



**USAID**  
FROM THE AMERICAN PEOPLE

**HEALTH POLICY  
INITIATIVE**



# INDONESIA HIV/AIDS STRATEGY AUDIT

**JANUARY 2007**

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by the USAID | Health Policy Initiative, Task Order 1.

The USAID | Health Policy Initiative, Task Order 1, is funded by the U.S. Agency for International Development (USAID) under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. HIV-related activities of the initiative are supported by the President's Emergency Plan for AIDS Relief. Task Order 1 is implemented by Constella Futures, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), Futures Institute, and Religions for Peace.

# INDONESIA HIV/AIDS STRATEGY AUDIT

The author's views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

# TABLE OF CONTENTS

ACKNOWLEDGMENTS .....	iii
ABBREVIATIONS .....	iv
I. INTRODUCTION .....	1
II. THE LEGISLATIVE PROCESS IN INDONESIA.....	2
III. OVERARCHING HIV POLICIES.....	5
IV. AUDIT OF THE NATIONAL STRATEGY AND RELATED POLICIES .....	8
Prevention.....	8
Counseling and Testing.....	11
Care, Treatment, and Support.....	12
Orphans and Vulnerable Children.....	13
Laboratories.....	13
Other: Policy Analysis and Systems Strengthening .....	14
V. CONCLUSION.....	16

# ACKNOWLEDGMENTS

This document was prepared by staff of the USAID | Health Policy Initiative, Task Order 1. It describes the current policy environment in Indonesia, and how that environment may support the framework outlined under the U.S. President’s Emergency Plan for AIDS Relief. We thank the following groups:

- The USAID/Indonesia Mission for its guidance and ongoing support during the audit of Indonesia’s National HIV/AIDS Strategy.
- Staff from the FHI/ASA project, who provided valuable insight and practical experience from direct HIV prevention implementation efforts in Indonesia.
- The KPA for their support during the development of this document.
- The Health Policy Initiative, Task Order 1 staff and consultants involved in the development of this document: Dr. Kai Spratt, Ms. Nadia Carvalho, Dr. Claudia Surjadjaja, and Dr. Izhar Fihir.

# ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
BKKBN	National Family Planning Board
CBO	community-based organization
CDC	Center for Disease Control
CST	care, support, and treatment
DPD	<i>Dewan Perwakilan Daerah</i>
DPR	<i>Dewan Perwakilan Rakyat</i>
HIV	human immunodeficiency virus
IDU	injecting drug user
IEC	information, education, and communication
IFPPD	Indonesian Forum of Parliamentarians on Population and Development
IHPCP	Indonesia HIV/AIDS Prevention and Care Project
IRC	Indonesian Red Cross
MOU	memorandum of understanding
NPCI	National Policy Composite Index
OI	opportunistic infection
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
STI	sexually transmitted infection
TB	tuberculosis
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

# I. INTRODUCTION

In 2005, Indonesia was home to an estimated 170,000 people living with HIV (PLHIV).<sup>1</sup> While the country's adult HIV prevalence rate is less than 1 percent, higher prevalence rates have been documented in the most at-risk populations, such as injecting drugs users (IDUs) and sex workers.<sup>2</sup> The strength of Indonesia's HIV-related policy environment will play a key role in ensuring that the country can avert future infections and provide treatment and care for those affected by the HIV epidemic. The policy environment provides the foundation and mechanisms through which effective, accessible programs and services can be established, implemented, and sustained over time.

To assist in improving the HIV policy environment, this audit evaluates Indonesia's National HIV/AIDS Strategy and other related prevention, care, and treatment guidelines and regulations. In particular, to help inform USAID's HIV-related technical and financial assistance in Indonesia, the audit describes the current policy environment in Indonesia and how that environment may support the framework outlined under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Section II of this paper presents an overview of the legislative process in Indonesia. Section III outlines the overarching policies and institutions that govern Indonesia's HIV response. Section IV provides an audit of the major components of the National HIV/AIDS Strategy. Section V concludes by identifying next steps for improving Indonesia's policy response to HIV.

---

<sup>1</sup> Grassley, N.C., and G.P. Garnett. 2005. "The Future of the HIV Epidemic." *Bulletin of the World Health Organization* 83: 378–383.

<sup>2</sup> UNAIDS/WHO. 2004. *Case Study on Estimating HIV Infection in Concentrated Epidemics: Lessons from Indonesia*. Geneva, Switzerland: Working Group on Global HIV/AIDS/STI Surveillance.

## II. THE LEGISLATIVE PROCESS IN INDONESIA

Understanding Indonesia's HIV policy environment first requires an understanding of the country's legislative system.

**Legislative Bodies.** “Legislative authority is constitutionally vested in the popularly elected House of People’s Representatives or *Dewan Perwakilan Rakyat* (DPR) and the new House of Regional Representatives or *Dewan Perwakilan Daerah* (DPD). The DPR has the power to make laws and has legislative, budgetary, and supervisory functions. The DPD must sit in session at least once a year and can submit bills to the DPR that relate to regional autonomy; the relationship between the center and the regions; the formation, development, and inclusion of the regions; the management of natural resources and other economic resources; and the fiscal balance between the center and the regions. This 500-member body serves five-year terms and meets annually, opening on August 16, the eve of National Day when the president delivers his National Day speech.”<sup>3</sup>

**Administrative Units.** Indonesia is composed of 33 provinces, 349 districts, and 91 municipalities. With the initiation of decentralized reform efforts in January 2001, the 440 districts and municipalities have become the key administrative units responsible for providing most government services. Further amendments to the Constitution in August 2002 (Chapter VI, Article 18) stipulated that each province, regency, and town have regional governments regulated by law. These regional governments can regulate and administer matters of government on “the basis of autonomy and the duty of assistance.”

