2006, WHO
Life expectancy at birth (years)	2004	67	World Health Report 2006, WHO
Total fertility rate (per woman)	2004	2.3	World Health Report 2006, WHO
Infant mortality rate (per 1000 live births)	2004	30	UNICEF / WHO
Under 5 mortality rate (per 1000 live births)	2004	38	World Health Report 2006, WHO
Socio-economic data	Year	Estimate	Source
Gross national income, ppp* per capita (Int.\$)	2004	3, 460	World Bank
Per capita total expenditure on health (Int.\$)	2003	113	WHO
UN Human Development Index (ranking)	2005	110	UNDP Human Development Report 2005
General government expenditure on health as % of total expenditure on health	2003	35.9	WHO
Adult literacy rate (%)	2000-2004	N/A	UNESCO
Male literacy rate (%)	2000-2004	N/A	UNESCO
Female literacy rate (%)	2000-2004	N/A	UNESCO
Net primary school enrolment ratio, male (%)	1998-2004	93	World Bank
Net primary school enrolment ratio, female (%)	1998-2004	92	World Bank
Human Poverty Index (ranking)	2005	41	UNDP Human Development Report 2005

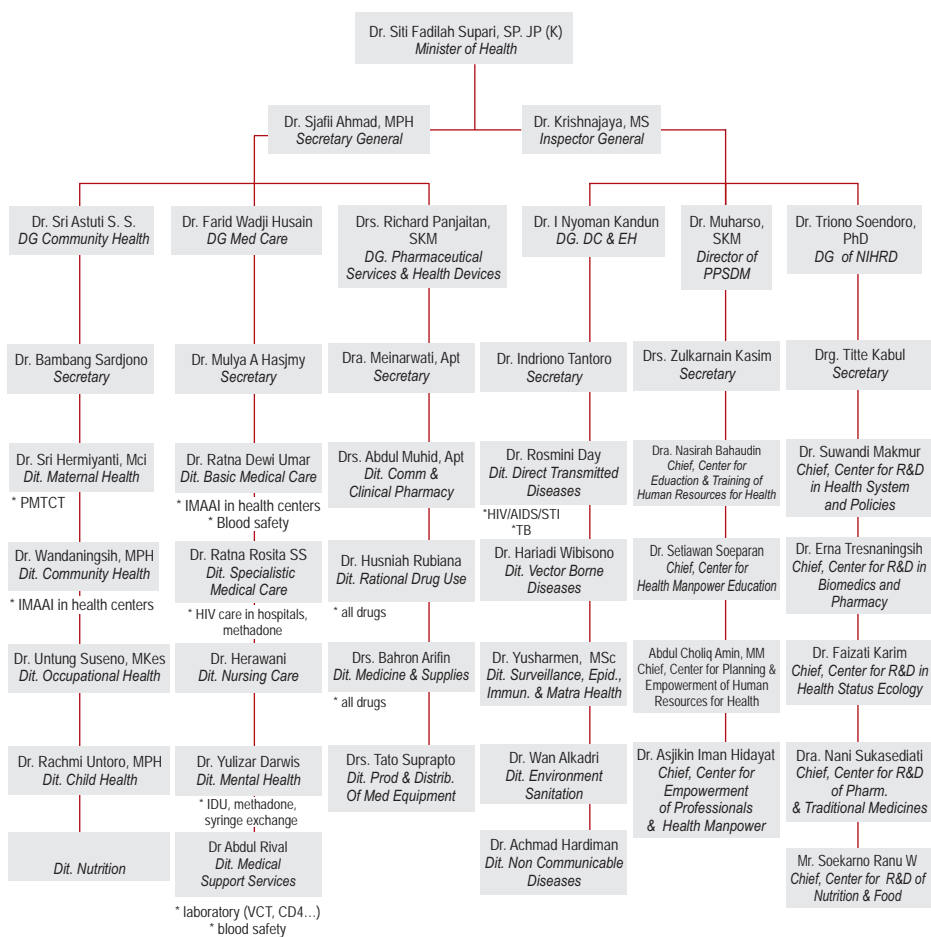
	2001	2002	2003	2004	2005
National funds spent by governments on HIV/AIDS from domestic sources (US\$)	2 950 000	3 500 000	6 350 000	9 550 000	13 000 000

