

**PROVIDER-INITIATED TESTING & COUNSELLING  
(PITC): SCALING UP HIV COUNSELLING AND TESTING  
IN INDONESIA**

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Provider-Initiated Testing and Counselling (PITC): Scaling up HIV counselling and testing in Indonesia

A thesis submitted in partial fulfilment of the requirement for the degree of  
Master of Public Health

by

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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis PITC: Scaling up HIV counselling and testing in Indonesia is my own work.

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## Table of Content

<b>List of Tables and Figures .....</b>	<b>iii</b>
<b>Acknowledgement .....</b>	<b>ii</b>
<b>Abstract.....</b>	<b>iii</b>
<b>Abbreviation and Acronyms.....</b>	<b>iv</b>
<b>Introduction .....</b>	<b>v</b>
<b>Chapter 1. Background information in Indonesia .....</b>	<b>1</b>
<b>1.1 Indonesia .....</b>	<b>1</b>
1.1.1 Geography and administration .....	1
1.1.2 Demography.....	1
1.1.3 Economic Situation .....	2
1.1.4 Political Situation.....	2
<b>1.2 Indonesia Health System.....</b>	<b>2</b>
1.2.1 Health System Structure.....	2
1.2.2 Health Policy and Financing .....	3
<b>1.3 Current HIV Situation in Indonesia.....</b>	<b>3</b>
<b>Chapter 2. Problem Statement, Objectives and Methodology .....</b>	<b>6</b>
<b>2.1 Problem Statement.....</b>	<b>6</b>
<b>2.2 Study Questions .....</b>	<b>8</b>
<b>2.3 Thesis Objectives.....</b>	<b>8</b>
2.3.1 General Objective .....	8
2.3.2 Specific Objectives.....	8
<b>2.4 Methodology .....</b>	<b>8</b>
2.4.1 Study Design.....	8
2.4.2 Study Methods.....	9
<b>2.5 Search Strategy .....</b>	<b>9</b>
<b>2.6 Study Limitations.....</b>	<b>9</b>
2.6.1 Limitation of study methodology .....	9
2.6.2 Limitation on data .....	9
<b>Chapter 3. HIV Counselling and Testing (HCT): Theoretical Background .....</b>	<b>10</b>
<b>3.1 HIV Counselling and Testing.....</b>	<b>10</b>
3.1.1 Importance of HCT .....	10
3.1.2 The 'Three Cs': Consent, Counselling, Confidentiality.....	10
<b>3.2 HIV Counselling and Testing Models.....</b>	<b>12</b>
3.2.1 Client Initiated Counselling and Testing.....	12
3.2.2 Provider Initiated Counselling and Testing .....	14
3.2.3 Mandatory HIV Testing .....	15
3.2.4 Diagnostic Testing.....	15
<b>Chapter 4. Situation Analysis of HIV Counselling and Testing in Indonesia .....</b>	<b>17</b>
<b>4.1 HIV Strategy/ Policy in Indonesia .....</b>	<b>17</b>
<b>4.2 HIV Counselling and Testing in Indonesia .....</b>	<b>18</b>
4.2.1 Client Initiated Counselling and Testing in Indonesia .....	18
4.2.2 Provider Initiated Testing and Counselling in Indonesia .....	19
4.2.3 Mandatory Testing in Indonesia .....	20

4.2.4 Diagnostic Testing in Indonesia.....	20
<b>4.3 Most at Risk Population (MARP) .....</b>	<b>20</b>
4.3.1 Sex Workers .....	21
4.3.2 Sex Workers' Clients .....	21
4.3.3 Injection Drug Users (IDUs) .....	22
4.3.4 MSM .....	23
<b>Chapter 5. Considerations around PITC model.....</b>	<b>25</b>
<b>5.1 Determinants of VCT Low Uptake .....</b>	<b>25</b>
5.1.1 Accessibility .....	25
5.1.2 Stigma and Discrimination .....	26
5.1.3 Gender issues .....	27
<b>5.2 Recent Discussions on PITC.....</b>	<b>27</b>
5.2.1 Universal Access .....	27
5.2.2 Informed Consent .....	28
5.2.3 Confidentiality, Stigma & Discrimination .....	30
5.2.4 Counselling .....	31
<b>Chapter 6. Discussion .....</b>	<b>33</b>
<b>Chapter 7. Conclusion and Recommendation .....</b>	<b>35</b>
<b>7.1 Conclusion .....</b>	<b>35</b>
<b>7.2 Recommendations .....</b>	<b>36</b>
7.2.1 Implementing PITC model .....	36
7.2.2 Improving the Ongoing VCT models.....	37
<b>References .....</b>	<b>38</b>
<b>Annexes.....</b>	<b>44</b>

## List of Figures

### Figures

Figure 1. Map of Indonesia .....	1
Figure 2. Number of AIDS Cases in Indonesia in Last 10 Years up to June 30, 2009 .....	4
Figure 3. Sex Worker Mobility 2004/2005 .....	21
Figure 5. IDUs mobility 2004/2005 .....	23

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“God gives. God takes. God’s name be ever blessed (Job 1:21)”

## **Abstract**

**Background:** HIV counselling and testing (HCT) is an entry to know someone's HIV sero-status that will enable him/her to access prevention, care, support, and treatment. In order to reach universal access, HCT needs to be scaled up as client-initiated counselling and testing approach (VCT) uptake is below expectation. WHO recommended provider-initiated testing and counselling (PITC). For its implementation in Indonesian setting, some considerations need to be taken particularly around Three C's principles: consent, counselling, and confidentiality.