**Legislative Process.** Indonesia’s Law No. 10/2004 on “Development of Law and Regulation” describes the detailed steps for how laws and regulations are formulated at both the central and local levels (e.g., province, district, and village levels). Laws or regulations can be drafted by either the government or the DPR. The processes that take place at the central level for laws and government regulations, and at the provincial level for local regulations, are similar. At the initial planning phase, all laws that need to be formulated or amended are included in a program planning document called the “National Legislation Program” or the “Local Legislation Program.” For the current DPR, this planning document is the “National Legislation Program 2004–2009.” When the government or DPR submits a draft law/regulation, DPR and government counterparts will initiate discussion on the proposed legislation within 60 days of its submission and continuing until both parties reach an agreement. The final draft is sent to the President, Governor, District Chief, or Mayor, as appropriate, for approval. The government passes the law by signing the final draft of the law/regulation. The law/regulation becomes effective on the date it is signed by the required government authority (e.g., President, Governor, District Chief, or Mayor). Once the law is passed, the ministry or unit under the ministry (e.g., directorate general) or local government (e.g., province or district) or other government unit can write a decree to translate the law into policy.

**Types of Legislation.** Legislation is developed through a variety of mechanisms. The official hierarchy of legislation in Indonesia is as follows (based on Law No.10/2004 Chapter II Article 7):

- 1945 Constitution (*Undang-Undang Dasar 1945*);
- Law (*Undang-undang*)/Government Regulation in substitution of the law (*Perpu*);
- Government Regulation (*Peraturan Pemerintah*);

---

<sup>3</sup> See <http://www.embassyofindonesia.org/land/landpeople.php> [accessed October 2, 2006].

- Presidential Decree (*Keputusan Presiden*); and
- Local Government Regulation (*Peraturan Daerah*)—the three types of local government regulation are Provincial Regulations, District Regulations, and Village Regulations.

Other legislative instruments are also in use, including Presidential Instructions, Circular Letters, and Ministerial Decrees (*Keputusan Menteri*) issued with accompanying guidelines. As a result of decentralization in 2001, legislation is made at the local level in the form of Provincial or District Regulations (*Perda*). For regulations at the local level to come into effect, they must be passed by the local parliament.

The various types and mechanisms for issuing laws and policies can result in inconsistencies between specific legislative instruments as well as inconsistencies between government law and the policies of the different institutions charged with managing and implementing the country's health programs. For an example, see Box 1. There is also a need for clarification and/or resolution of uncertainties and conflicts in the legislative authorities and responsibilities of the executive, legislative, and judicial branches of the Government of Indonesia at all levels.<sup>4</sup>

#### **BOX 1. HIV PREVENTION FOR AT-RISK GROUPS IN BALI**

The case of HIV prevention among IDUs—one of the populations most at-risk for HIV infection in Indonesia—demonstrates how the guidelines of one agency or legislative instrument may conflict with those of another. Indonesia's Penal Law classifies injecting drug use as illegal and, therefore, IDUs are to be arrested. However, in the highly affected province of Bali, the National AIDS Commission and the National Narcotics Board signed a Memorandum of Understanding (MOU) that allows the province to initiate a harm reduction<sup>5</sup> program that includes HIV prevention activities. In this case, it is unclear whether the MOU is in violation of the Penal Law.

**Health Policy Environment.** Indonesia's Constitution of 1945 identifies health as a means to promote public welfare and the development of human capital and as a national priority—especially in Chapter X on human rights and Article 28 H (1) on rights to health (2<sup>nd</sup> Amendment). Over the years, the government has taken various steps in this direction and has greatly improved the public health of the citizenry. The steady decrease in infant and child mortality and the increase in life expectancy illustrate the efficacy of such efforts. In 2002, the Constitution was amended to extend social security to the whole population, and established the principle of equitable healthcare. In addition, the government formulated a *Poverty Reduction Strategy Paper* that focuses on four main areas of action, including social protection for the poor.

The current legal framework within which the Indonesian health system operates is one where legal authority is held by the central government. When Indonesia rapidly decentralized most central government responsibilities to the districts and provinces, pre-existing health laws were not changed to reflect this new reality. In the context of decentralization, new legislation frameworks on health sector

<sup>4</sup> Newby, L., G. Dip, R. Kolehmainen-Aitken C. Supriadi, and B. Wasisto. 2004. *The Content and Uses of Health Laws: An Overview of Selected International Models and Lessons Learned for Possible Application in Indonesia*. Jakarta, Indonesia: Management Sciences for Health and Ministry of Health, Indonesia.