Source: Epidemiological facts sheets, Indonesia, August 2006, Geneva, WHO/UNICEF/UNAIDS

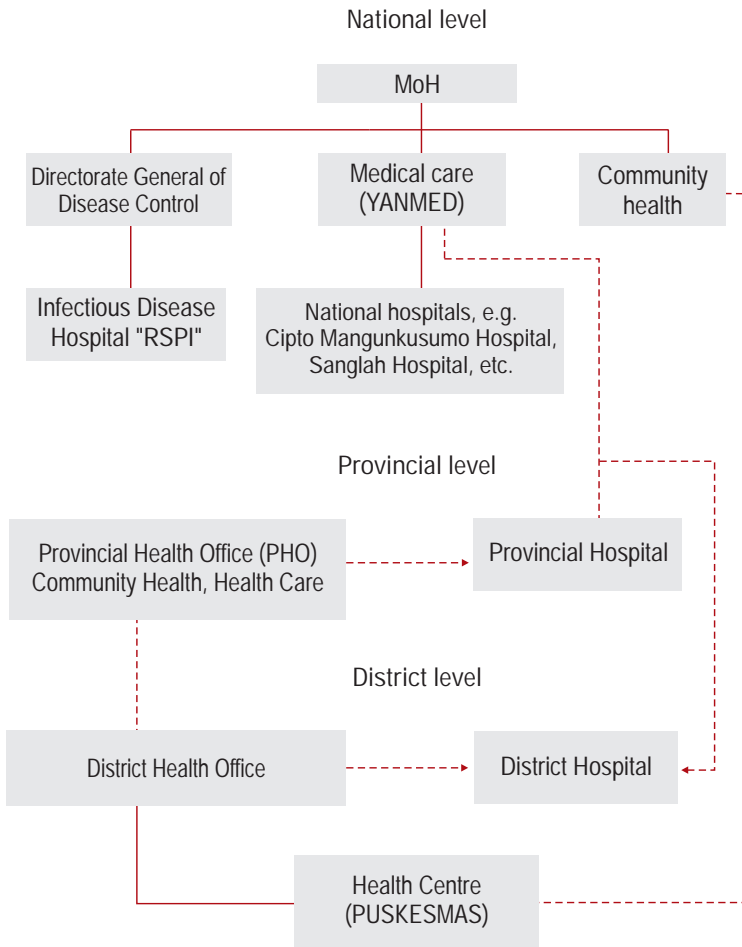
*Purchasing-power-parity

Annex 2: Organization of the Ministry of Health

Organizational Structure Ministry of Health, Republic of Indonesia



Annex 3: Organization of health services at the provincial and district level



RSPI Rumah Sakit Pondok Indah

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The mission programme, field visit reports, institutions visited and people met as well as list of documents reviewed can be requested from the Sub-directorate AIDS and STI, Directorate General of Disease Control and Environmental Health and WHO Indonesia Country Office, email: who@who.or.id, fax: +62 (21) 520 1164 attention to Medical Officer (HIV/AIDS).

As part of the process of development of the National Strategic Plan on HIV/AIDS for 2007–2011, the Ministry of Health and the World Health Organization, in collaboration with a range of partners, organized a review of the health sector response to the HIV epidemic in Indonesia. The overall objective was to assess the progress of the national AIDS programme, especially in relation to the health sector response, and recommend appropriate measures for revision of interventions and strategies. This publication documents the key findings of the review team, and highlights opportunities for strengthening prevention and control efforts aimed at halting the HIV epidemic and reversing its trend in Indonesia.



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