**Objectives:** This thesis would like to see if HCT scaling up could be done in Indonesia. It tries to describe HCT approaches and discuss on scaling up HCT, particularly the PITC approach that was recommended by WHO. This thesis aims to look at factors that need to be considered if PITC is implemented in the Indonesian context.

**Methodology:** Review of journal papers and reports was conducted. Literature was obtained from Pubmed database and KIT library as well. While Web based document was explored by using Google search engine. To complete the result of studies, my experiences during working in Sub Directorate AIDS & STI, Ministry of Health, Republic of Indonesia was used.

**Results:** Various models of HCT are conducted in Indonesia, according to its target groups. There have been discussions on the weakness and strength of PITC model worldwide. This discussion is divided between public health and human rights perspectives, around the Three C's principles.

**Conclusion & Recommendations:** PITC model could be adopted in Indonesia to complement VCT models that already exist. However, some requirements must be in position, which are access to prevention, care, support, and treatment; readiness of human resources in health facilities; and anti-discrimination law and human rights principle based on the Three C's.

**Keywords:** HIV, AIDS, HIV Counselling and Testing, VCT, PITC, HCT Scale Up, Indonesia.

**Word Count:** 13,301

## Abbreviation and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
BPS	<i>Badan Pusat Statistik/</i> Statistics Indonesia
CST	Care, Support and Treatment
EDC	Export Development Canada
GF-ATM	Global Fund- AIDS, TB, Malaria
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MARP	Most-at-risk Population
MoH	Ministry of Health, Republic of Indonesia ( <i>Departemen Kesehatan Republik Indonesia</i> )
MoL	Ministry of Labor
MPW	Ministry of Public Work
MSM	Male who have Sex with Male
NAC	National AIDS Commission ( <i>KPAN/ Komisi Penanggulangan AIDS Nasional</i> )
NEP	Needle Exchange Programme
NGO	Non Governmental Organization
NNB	National Narcotics Board ( <i>BNN/ Badan Narkotika Nasional</i> )
OI	Opportunistic Infection
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention Mother to Child Transmission
Puskesmas	<i>Pusat Kesehatan Masyarakat</i> (Community Based Health Center)
STI	Sexual Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TNI	<i>Tentara Nasional Indonesia</i> (Armed Forces of Indonesia)
TRIPS	Trade Related Aspect of Intellectual Property Rights
UN	United Nation
UNAIDS	United Nation Joint Program on AIDS
UNGASS	United Nation General Assembly Special Session on AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WTO	World Trade Organization



## **Introduction**

The Indonesian government has a plan to scale up HCT as part of the efforts to reach Universal Access. As the VCT continues, the government also includes PITC model in the HIV programme. In this moment, a national PITC guideline is on process to be formulated. However, there are debates taking place about PITC implementation. In relation to that, this thesis is looking on some considerations that need to be taken for PITC model implementation in the Indonesian context.

The author of this thesis works at Sub Directorate AIDS & STI, Ministry of Health, Republic of Indonesia as a staff programme at national level. She holds a psychology bachelor degree. Her interest in HIV/AIDS grows as she works in the field. From 2006, she has been involved in VCT and Harm reduction programmes.

This thesis is intended for the Ministry of Health, especially, but also could as a recommendation for health service provider, most-at-risk population, People Living with HIV (PLHIV), civil society, non governmental organization, and others who have interest in HIV counselling and testing. Overall, this thesis is going to be useful for the HIV programme in Indonesia.

This thesis consists of seven chapters. Chapter 1 includes information about Indonesia's geography and health system. Chapter 2 includes problem statement, objectives and methodology. Chapter 3 includes theoretical background on HCT. In Chapter 4, situation analysis of HCT in Indonesian is given. Chapter 5 consists of determinants of VCT low uptake recent discussion on PITC. Chapter 6 is the discussion and chapter 7 is conclusion and recommendation.

## Chapter 1. Background information in Indonesia

This chapter includes information about Indonesia in relation to its geography, administration, demography, economic, and political situation. Thereafter, Indonesia's health system is described, including the structure, policy and financing. At the end of this chapter, a general overview of the current situation on HIV situation in Indonesia is given.

### 1.1 Indonesia

#### 1.1.1 Geography and administration

As an archipelago country, Indonesia consists of around 17,508 islands (Country studies, 1993). There are five main islands, namely Sumatra, Java, Kalimantan, Sulawesi, and Papua. There are two big archipelagos, Nusa Tenggara and Maluku, and about sixty smaller archipelagos. The Indonesian archipelago is scattered on both sides of the Equator; it is astride or along major sea lanes from Indian Ocean to Pacific Ocean. Indonesia comprises 2,000 kilometres from North to South and 5,000 kilometres from East to West, with total area about five million square kilometres of land and water. Indonesia is divided into 33 provinces and 465 districts (370 municipalities and 95 cities) (MoH, 2007).

**Figure 1. Map of Indonesia**



**Source: Country Studies, 1993**

#### 1.1.2 Demography

Statistics Indonesia - the National statistic bureau - estimates total population of Indonesia is about 218 million (Statistics Indonesia, 2005). Number of the population aged 15-49 is 118 million, making up 55 % of the total population. Annual population growth rate is 1.1 % for the years 2005-2010.

The percentage of population living in rural area is higher than urban area, 56.9% and 43.1% respectively (Statistics Indonesia, 2005). However, statistics on population by municipality shows that almost half of the population live in Java Island. Jakarta, West Java, Yogyakarta and Banten are provinces with the highest density; all of them are located in Java Island. Java is the island where the capital city is located and is considered as the centre of economics.