<sup>5</sup> Note: Comprehensive harm reduction programs for IDUs can include a range of interventions, including substance abuse treatment and HIV prevention activities. The U.S. Government does not condone illegal drug use and federal funds cannot be used to purchase or distribute needles and syringes for the purpose of injecting illegal drugs.

governance, public health functions, and service delivery are urgently needed. The present national “basic health law” (Law 23/1992) sets policy and identifies areas of regulatory activity. However, implementation requires the development of further regulations and Ministerial Decrees, a process that is no longer workable within a decentralized health system. In 2001, the Subcommittee on Health (Commission VII) of the Indonesian Parliament (DPR) took the legislative initiative to revise Law 23/1992. A new Health Law Bill was then drafted and disseminated in 12 provinces and several districts.<sup>6</sup>

While not specifically binding in nature, the government has committed to achieving the Millennium Development Goals, which involves addressing various aspects of poverty reduction and health. In January 2004, Parliament passed a comprehensive social security bill, declaring the introduction of social health insurance as a high priority. The new policy is essential for improving the low health status of the population and for reducing poverty related to ill health. It also addresses the impact of ill health on the economy, such as low productivity due to high absenteeism, care for family members, reduced life expectancy, and consuming large parts of income and savings<sup>7</sup> for healthcare.

---

<sup>6</sup> Health Law Academic.

<sup>7</sup> Scheil-Adlung, X. 2004. “Protection for the Poor: A joint UNSFIR-ILO Working Paper.” Geneva, Switzerland: International Labor Organization (ILO).

### III. OVERARCHING HIV POLICIES

Indonesia adopted its first National HIV/AIDS Strategy in 1994. The strategy was intended as a guideline for all government sectors, local governments, NGOs, and the private sector and workplaces on responding to HIV. A rapidly changing epidemiologic situation required revisions of the original document and the formulation of the current Indonesia National HIV/AIDS Strategy (2003–2007). Indonesia has supported other policies and international consensus statements regarding HIV and AIDS—including the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) “Declaration of Commitment” that resolved that, by 2003, regulations and other provisions would be ratified, supported, or enforced as law to eliminate all forms of discrimination and confirm the basic human rights and freedoms of PLHIV and members of other vulnerable groups.

According to the 2006 country report submitted by the Indonesian Ministry of Health to UNAIDS<sup>8</sup>:

*Indonesia is stepping up the response to the epidemic. In 2004, the government allocated US\$13 million, a 106% increase over the HIV/AIDS budget for 2003. The National Composite Policy Index also increased from 65% in 2003 to 75% in 2005. The National AIDS Commission was reorganized and strengthened. Twelve ministries and local governments have translated the National Strategy into strategic plans and annual work programs. The Ministry of Health is taking steps to revive the national sentinel surveillance programme which had not functioned properly since administrative decentralization was introduced in 2001. Most high prevalence provinces now also have reliable estimates of the number of people at high risk who are living with HIV/AIDS. A unified monitoring system, AIDS info (the HIV/AIDS Joint Database), was launched in October 2005. The information within AIDS Info will eventually cover all HIV/AIDS Programs in Indonesia as well as HIV/AIDS data that is updated on a monthly basis, HIV estimates, HIV prevalence and behavioural surveillance data. However, there are not enough people at risk being reached by prevention programmes (less than 10%), and too few have access to VCT (18% of IDUs and 14% of sex workers). Among vulnerable groups, knowledge about HIV/AIDS is improving, but it is still inadequate: just 43% of men who have sex with men and 24% of female sex workers could correctly identify ways of prevention (Ministry of Health, 2006, p. 7).*

In the same report, key stakeholders assessed Indonesia’s policy environment related to HIV and AIDS as shown in Table 1 and 2 below.

---

<sup>8</sup> Ministry of Health, Indonesia. 2006. *Country Report on the Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS) Reporting Period 2004 – 2005*. Jakarta, Indonesia: Ministry of Health.

**TABLE 1. RESULTS OF NATIONAL POLICY COMPOSITE INDEX (NPCI) PART A**

Topic	Rating	
	2003	2005
Strategic plan	6	7
Political support	6	6
Prevention	6	7
Care and support	6	7
Monitoring and evaluation	5	6

**TABLE 2. RESULTS OF NPCI PART B**

Topic	Rating	
	2003	2005
Human rights		
· Policies, laws, and regulations in place	3	4
· Efforts to enforce existing policies, laws, and regulations	5	6
Civil society participation	6	7
Prevention program	6	7
Care and support	6	8

While most areas of political commitment have improved in Indonesia since the 2003 “self-report,” areas with the lowest scores in 2005 include political support for HIV; human rights policies, laws, and regulations; enforcement of human rights laws and regulations; and monitoring and evaluation.

The Sentani Commitment serves as Indonesia’s overarching vision for addressing HIV. The statement was adopted at a January 19, 2004, meeting between the Coordinating Minister for People’s Welfare, six Ministers comprising major members of the National AIDS Commission, and provincial leaders from the six provinces most affected by HIV. The Sentani Commitment establishes seven objectives, including promoting condom use in every high-risk sexual activity; preventing HIV among IDUs; providing antiretroviral (ARV) treatment to at least 5,000 PLHIV by the end of 2004; reducing stigmatization and discrimination of PLHIV; establishing and empowering provincial and district AIDS committees; developing laws and regulations conducive to HIV prevention, care, and support programs; and scaling up efforts for information, education, and communication (IEC), including collaboration with religious groups. Like UNGASS, the Sentani Commitment is not a legal document and, therefore, does not legally bind the government at the national or local levels to implement these objectives.

Indonesia’s National HIV/AIDS Strategy (2003–2007) outlines seven priority areas: (1) HIV Prevention; (2) Care, Treatment, and Support for PLHIV; (3) HIV and Sexually Transmitted Infection (STI) Surveillance; (4) Operational Studies and Research; (5) Enabling Environments; (6) Multi-stakeholder Coordination; and (7) A Sustainable Response. The strategy encourages program executors to further develop strategies and activities endorsed in the strategy.

The overall health policy environment, however, is in transition in Indonesia. At the time of this study, amendments to Law 22 (on decentralization) were under debate in the national parliament. With rapid decentralization, national, provincial, and district authorities still lack clarity about the extent to which they have authority to make policy and guidelines and how local efforts should be funded and implemented. Despite this, several provinces and municipalities have issued their own local regulations (*Peraturan Daerah*) and decrees (*Surat Keputusan*) or have developed their own strategies.

Two provinces have passed provincial regulations on Prevention and Control of HIV/AIDS: East Java (August 23, 2004) and Riau (June 30, 2006). In addition, three districts/municipalities in East Java are in the final review of district regulations (Banyuwangi, Surabaya and Malang). Papua is in the final review of its provincial regulation, but three districts in Papua have passed their own district regulations (Maumere and Jayapura in December 19, 2003). One district in Kepulauan Riau (Bintan) has a Bupati decree on condom use and routine check-ups for most at-risk groups (October 1, 2005). By having a provincial regulation on HIV, the relevant technical department (e.g., Health, Manpower) at the provincial and district level can request funding from the local government. The local regulation also serves as the basis for the local authority to enforce the HIV prevention measure, for example, condom use programs for sex workers and their clients.

# IV. AUDIT OF THE NATIONAL STRATEGY AND RELATED POLICIES

This section provides an overview of the key components contained in Indonesia's National HIV/AIDS Strategy. To assist in guiding USAID's HIV assistance in Indonesia, it considers the extent to which the policy environment is supportive of the framework outlined under PEPFAR. The main categories reviewed are: Prevention; Counseling and Testing; Care, Treatment, and Support; Orphans and Vulnerable Children; Laboratories; Strategic Information; and Other Issues, including Policy Analysis and Systems Strengthening.

## PREVENTION

Under the National HIV/AIDS Strategy, the overall prevention goal is “to prevent and limit the spread of HIV, to improve the quality of life of PLHIV, and to alleviate the socioeconomic impacts of HIV/AIDS.” Specifically, this includes: (1) providing and disseminating information, and creating a supportive environment for HIV prevention with an emphasis on prevention among most at-risk populations and the people with whom they interact; (2) providing care, treatment, support, and counseling to PLHIV and integrating these with prevention efforts; (3) enhancing the role of young people, women, families, and the wider community, including PLHIV, in a range of HIV prevention initiatives; and (4) creating and fostering partnerships between government agencies, NGOs, the private sector and the business community, professional organizations, and national and international donor agencies.

Perhaps given the concentrated nature of Indonesia's HIV epidemic, the strategy does not specifically refer to abstinence or be faithful prevention approaches—which are key components of the balanced prevention approach recommended by PEPFAR. The importance of the family and the need for prevention interventions to respect cultural norms and sensitivities are endorsed.

The strategy recognizes that “infection-risk groups are groups of people who are linked to high-risk behavior, such as sex workers and their clients, injecting drug users, and people detained in correctional/detention centers.” In addition, the strategy notes, “Vulnerable groups are groups of people who, because of the nature of their work, their environment, low level of family support and welfare, or health status, are vulnerable to HIV. These groups may include highly mobile people, women, youth, street children, poor people, pregnant women, and blood transfusion recipients.”

Activities to achieve prevention goals that are endorsed in Indonesia's strategy include the following:

*1.2.1. Intensify information, education and communication - Improving knowledge, changing attitudes, and promoting positive behavior to prevent transmission.*

*1.2.2. Reduce vulnerability - This can be achieved by improving education, economic status and gender equality.*

*1.2.3. Increase condom use - Promoting the use of condoms at every risky sexual encounter as a means of preventing HIV and STI infection.*

*1.2.5. Step up efforts to reduce the prevalence of sexually transmissible infection. Because STI patients have a 2–9 times greater risk of being infected with HIV than people who do not have STI, efforts to test for and treat such infections must be stepped up.*

*1.2.8. Step up efforts to prevent HIV transmission among injecting drug users. Sharing needles can transmit HIV directly into the bloodstream. Efforts to prevent this through harm reduction should be based on a national-level inter-sectoral agreement between, inter alia, the National AIDS Commission, the Ministry of Health, the National Narcotics Board, Police Department, the Ministry of Justice and Human Rights, the Ministry of Social Welfare, the Ministry of Education, the Ministry of Religious Affairs, and NGOs.*

The formation of the Task Force on Harm Reduction is a direct result of Goal 1.2.8 in the strategy. As of 2006, the Ministry of Health is the only ministry with a strategy and policy on harm reduction. The Ministry of Health passed a ministerial decree on IDU harm reduction (Ministerial Decree No. 567 / 2 August 2006) and endorsed a national guideline on IDU harm reduction. The Task Force on Harm Reduction, under the National AIDS Commission, is in its final review of a broader policy on harm reduction that will further support the implementation of the ministerial decree on IDU harm reduction.<sup>9</sup>

Interestingly, the HIV/AIDS Prevention Policy is contained within the revised strategy (Section 3). In many countries, policies and strategies are separate documents. Generally, a policy presents the country's vision and overarching goals and approaches, while the strategy puts forth the activities to achieve those objectives. In Indonesia, the prevention policy has been incorporated into the strategy itself. Also, while the strategy covers care and treatment, it does not include designated policies for these components.