### **1.1.3 Economic Situation**

Gross national income is estimated at 3,830 international dollars per capita (World Bank, 2009). Total expenditure on health per capita is estimated of 78 international dollars (UNAIDS, 2008). Number of person living below the poverty line in 2006 is about 34 million, around 15% of the total population (Statistics Indonesia, 2007).

### **1.1.4 Political Situation**

The political structure in Indonesia is a presidential government with multi-party cabinet. The president is elected for five-year terms, directly by the people. The president has an executive power. Therefore, he/she has the authority to administer the government. The president is assisted by a cabinet consists of line ministries to govern the departments (EDC, 2009).

## **1.2 Indonesia Health System**

### **1.2.1 Health System Structure**

Indonesia has a decentralized health system comprising of provinces, districts, and autonomous city government (WHO, 2007). Each sub district has one or more community health centres called Pusat Kesehatan Masyarakat (*Puskesmas*). *Puskesmas* is headed by a doctor and assisted by at least two nurses. Each *Puskesmas* has to implement 8 specific programmes. At village level, it provides prevention and promotion services. There are 8,234 *Puskesmas* providing basic health services and *Puskesmas'* ratio per 100.000 population is 3.65 (MoH, 2007). There are 1,033 general hospitals in Indonesia, provided by the government (56.34%) and private (43.66%).

Since the decentralization policy applied in 1999, the local government has its own authority. The referral system works from the lower level up to the highest level, from the health post until general hospital at the provincial level. The organizational structure of Indonesia health system can be seen in annex 1 (WHO, 2007).

Indonesian health care workers are not well distributed throughout the country (Country study, 1993). Most of them are only located in big cities. There are not enough doctors in rural area, about 13 doctors per 1000.000 people. This is one of the lowest ratios in Asia (World Bank,

2008). In order to alleviate this problem, the government required two to five years of public service by all medical school graduates, public and private. Physicians first have to complete this service if they want to continue for specialist training.

### **1.2.2 Health Policy and Financing**

The Ministry of Health, Republic of Indonesia (MoH) formulated a vision to reach "Healthy Indonesia 2010". The goals are:

- ◆ To initiate and lead national development with a health orientation
- ◆ To promote public self-reliance in achieving healthy life
- ◆ To maintain and enhance quality, accessible, and affordable health services
- ◆ To maintain and enhance individual, family, and public health along with improving the environment

The strategy for National Health Development is prioritizing on four pillars to be addressed:

- ◆ Initiating health-oriented national development
- ◆ Professionalism
- ◆ Community Managed Healthcare Programme (*Jaminan Pemeliharaan Kesehatan Masyarakat*)
- ◆ Decentralization (MoH, 2003)

In order to provide equity in access to health care and health service for all, the government has the responsibility to provide basic services, such as hospital, public health centres, and health posts that reach the rural areas. The financing systems in health sector comes from various sources: public, private, out-of-pocket by individual expenditure, insurance, and external funding (WHO, 2007b)

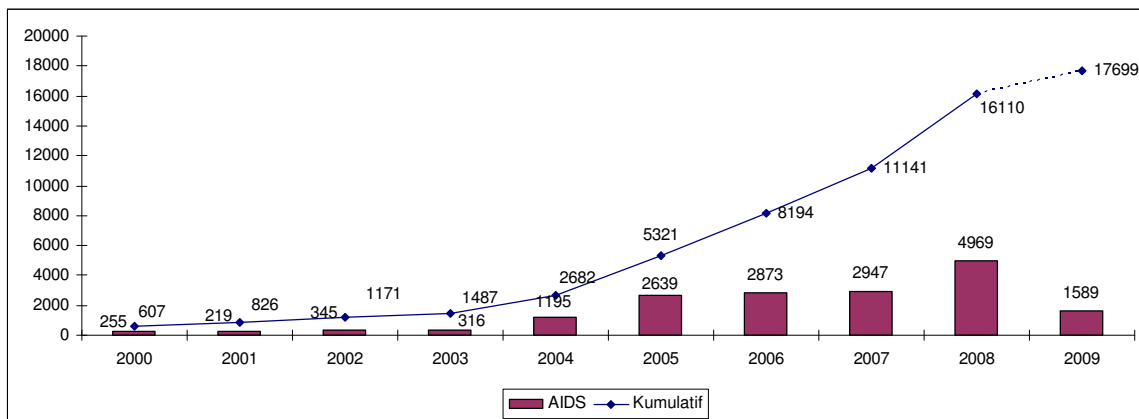
### **1.3 Current HIV Situation in Indonesia**

The first Acquired Immune Deficiency Syndrome (AIDS) case was reported in 1987 (MoH, 2009a). Since then, the number of HIV and AIDS cases reported is increasing. MoH quarterly report of June 2009 stated that there are 17,699 AIDS cumulative cases nationally. An estimation project in 2006 conducted by Statistics Indonesia and MoH showed that there are about 193,030 PLHIV in Indonesia (MoH, 2006).

Human Immunodeficiency Virus (HIV) infection largely occurs on Injecting Drug User (IDU) and clients of sex workers (MoH, 2006b). The transmissions mostly occur through the use of contaminated equipment and unprotected paid sex. This situation becomes more complex because many IDUs have multiple-risk behaviours. Besides unsafe injecting, they also engage in unprotected sex with steady partner and unprotected transactional sex. IDUs and clients of sex workers become a bridging population of HIV transmission to a lower risk population.

The HIV prevalence rate in general population is estimated about 0.16% (MoH, 2006). However, high prevalence is found in most-at-risk population (MARF), such as IDU (41%), partner of IDU (13%), transgender (13%), prisoner (5%), and sex worker (SW) (4%). By province, the highest rate is found in Papua, 2.4 %. It is 18 times higher than the national level (MoH, 2009a). In general it can be said that Indonesia has a concentrated HIV epidemic, while the Papua province could be considered to have a generalized HIV epidemic.

**Figure 2. Number of AIDS Cases in Indonesia in Last 10 Years up to June 30, 2009**



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

As the epidemic spread, the government felt that there was an urgent need to response HIV and AIDS. Thus, Presidential Regulation No. 75 of 2006 established a National AIDS Commission (NAC), called *Komisi Penanggulangan AIDS Nasional* (KPAN) to scale up HIV and AIDS response intensively and comprehensively, in a coordinative manner (NAC, 2008).

NAC's priority areas in response to HIV and AIDS for 2007-2010 are as follows:

1. HIV and AIDS prevention
2. Care, support and treatment to PLHIV
3. HIV and AIDS and IMS surveillance
4. Operational research
5. Enabling environment
6. Multi-stakeholders coordination and harmonization
7. Response sustainability (NAC, 2008)

The key targets in the national health sector plan for the year 2014 are:

1. Accelerate and expand comprehensive service programme.
2. Increase the number of health facilities providing STI, Methadone Therapy Programme, VCT, TB-HIV, ART, and Opportunistic Infection (OI)
3. Improve quality of supervision, technical assistance monitoring and evaluation by strengthening available leadership and system implementation coordination.
4. Strengthen consolidation and coordination in all levels of health sector structures.
5. Strengthen comprehensive programme and budget planning which are synergic in all levels.
6. Strengthen programme implementation flow which is synergic in each and across levels.
7. Strengthen integrated surveillance policy and mechanism.
8. Strengthen coordination across programmes and sectors.
9. Encourage healthy life style and low-risk HIV transmission perspective (MoH, 2009b).

In 2007 the MoH -in coordination with related stakeholders- conducted an external review of the health sector response to HIV and AIDS (WHO, 2007c). The review reported that Indonesia shows a strong commitment in response to HIV and AIDS on political and financial aspect. Despite of government's commitment to increase overall funding for HIV/AIDS response, the national AIDS programmes remain highly dependent on international donor funds. This condition raises concern about HIV and AIDS programmes' sustainability in Indonesia.

The same review also found that government's increased commitment resulted rapid increases in the number of VCT service sites and people tested, in the number of opiate users taking methadone substitution therapy, in the number of needle exchange programmes started and in the number of people with HIV taking antiretroviral medicines. Unfortunately, these positive increases were not followed with the improvement of number of services delivery sites and the quality of programmes. The review team opined that there is a need for commitment to translate policies into action (WHO, 2007c).

## **Chapter 2. Problem Statement, Objectives and Methodology**

This chapter describes the problem statement, objective and methodology of this thesis. It explains about the questions to be answered by this paper.

### **2.1 Problem Statement**

HIV is a global pandemic with 33 million people estimated infected by this virus all around the world. In 2001, nations gathered for United Nations General Assembly Special Session (UNGASS) on HIV and AIDS and agreed to respond to HIV in order to achieve Millennium Development Goal (MDG) 6. Indonesia was one of the countries that has signed the *Declaration of Commitment on HIV/AIDS*. Part of this commitment requires that prevention, care, support and treatment to be done comprehensively. This comprehensive effort should consider the country epidemiology (UNAIDS, 2008a).

MoH and Statistics Indonesia conducted a projection study in 2006 to look at how HIV infections will affect Indonesia's health system in the future. That study shows HIV cumulative infections—in absence of intervention- in Indonesia will reach 400,000 cases in 2010 with 100,000 deaths. By 2015 it will reach 1,000,000 cases and estimates that 350,000 people will die because of HIV related infections (MoH, 2006). Indonesia has to make significant efforts in response to HIV and AIDS in order to prevent this projection in becoming reality.

HIV prevention continues to be the core response to the HIV epidemic (UNAIDS/WHO, 2004). Without effective HIV prevention, the number of people who will require HIV treatment will always increase. HCT plays a key role both in treatment and in prevention. Access to HCT will enable people to know their HIV status. Knowing their status, people will be able to access effective treatment.

There are inconsistencies in the study findings on the efficacy of HCT to behaviour change (Weinhardt et al., 1999; Denison et al., 2007). People who do not know their HIV sero status are more likely to transmit HIV to others compare with those who know they are infected with HIV (Branson, 2007). Weinhardt et al. (1999) found that lower risk behaviour are more likely to be found on those who got tested positive, especially in discordant couples, rather than those who were tested negative or untested. A meta-analysis conducted by Denison et al. (2007) support VCT as an effective prevention strategy on increasing protected sex. These findings show HCT is more effective for secondary prevention than for primary prevention.

There are different models of HCT implementation, but client initiated counselling and testing – known as VCT - are use widely for over 20 years

since it was developed in the mid-80s. However, the current reach of HIV testing services remains poor. Globally, there are only around 10 per cent of those who need voluntary counselling and testing (VCT) have access to it in low and middle income countries (UNAIDS/WHO, 2004). It means that much larger number of people do not know their HIV status. Because of the coverage of client-initiated counselling and testing services is under expectation, WHO and UNAIDS issued a draft operational recommendation in 2006 for an approach to HIV testing. The approach is known as provider-initiated testing and counselling (PITC). It was design to redress the big gap between number of people who are infected and number of people who know their HIV status (Bass, 2006).

HCT coverage and usage in Indonesia is low (MoH, 2009). In order to scale up HCT in Indonesia, the government of Indonesia is in the process of adapting PITC approach that was recommended by WHO. The idea is to reduce missed opportunities to identify HIV positive persons from patients looking for treatment in the health services by the health care provider, such as in tuberculosis (TB) and STI clinics.