The HIV/AIDS Prevention Policy recognizes that appropriate efforts must address different at-risk groups, and sets out the following principles:

*3.1. HIV/AIDS prevention must take into account religious and cultural values and social norms, and activities must be aimed at upholding and strengthening family welfare and cohesion.*

*3.2. HIV/AIDS prevention efforts should be implemented by the community, the government, and NGOs on a partnership basis. The community, together with NGOs, should be the leading agents while the government takes responsibility for steering, guiding, and creating a conducive atmosphere to support HIV/AIDS prevention.*

*3.3. Prevention must be based on the understanding that HIV/AIDS is a national issue that needs to be tackled through a national response.*

*3.4. HIV/AIDS prevention efforts must give due attention to the vulnerable sectors of society, including those belonging to marginalized groups and those whose work puts them at risk of exposure to HIV/AIDS.*

*3.5. HIV/AIDS prevention efforts must respect the dignity and rights of PLHIV and their families, and take gender equality and justice into consideration.*

*3.6. Efforts to prevent HIV transmission should be carried out through information, education, and communication (IEC) aimed at promoting a healthy lifestyle.*

---

<sup>9</sup> Note: Comprehensive harm reduction programs for IDUs can include a range of interventions, including substance abuse treatment and HIV prevention activities. The U.S. Government does not condone illegal drug use and federal funds cannot be used to purchase or distribute needles and syringes for the purpose of injecting illegal drugs.

3.7. *Effective prevention efforts include 100% condom use for sex workers, their clients and partners of PLHIV, and “double protection” condom use in families.*

3.8. *Harm reduction activities should be employed to reduce HIV infections among injecting drug users.*

3.9. *HIV/AIDS prevention should be an integrated response aimed at promoting healthy behavior, preventing illness, improving treatment and care based on scientific facts and data, and providing support for PLHIV.*

While the national *HIV/AIDS Prevention Policy* supports 100% condom use for sex workers and their clients and double protection, the Basic Law for Populations (Law No. 10/1992) from the National Family Planning Board (BKKBN) considers a husband and wife or eligible couple as the only groups able to get family planning methods from the government. However, condoms are being promoted in certain districts and provinces for dual protection. For example, the East Java Provincial Regulation and Papua’s draft legislation call for both 100% condom use in high-risk situations and condom use for double protection. It is not yet clear if the 100% condom use program will be in conflict with the Basic Law as it promotes providing condoms to unmarried sexual partners.

## **Prevention: Medical/Blood Safety**

Blood transfusion is one mode of HIV transmission, and blood screening is a key preventive measure to control the spread of the virus. The proportion of blood testing positive for HIV increased sharply from 0.07 percent in 2000 to 0.2 percent in 2002 in Jakarta, and nationally from 0.01 percent in 2000 to 0.07 percent in 2002. The national strategy recognizes people receiving blood transfusion as a “vulnerable group” and requires that “all donor blood must be screened for HIV because of the extremely high risk of transmission through transfusion. Every district/municipality should therefore be equipped with a blood transfusion unit that can provide safe blood” (Section 1.2.4.).

In 1992, the Ministry of Health passed a decree for the mandatory testing for HIV, syphilis, and hepatitis B and C during blood transfusions, but blood safety still remains an issue of concern. The strategy endorses the upgrading of laboratories to support HIV and STI surveillance and diagnosis and the establishment of referral laboratories (Section 3.2.5). Out of 440 districts, 185 districts have a certified “blood transfusion unit” under the network of the Indonesian Red Cross (IRC). The remaining districts have blood transfusion units in the hospitals. In March 2006, the IRC renewed the standard protocol and requirements for setting up a blood transfusion unit in anticipation of the need to improve the prevention of HIV and other infectious diseases through blood transfusion.

The Ministry of Health requires blood transfusion units to follow an “unlinked anonymous principle” in mandatory blood screening. According to this principle, the donor should not be screened before donating the blood; however, donated blood that tests positive for HIV will be destroyed. The name of HIV-positive donor is not to be disclosed.

Blood safety is a component of the national strategy that has been operationalized, to some extent, by government regulations, ministerial decrees, local regulations, and organizational guidelines. The decree on blood safety was followed by a Standard Operating Procedure for Mandatory Blood Screening. The Law on Blood Safety is based on the Government Regulation (PP No. 18/1980). Based on the law, various decrees and guidelines have been adopted: MOH Decree No. 478/1990 on the policy for blood safety; Directorate General (e.g., MOH/Medical Services) Decree No. 1147/1991 with the technical guidelines on “Safe Blood Transfusion;” and MOH Decree No. 622/1992 on HIV screening for blood.

There are also a few decrees from the IRC on the standard procedures for blood transfusions. At the local government level, East Java issued a Regulation on HIV/AIDS that includes a clause on screening blood for HIV.

### **Prevention: Medical Transmission/Medical Injection Safety**

The national strategy states that “Universal precautions must be strictly observed by everyone who could be directly exposed, such as medical officers and paramedics, social workers, police officers/detectives, undertakers, field workers and so on. For this reason, they must be given the knowledge, skills, and facilities to enable them to prevent transmission.” In December 2002, the Ministry of Health’s Center for Disease Control (CDC) Directorate issued a comprehensive technical guideline for infection prevention at health facilities. The guidelines include: hand washing, safe handling of sharp instruments, equipment processing, safe apparel, and disposal of contaminated materials. There are no regulations requiring the practice of universal precautions and, as such, there is no enforcement of the universal precautions by the CDC. In East Java, regulations requiring the practice of universal precaution are clearly stated in Government Regulation for HIV/AIDS Prevention (Perda No. 5/2004 Chapter III Article 3 No. 3 point g).