PITC model has the ability to pick up possible HIV infected patients who come to health services (Ivers et al., 2007). As mentioned before, those who are diagnosed will have the opportunity to get other HIV related services, including treatment when necessary. Several studies show that the success of treatment is related with early start on ART (Egger et al, 2002; ART-LINC & ART-CC, 2006; ART-CC, 2008). PLHIVs who received early treatment which initiated before advanced immune dysfunction can lead to longer and healthier years of life. A mathematical model shows that HIV elimination could be feasible if the universal voluntary and testing is conducted once a year of all people older than 15, followed with immediate initiation of ART (Granich et al., 2009). The challenge is the ART provision for the whole PLHIV population in long term, with the possibility of high toxicity and HIV drug resistances (Gilks et al., 2006)

In the guidance on PITC, WHO suggests an opt-out approach to be implemented in health facilities (WHO/UNAIDS, 2007). HIV testing is given to all patients who attend health facilities as a standard part of medical care. For low-level epidemic settings, as in Indonesia, this approach is modified. HIV testing will not be given to all patients, but selectively to adults, adolescents, and children who show signs and symptoms of HIV infection. They, however, could decline the HIV test if they do not want it to be performed. Voluntary testing becomes an issue for an opt-out approach because patients are automatically given HIV testing unless they decline it directly. In health care based setting, voluntary testing may not be really taking place due to various reasons, such as the power relation between patients and health professionals, insufficient information about HIV and AIDS, or the absence of knowledge



about patients' rights to opt-out. In this case, violation of human rights might happen.

There are other VCT models that can be taken into consideration to scale up HCT including home based care, mobile/ community outreach, or free-standing services. These models will be elaborated further in chapter 3. They should be taken into account because of their capacity to make HIV services closer to the community.

To develop an appropriate model for Indonesia, it is necessary to see if PITC is the right model in Indonesia's situation. As a concentrated epidemic country, Indonesian target groups for HIV prevention programme are most-at-risk populations (MARPs). The epidemiology and social context of HIV in Indonesia are important to be taken into consideration.

## **2.2 Study Questions**

How to scale up HIV counselling and testing in Indonesia?

1. What are the HCT models that have been done in response to HIV/AIDS in Indonesia?
2. What are the pros and cons around PITC implementation to scale up HCT from the global perspective?
3. Is the proposed model by Indonesian government (PITC) suitable for Indonesian context?

## **2.3 Thesis Objectives**

### **2.3.1 General Objective**

To explore various HCT models that already exist and to identify and to discuss critical issues to be considered while scaling up using the PITC model in Indonesia, in order to give recommendations to the government for the HIV programme.

### **2.3.2 Specific Objectives**

- ◆ To describe current HCT in Indonesia.
- ◆ To discuss considerations on PITC model implementation.
- ◆ To use the findings to provide recommendations for scaling up HIV counselling and testing in Indonesia.

## **2.4 Methodology**

### **2.4.1 Study Design**

This thesis is a descriptive literature study.

### **2.4.2 Study Methods**

The following study methods are used in this thesis:

The thesis is mainly based on literature review. The KIT library and VU proxy library used to search the published literature review on the topic. A short questionnaire is also used to gather basic information about PITC implementation in Indonesia as there was no written report available yet.

### **2.5 Search Strategy**

The literature search for this thesis used keywords, including HIV, AIDS, VCT, HCT scale up, PITC, Indonesia, and some combination among these key words. Some search was done through the reference of articles identified in the first search trial. Most of the literature was found through website and search engines, namely MoH Indonesia, National Aids Commission, Statistics Indonesia (BPS), UNAIDS, WHO, Pubmed, Cochrane Library, KIT Library, Science Direct, and Google. This paper also used some unpublished reports from the author's organization, Ministry of Health, Republic of Indonesia. Additionally, the author's personal experiences on supervision and monitoring during the working period in MoH have also been used.

### **2.6 Study Limitations**

#### **2.6.1 Limitation of study methodology**

This study used secondary data that were collected by other studies. Therefore, the validity of those data could not be checked. Although a lot of publication were found about HCT, but very few published paper were available on HIV counselling and testing in Indonesia. Some of the literature found to be useful was both online and as hardcopy inaccessible, although it was available in form of summary. Written report on PITC implementation in Indonesia were not available. In order to have an initial data, the author had to collect information by using a short questionnaire.

#### **2.6.2 Limitation on data**

Poor data recording system in home country may affects the data quality presented in this paper. Having working in the MoH, the author experienced the difficulties of gathering data at central level. Decentralization has made compilation, validation, analysis, report generation and utilization of available data at all levels become challenging. For example, it is difficult to know how many people were already tested and counselled in VCT sites. This problem may occur because VCT sites are run by different organizations and not all of them reports routinely to the national level. Data are scattered in different institutions and not compiled at national level.

## **Chapter 3. HIV Counselling and Testing (HCT): Theoretical Background**

In this chapter, a theoretical background on HCT will be described in order to give basic understanding about the importance of HCT, the Three C's principles, and various HCT models that have been implemented as part of HIV prevention programmes. Its implementation in Indonesia will be detailed in the next chapter of this paper.

### **3.1 HIV Counselling and Testing**

#### **3.1.1 Importance of HCT**

HIV test is carried out to know whether HIV is present in the body (UNAIDS, 2008b). Most of HIV tests usually use to detect the antibodies produced by immune system in response to HIV infection, not the virus itself because it is much easier and cheaper to detect antibodies. Knowing HIV status is crucial because it is the entry point to access prevention, care, support and treatment.

HIV testing is ideally accompanied by counselling which is aimed to give sufficient information to evaluate the risk behaviour of the person who is going to take an HIV test. Knowing their personal risk will help them decide whether or not to take HIV test, and also to take precaution efforts related to HIV infection in future time. Besides that, counselling provides support when they receive their test result (UNAIDS, 2000). As mention previously, there are inconclusive research findings in regards to HCT effectiveness to change behaviour (Weinhardt et al., 1999; Denison et al., 2007; Branson 2007).

As we go on through this chapter, we will encounter different approaches to HIV testing. UNAIDS/WHO (2004) distinguished four types of HIV testing, namely Voluntary counselling and testing (VCT); Diagnostic HIV testing; Routine offer of HIV testing by health care provider, which later on known as Provider initiated testing and counselling (PITC); and Mandatory HIV testing.

#### **3.1.2 The 'Three Cs': Consent, Counselling, Confidentiality**

Since the HIV test became available in 1985, the condition of the 'Three Cs' is advocated. These principles continue to be the foundation for conducting HIV testing of individuals (UNAIDS/WHO, 2004).

##### **a. Consent**

Consent is the permission given by an individual undergoing any kind of intervention (such as an HIV test) after they have received complete information about the intervention. Informed consent protects the person's freedom of choice and respects their autonomy. It gives individual a chance to make decisions about their body and health (Alliance, 2006). Before taking an HIV test, the client must give informed

consent to ensure that clients fully understand about the undergoing process and its implication. Health care providers should provide certain pre-test information to that person and give the opportunity for questions to be answered. This process is ideally given individually, in private and in the presence of health care provider (UNAIDS, 2008b).

### **b. Counselling**

UNAIDS (2002) define HIV counselling as “a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decision related to HIV/AIDS. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour”. There are two parts of counselling: pre-test and post-test counselling. Pre-test counselling is the dialogue client has with the counsellor before he/she takes an HIV test. Post-test counselling takes place after receiving the HIV test result. Both of them are necessary to be taken as part of HIV diagnosis with its own objectives to complete (Alliance, 2006).

Pre- and post-test counselling could benefits those who want to take HIV test, regardless of their test results. Counselling assists those with negative test results to stay negative, and those who are positive to minimize HIV impact on their own and other’s lives (Meursing and Sibindi, 2000; Banteganya et al., 2008). Counselling also helps clients and their families to find ways of coping with HIV, such as emotional support and referral services. Through counselling session, counsellor would be able to identify and assist clients in need for crisis intervention. Looking at these benefits, pre- and post-test counselling should be considered as a necessary minimum service (Meursing and Sibindi, 2000).

Pre-test counselling was a core component of the original voluntary counselling and testing. It was designed to help clients to assess personal risks and to identify practical strategies to deal with their test results. Counselling and testing is looked as both primary and secondary prevention strategy to reduce risk of HIV exposure and onward transmissions. However, in many settings individualized pre-test counselling is replaced by pre-test group information (UNAIDS, 2008b).

### **c. Confidentiality**

“Confidentiality refers to the ethical and/or legal duty of the health care provider not to disclose to anyone else, without authorization, information that was given to, or obtain by, the health care provider in context of their relationship with the client” (Alliance, 2006). There are different types of testing available related to confidentiality (UNAIDS, 2008b):

- i. Confidential HIV test: Health professionals conducting the HIV test keep the test result confidential within the medical records. Without written permissions by the person tested, result cannot be shared with another individual.

- ii. Anonymous HIV test: A code or number is assigned to the test to replace the tested person's name. It allows the person tested to receive the results of the test, but no records are kept that would link the person to the test.

Shared confidentiality is encouraged (UNAIDS, 2008b). It refers to confidentiality that is shared with significant others that may include family members, loved ones, caregivers, and trusted friends. People who did not seek for HIV services are afraid of stigma and discrimination that might come from families and communities (UNAIDS, 2000). That is why revealing the test result must be done carefully. Stigma and discrimination can also occur in healthcare, professional and social settings. Although the HIV test result should be kept confidential, other health professionals might need to be aware of the person's HIV-positive status in order to give appropriate care. Those health professionals include counsellor and health and social services worker. The decision to have shared confidentiality should be left to the client's hand.

## **3.2 HIV Counselling and Testing Models**

### **3.2.1 Client-Initiated Counselling and Testing**

Client-Initiated Counselling and Testing is known as VCT. UNAIDS (2002) defines VCT as "the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV". VCT typically consists of a pre-test counselling session with a trained counsellor on basic HIV information and evaluation on personal risk, followed by an HIV antibody test, and a post-test session where the test result is given and clients are counselled on their risk behaviours (Bateganya et al., 2008).

VCT is an essential component of HIV prevention and care strategies worldwide (Denison et al., 2008). There are two possible reasons that make VCT become the central of HIV prevention strategy; it is cost-effective relative to other preventions in the developing world and its possibility to reduce risk behaviour. As ART becomes more accessible and available, VCT also becomes an important tool to connect people to care (Morin, et al., 2006). However, providing VCT in resource-constrained settings may strain the already weak health infrastructures (Denison et al., 2008).

VCT is believed to motivate people to change their behaviours to prevent the transmission of the virus. A meta-analysis shows that VCT has an effect on increasing protected sex (Denison et al., 2008). However, there are inconsistent findings on this matter. Another study showed that reduce risk behaviour are found in those who are tested positive – especially if they are sero-discordant couples- but not in those who are tested negative or untested (Weinhardt et al., 1999).

VCT is the standard type for HIV testing, but it relies mostly on individuals' initiative to look for HIV testing and to give voluntary informed consent. There are several models of VCT deliveries (WHO, 2002; Bateganya et al., 2008), as mention below:

**a. VCT Centres**

These usually are stand-alone services, which are not associated with existing medical institution. They are mainly provided by NGOs. These centres are more common in high prevalence setting and placed in very visible and accessible to the communities (Alliance, 2006).