### **Prevention: Mother-to-Child Transmission**

Mother-to-child transmission of HIV is still a rare event in Indonesia and the national strategy has few references to this issue. The strategy endorses improving “measures to prevent mother-to-child transmission” and notes that “[u]se of ARV during pregnancy, safe birthing procedures, and the use of breast milk substitutes can all help to prevent mother-to-child transmission.” Section 2.2.5 of the strategy (Care, Treatment, and Support of PLHIV) also notes that “the infrastructure for health services, voluntary counseling and testing [and] prevention of mother-to-child transmission of HIV” should be strengthened.

Recently, the CDC charged the Ministry of Health’s Department of Maternal and Child Health with the direct management of the national roll out of prevention of mother-to-child transmission (PMTCT) services. The National Guidelines on PMTCT were finalized and printed in August 2006, and include a policy statement on PMTCT, the strategy, and technical guidelines. The training modules for staff have also been developed. A five-year strategic plan for reproductive health, which may provide an additional opportunity for addressing PMTCT issues, is under development as well.

## **COUNSELING AND TESTING**

The national strategy states that “NGOs and community-based organizations (CBOs) play a key role in HIV/AIDS prevention in Indonesia by reaching people and groups with specific needs—youth, faith-based groups, women, professionals, and PLHIV—that are often not easily reached by the government. Their activities include outreach, training, mentoring for PLHIV, giving support, and counseling and testing. NGOs and CBOs also play a part in motivating PLHIV to establish self-help groups to provide mutual support and enable them to become more involved in HIV/AIDS prevention.” In addition, the strategy identifies the Ministry of Social Welfare as “responsible for counseling” though not specifically voluntary counseling and testing (VCT) (Annex 1 of the national strategy). And, as above under PMTCT, the strategy urges the development of infrastructure to provide VCT in the national health services.

A VCT training package was published by the Indonesian CDC and is supposed to be implemented nationally. Master trainers have been trained with funding from Round 1 of funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, guidelines for key populations, training of

counselors, operationalizing VCT services, and promoting a positive environment through the mass media and social mobilization efforts still need to be developed.

## CARE, TREATMENT, AND SUPPORT

### Treatment

The strategy suggests that high quality care, treatment, and support be made available for PLHIV (Section 2.2.3), but mentions ARVs only in the context of PMTCT. ARVs were first made available in Indonesia in 1996 following the International AIDS Conference in Vancouver, Canada, through a “Special Study Group on HIV/AIDS” located at the national referral hospital in Jakarta. In 1997, the use of ARVs was approved by the Indonesia Food and Drug Administration (under the Ministry of Health) and, by 2000, Indonesia started to import generic ARVs from India. In March 2003, a local pharmaceutical company started to assemble first-line ARV drugs locally (e.g., base substances are imported and put together into tablets in Indonesia), and the government subsidizes treatment by 50 percent to PLHIV who need treatment. Second-line ARV drugs continue to be imported into Indonesia.

In 2003, a comprehensive national guideline for care, support, and treatment (CST) services was developed in response to the Declaration of Commitment from UNGASS 2001. The government considered CST and ARVs as key program interventions to control HIV transmission among the most at-risk groups. In order to improve access to ARV treatment and in response to the World Health Organization (WHO) “3 by 5 Initiative,” in July 2004, the Ministry of Health designated 25 hospitals as ARV treatment sites. PLHIV can access ARV treatment free of charge at these hospitals. People living with HIV and tuberculosis (TB) can also free TB treatment. Poor PLHIV can apply for free treatment, but to do so they must apply for a card stating their poverty status, and this is only available to residents of the province (employment provides proof of residency). To scale up access, the Ministry of Health is planning to increase by 50 the number of hospitals designated as ARV treatment sites.

A national guideline for ARV treatment was published in December 2004. This guideline provides standard clinical protocol for ARV treatment. Release of this guideline was followed by the guidelines for monitoring clients on ARV treatment (March 2005) and guidelines for laboratory diagnosis for HIV-related opportunistic infections (OIs).

### Palliative Care

The strategy states that the need to expand care and support services for PLHIV and to ensure protection of their basic human rights (to prevent, reduce, and eliminate stigma and discrimination) is an essential commitment on behalf of the government. Care, treatment, and support for PLHIV are encouraged through a clinical approach and through community- and home-based care, as well as by supporting the establishment of PLHIV support groups.

The guideline for palliative care is a part of the comprehensive national guideline for CST services (2003). The guideline covers criteria for palliative care and standard protocol for case management of terminally-ill patients that includes treatment for pain relief, and counseling for the patient and their family member in preparation for death of the patient. The Directorate of Medical Services within the Ministry of Health, with technical assistance from the Indonesia HIV/AIDS Prevention and Care Project (IHPCP)/AusAID, is currently drafting a national guideline for palliative care for AIDS patients.

NGOs and CBOs are mentioned in the strategy as playing a key role in the HIV response in Indonesia by reaching people and groups with specific needs—youth, faith-based groups, women, professionals, and PLHIV, for example—that are often not easily reached by the government. Their activities include outreach, training, mentoring for PLHIV, giving support, and counseling. NGOs and CBOs also play a part in motivating PLHIV to establish self-help groups to provide mutual support and enable them to become more involved in HIV prevention.

Neither the strategy nor the policy makes any reference to TB treatment, except under Section 2.2.6. which seeks to “improve PLHIV access to a high quality of healthcare, including pricing that is more affordable, high quality antiretroviral drugs, and medications to treat opportunistic infections.”