**b. Free-Standing Services**

This programme offers VCT services away from health services, but they can refer their clients to care and support services. The advantages of free-standing services are having dedicated staff, flexible operation hours, and strong community links. However, staff burnout may limit available services and stigma may limit attendance (Bateganya et al., 2008).

**c. Integrated VCT**

These VCT service is integrated into existing healthcare setting, such as STI clinics, TB clinics, family planning and mother and child health (MCH) services. The advantages of this model are easy cross-referrals and less operational cost. But, they may not draw specific groups who seldom go to health facilities, such as young people and men. Another disadvantage of this model is the staff may not be committed to the VCT program, because they have other roles and responsibilities within the healthcare site (double-task). (Bateganya et al., 2008)

**d. Mobile or Community Outreaches**

This programme is used for 'hard-to-reach populations'. Mobile VCT services are offered at the village and community level, such as marketplaces and transport venue (Precious, et al., 2008). It has the ability to remove structural barriers (fees, inconvenience, access and waiting for results), increase safety (anonymity, strict confidentiality, and high-quality of counselling), and can link to other services. However, it can be expensive as it requires many resources (equipment and man power). The challenges are to ensure follow-up after post-test counselling and to ensure quality at temporary sites while also dealing with clients who have other pressing health needs. (Alliance, 2006; Bateganya et al., 2008)

Providing mobile testing along with community outreach and support may significantly increase the proportion of people who know their HIV status and at the same time build greater HIV awareness in the community. The mobile unit also strongly welcomes participants who seek only information

or counselling, without HIV testing, to reduce stigma associated seeking services from mobile unit (Precious, et al., 2008).

#### **e. Home-based VCT (HB-VCT)**

This model offers VCT in people's homes. It involves lay counsellor or community health workers to provide counselling and testing. Pre-test counselling is usually given to the entire family. The consent is taken from eligible family members. This model tries to address the needs of the entire family at once. Discussion on prevention and behaviour change may be more effective in the context of family member and the home. The advantages of this VCT types are reduced stigma, cost-effective (if lay community counsellors are utilized), opportunity of couple counselling and easier disclosure especially for discordant couple. The disadvantages are time consuming and the difficulties of family disclosure. (Bateganya et al., 2008)

### **3.2.2 Provider Initiated Counselling and Testing**

In August 2006, WHO and UNAIDS issued a statement that they promoted PITC in health facilities. A few months later, in May 2007, they released a global guidance on PITC in health facilities (WHO, 2007). The PITC guidance has stated purpose of scaling up HCT to ensure "the timely detection of HIV, prevention of HIV prevention, treatment, care and support services" (WHO/UNAIDS, 2007; Gruskin, 2008). The challenge is to attain medical ethics, clinical, public health and human rights objectives altogether in PITC implementation.

The PITC guidance recommends that HIV counselling and testing should not be recommended to all persons attending all health facilities in concentrated epidemic setting because most people will have a low risk of HIV exposure (WHO/UNAIDS, 2007). Priority is given to adult, adolescents and children who come to health facilities with symptoms and signs suggestive of underlying HIV infection, including tuberculosis, children known to have been exposed to HIV vertical transmission. These health facilities or services should be considered to implement PITC:

- ◆ STI services
- ◆ Health services for most-at-risk populations
- ◆ Antenatal, childbirth and postpartum services
- ◆ Tuberculosis services

This is a rights-based approach because the service offers people who might benefit from knowing their status, even if they did not originally seek these services (Alliance, 2006). HIV test is offered as part of routine medical care, usually with other tests that are offered during the patient's clinical visit. Counselling is offered in terms of groups and more emphasis is put on post-test counselling. Patients who refuse the test are considered to have opt-out. This model has been implemented in many countries in PMTCT, TB, STI clinics, and medical wards.

In generalized epidemics, WHO/UNAIDS recommended PITC for all adults in health facilities irrespective of their reason for seeking service. In concentrated and low-level epidemics PITC is recommended to be delivered in antenatal, childbirth and postpartum services based upon assessment of epidemiological and social context (Gruskin, 2008).

### **3.2.3 Mandatory HIV Testing**

Mandatory HIV testing involves performing an HIV testing without getting consent from the individuals. It is employed to address HIV among specific populations, such as pregnant women, with the aim of preventing HIV transmission to their unborn children. It also used in medical circumstances in which a patient is unconscious, his/her parent or guardian is absent, or when the HIV status is necessary for optimal treatment. Mandatory testing has been used for sexual offender, prisoners, and military recruits (Bateganya et al., 2008).

UNAIDS/WHO recognise that many countries require HIV testing for immigration purposes on a mandatory basis. Some countries conduct mandatory testing for pre-recruitment and periodic medical assessment of military personnel to check their fitness. In this case, UNAIDS/WHO recommend that such testing must be accompanied by counselling for both HIV-positive and negative individuals. For those who receive a positive test result, referral to medical and psychosocial services must be available (UNAIDS/WHO, 2004).

Mandatory HIV testing for every couple before marriage becomes a debate in some countries, such as India and Malaysia. This type of testing is against the privacy and liberty of an individual. They are not able to make an informed decision of their own health and body. It is better to emphasize on awareness, education and empowerment and encourage voluntary counselling and testing (Lawyers Collective, 2009).

In their policy statement UNAIDS/WHO (2004) stated that "UNAIDS/WHO support mandatory screening for HIV and other blood borne viruses of all blood that is destined for transfusion or for manufacture of blood products. Mandatory screening of donors is required prior to all procedures involving transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts and organ transplant. UNAIDS/WHO do not support mandatory testing of individuals on public health grounds."