Operations research is a priority area in the strategy and Section 4.2.2. on clinical management studies mentions that “studies on the benefits and safety of new treatments and clinical strategies, and on resistance to the drugs used to treat AIDS, STIs, and opportunistic infections” should be conducted.

## ORPHANS AND VULNERABLE CHILDREN

There are no references to orphans and vulnerable children in the strategy document.

## LABORATORIES

The strategy recognizes that for “proper HIV, AIDS, and STI surveillance, good laboratories are needed in sufficient number in each region, supported by a network of diagnostic laboratories and referral laboratories. This calls for a standardized surveillance system with national coordination and direction from the Ministry of Health” (Section 3 on HIV/AIDS and STI Surveillance). One of the goals articulated under Section 3.2.5. is to “upgrade laboratories to support HIV, AIDS and STI surveillance as well as for diagnostic purposes, and develop a network of referral laboratories.”

Laboratories have a critical role in HIV/AIDS-related treatment and care, and quality-assured laboratory support is mandatory not only in the diagnosis of HIV and associated conditions, but also in monitoring the progress of ARV treatment, patient adherence, and quality of care. In 2005, the Ministry of Health issued the Standard Operating Procedures for Laboratory Providing HIV Tests. This guideline—which is adopted from the WHO standard—outlines the procedure to conduct laboratory testing for HIV and the combination of HIV and other OIs (e.g., viral, fungi, bacterial). Following this, the government published a technical guideline for the Rapid Test, which gives further details on the requirement for providing rapid tests. The guidelines regulate and set standards for reagents, such as registration, sensitivity, and specificity of each reagent according to WHO Strategy-3. It also explains the standard for providing VCT. To enhance laboratory capacity through public-private partnerships and collaboration and to have clear communication among local and private hospitals and laboratories, the Ministry of Health recommended that: 1) counseling should be done prior to an HIV test; 2) ARV and diagnostic reagents should be available at each site; 3) hospitals with CD4 capacity will be referral sites at the district level; 4) all provincial laboratories should facilitate referral services for testing and OI treatment; and 5) each service site must have a coordination team for HIV services.

## OTHER: POLICY ANALYSIS AND SYSTEMS STRENGTHENING

Policies and systems to address stigma, discrimination, and human rights violations and gender inequality are essential for effective HIV programs. Indonesia's Constitution (as amended August 2002) sets out broad guarantees to protect citizens' rights as well as the responsibilities of the state in safeguarding citizens' rights. Constitutional guarantees include:

- Equal status before the law and in government and the right to work and to live in human dignity (Article 27).
- The right to develop themselves to fulfill basic needs, the right to education and to obtain benefit from science and technology, art and culture, in order to improve the quality of their life and the welfare of the human race.
- Equal treatment before the law (Article 28I).
- To be free from discriminatory treatment on any grounds and the right to obtain protection from such discriminatory treatment.

Further, the protection of basic human rights is the responsibility of the government and is to be regulated and provided for in regulations and legislation (Article 28J).

**Stigma and Discrimination.** The National HIV/AIDS Strategy recognizes that stigma, discrimination, and human rights violations are common and that many aspects of HIV prevention are not adequately supported by legislation. The strategy explicitly endorses a supportive environment for the reduction of stigma, discrimination, and human rights violations and states that the removal of such impediments to HIV prevention efforts is urgently needed. Suggested activities are:

### *5.1. Goal*

*To pass legislation that will create an environment that fully supports the implementation of HIV/AIDS prevention.*

### *5.2. Activities*

*The activities that can be carried out to achieve this goal are as follows:*

#### *5.2.1. Study and drafting of legal instruments*

*To make a study of the existing legislation and to draft new laws and regulations needed to support HIV/AIDS prevention.*

#### *5.2.2. Advocacy*

*Advocacy to the Government and the House of Representatives to pass legislation to create an enabling environment in order to eradicate the stigma, discrimination and human rights violations that occur in the provision of service to PLHIV and their families, as well as regulations to support specific prevention programs such as 100% condom use and harm reduction.*

#### *5.2.3. Improve civil service capacity*

*Build capacity among officials at each administrative level of government to eliminate discriminatory practices and attitudes, as well as violations of human rights, in the provision of services to PLHIV and their families.*

#### *5.2.4. Conduct outreach activities*

*Conduct outreach activities to the community to break down stigma and to eliminate discrimination and human rights violations against PLHIV and their families.*

The Indonesian Forum of Parliamentarians on Population and Development (IFPPD), in collaboration with AusAID/IHPCP and USAID/Family Health International/Aksi Stop AIDS, initiated a series of advocacy workshops/meetings targeting new parliament members to address stigmatization and discrimination and to raise their awareness of HIV issues. A legal review was conducted on all laws and regulations related to HIV, especially Law No. 4/1984 on Epidemic/Infectious Diseases Outbreak, Law No. 23/1992 on Health, Law No. 5/1997 on Psychotropic Drugs, and Law No. 22/1997 on Narcotics. The review found that, with the rapid spread of HIV, laws are no longer sufficient to address the current situation. For example, Law No. 4/1984 on Epidemic/Infectious Diseases Outbreak focuses more on outbreak and quarantine; it does not cover HIV as a non-outbreak infectious disease. This law has been reviewed and will be amended into the Law on Prevention of Infectious Diseases (Draft Law 14 March 2005), which will cover a broader type of infectious disease including HIV. Law No. 23/1992 on Health is also in the final draft for amendment; in this draft, HIV is covered under the clause on infectious disease and reproductive health. In the proposed revised bills on health and epidemics, HIV prevention, care, and treatment have been given special attention, as well as reducing stigmatization and discrimination against PLHIV and most at-risk populations. Law No. 22/1997 on Narcotics only covers supply reduction and demand reduction, but not HIV prevention among IDUs. This law is under review to be amended and combined with the Law No. 5/1997 on Psychotropic Drugs. The new law will provide the legal basis for HIV prevention programs for IDUs. These bills are now in the final process of approval by the executive body/president and are on the priority legal reform agenda for 2006–2009.

Recognizing that discrimination is one of the major barriers to effectively curbing the spread of HIV and the fact that PLHIV still suffer from discrimination in employment, schooling, and medical assistance, the Minister of Manpower and Transmigration passed a ministerial decree (April 28, 2004) on prevention of HIV in the workplace. The decree was drafted through an extensive consultation with the tripartite forum (the Government of Indonesia, employers, and labor unions) and with support from the International Labor Organization. The decree calls for employers to design HIV prevention programs for the workplace, to ensure equal rights for HIV-positive workers to health services, and to prevent stigma and discrimination against HIV-positive workers. All government institutions, employer associations, and worker organizations should abide by this decree, which has an accompanying operational guideline. In 2005, the ministry rolled out an extensive nationwide HIV/AIDS Workplace Prevention Program with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The impact of the program has yet to be evaluated.

The effort and commitment to eliminate discrimination is further strengthened with a Tripartite Declaration Commitment to Combat HIV/AIDS in the World of Work, which was signed in February 2003 by the Government of Indonesia, Coordinating Minister for People's Welfare, Minister of Manpower and Transmigration, Indonesia Chamber of Commerce, Indonesia Employers Association, and Workers Organization.

**Gender Issues.** With reference to gender, the Ministry of Health published a Guideline for Gender-Sensitive Health Services directed to all service providers at the primary care level. These self-instructed guidelines are intended to improve service providers' knowledge about gender so as to enable them to plan gender-responsive programs and to provide gender-sensitive health services. Although the guidelines were not designed explicitly for gender related to HIV, it has shown the level of commitment from the government to address this important issue.

## V. CONCLUSION

This audit provides an overview of key aspects of Indonesia's National HIV/AIDS Strategy. Indonesia's HIV-related policy environment provides program implementers with both opportunities and challenges. To begin with, the central government is committed to mounting a national response to curb the spread of HIV. The national strategy includes several components of a comprehensive response to the HIV epidemic, including prevention activities for most at-risk groups, provision of care and treatment, reduction of stigma and discrimination, and commitment to strengthen laboratories for diagnostics, surveillance, and treatment monitoring. The government is also in the process of revising various laws and regulations to better respond to the HIV epidemic, such as the Law on Prevention of Infectious Diseases, Law on Health, and Law on Psychotropic Drugs.

In conducting the audit of Indonesia's national strategy, three challenges to effective HIV policy implementation became evident:

- **Implementation.** Inclusion of goals and activities in a policy or strategy do not necessarily translate into programs at the provincial, district, or local level. Strategy implementation must first be supported by decrees and guidelines from the relevant government ministry, department, or agency. In some cases, components of Indonesia's national strategy are supported by accompanying guidelines and decrees, such as the CST guidelines, ARV guidelines, and standard operating procedures for laboratories. But, even when such guidelines exist, effective implementation requires dissemination of the guidelines, training on their use, adequate resources for implementation, and monitoring.
- **Decentralization.** Decentralization efforts are affecting a range of government services as provincial, district, and local governments have become responsible for service provision. Previous mechanisms for funding and implementing health strategies, such as requiring the adoption of central ministry decrees, are not feasible given the new situation. Local ownership, authority, and capacity must be supported through the appropriate policy reforms. There is also a need to initiate a discussion for review of laws (*Undang-undang*) that will be the basis for central government regulation (*Peraturan Pemerintah*) and local government regulation (*Perda*) for a comprehensive HIV program response at both the central and local levels.
- **Inconsistent guidelines and policy directives.** There is a need for a crosscutting analysis of all sectors to ensure that the regulations and priorities of different sectors are aligned with the country's HIV prevention, treatment, and care goals. Regulations devised through one legislative instrument or ministry pertaining to most at-risk populations, for example, may hinder the health sector's ability to prevent HIV transmission among these groups. Other key government sectors need to closely coordinate with the health sector for an effective national response to HIV.

Furthermore, as with other areas of the health sector, the government at all levels has limited capacity to design, disseminate, and implement new or revised laws, regulations, policies, and guidelines related to HIV prevention, treatment, and care and support. More effort must be made to strengthen the capacity of public and civil society sectors in advocacy to foster innovative policymaking and policy implementation. Political leadership is crucial to mounting an adequate national HIV response. With better understanding of HIV and its implications on national development and security, parliamentarians at provincial and district levels will be better able to make informed decisions regarding budget allocation and formulation of regulations/laws.

Health Policy Initiative, Task Order I  
Constella Futures  
One Thomas Circle, NW, Suite 200  
Washington, DC 20005 USA  
Tel: (202) 775-9680  
Fax: (202) 775-9694  
Email: [policyinfo@healthpolicyinitiative.com](mailto:policyinfo@healthpolicyinitiative.com)  
<http://ghiqc.usaid.gov>  
<http://www.healthpolicyinitiative.com>