### **3.2.4 Diagnostic Testing**

PITC offers HIV testing as a routine part of services to patient with symptoms. HIV diagnostic testing prescribed HIV testing by health professionals along with other diagnostic tests to make diagnose for the patient in care when he/she is suspected to have HIV infection. Diagnostic HIV testing usually takes place when a person shows signs or symptoms that are consistent with HIV-related disease or AIDS. This act is needed to



help health professionals to make clinical diagnostic and management for the patient. This includes HIV testing for all tuberculosis patients as part of routine management (Batanganya, 2008).

In summary, HCT is an entrance point for HIV prevention and treatment. Scaling up HCT is necessary to ensure that people have opportunity to access HIV-related services that they need. There are different models of HCT to be considered for HCT scale up. Each of these models has different ways to reach the population, but the Three Cs is the basic principles of HCT that must be uphold.

## **Chapter 4. Situation Analysis of HIV Counselling and Testing in Indonesia**

In the previous chapter, theoretical information about HCT was given. This chapter is meant to give perspective on how HCT is practiced in Indonesia. In addition, the author elaborates description of MARPs in Indonesia and study findings on good practices for MARPs in developing countries. To date, very little research about HCT or PITC have been done and documented in Indonesia. For that reason, only few publications that may be applicable to Indonesian setting are reviewed here.

### **4.1 HIV Strategy/ Policy in Indonesia**

HIV prevalence and epidemic dynamics vary greatly across Indonesia with 11 provinces being most heavily burdened (MoH, 2009a). HIV transmission in Indonesia was initially related to sexual transmission, but transmission among Injecting Drug Users has increased eight-folds since 1998 (UNAIDS,2005). IDU represents most new HIV cases reported nationally, with concentrated HIV epidemics among female sex workers and their clients. Because of limitations in the national HIV/AIDS surveillance system, few cases are identified and reported to the national level.

HIV testing and counselling services implementation in Indonesia is based on the principles promoted by WHO. The MoH has standardized the national guidelines for HIV testing and counselling and the training modules. As per 2007, there are 290 VCT sites provide HIV counselling and testing services for the whole Indonesia population. HIV counselling services are included in services related to management and treatment of sexually transmitted infections. However, the number of sites is inadequate in relation to the size of the country, and stigmatization remains an obstacle to utilize them (WHO, 2007c).

The epidemics and responses in Asia and Pacific regions, including Indonesia, are characterized by (WHO, 2007d):

- ◆ It is driven by risk behaviours among most at risk population (MARPs)
- ◆ There are low level of HIV awareness among the population, particularly among MARPs and young people.
- ◆ Stigma and discrimination are spread widely in the community.
- ◆ HIV services have a limited coverage.

From July 2004, the Government committed to provide access to subsidized antiretroviral therapy (ART) for everyone needing the treatment, with the ultimate goal of ensuring universal access. Although ART is offered free of charge, there are other associated costs that are unaffordable (WHO, 2007c). Management of ARV faces some challenges as stock outs of ARV drugs are reported by provinces. To follow up

demands on second-line therapy, government is carefully providing this regimen and under strict supervision to make sure it is used appropriately. Until June 2009, MoH surveillance shows that there are 21,653 PLHIV on ARV treatment from 28,050 PLHIV eligible for ART (MoH, 2009a). About 77% PLHIV get treatment that they needed. It means that there are barriers for treatment in Indonesia.

## **4.2 HIV Counselling and Testing in Indonesia**

HCT in Indonesia is using various models that were mentioned in the earlier chapter. VCT, PITC, diagnostic testing and mandatory screening is taking place in Indonesia. Each approach will be discussed in more details in this sub chapter. However, major challenges in Indonesia context is that testing and counselling is offered to individuals with symptom, resulting in late diagnosis of HIV disease and delayed treatment as they already in advance stages (WHO, 2007c).

HCT services are provided mostly by the government and NGOs. There is involvement by civil society and the private sector. HCT provided by the government is usually placed in the existing services, such as hospitals, *puskesmas*, and prisons. Numerous NGOs have been working in the HIV response, mainly in prevention programme by reaching people and groups with specific needs, such as youth, faith-based groups, women, professionals, high-risk groups and PLHIV that are hard to reach by the government. They conduct outreach, training, mentoring for PLHIV, support, and counselling. However, coordination is weak and varies significantly across institutions.

There is limited participation from civil society and private sector for the AIDS response. Large local NGOs are often involved in the NAC and the various working groups at central and provincial level meetings. Even though limited, the involvement of the private sector in the response to HIV in Indonesia is growing. Companies usually give donations for World AIDS Day and to smaller implementing agencies in their own companies or geographical areas. The private sector involvement has significantly increased through workplace programmes for HIV prevention.

The external review team noted that referral networks are well established between testing and counselling services and TB, STI and antenatal clinics and linkage to ART programmes and ongoing support by counsellors and case managers. But, referral mechanisms between health centres, district hospitals and provincial hospitals are not well established (WHO, 2007c).

### **4.2.1 Client Initiated Counselling and Testing in Indonesia**

The implementation of VCT services is based on the guidelines from WHO. The national guideline on VCT was formulated in 2005 and MoH provides training and assistance for VCT sites. HIV testing and counselling was

included in the National Strategic Plan 2003-2007. HCT services are voluntary, respecting informed consent and confidentiality in accordance with the guidelines. Maintaining confidentiality of patient records is a challenge for VCT sites (WHO, 2007c).

There are 290 VCT sites available in 19 provinces in Indonesia (MoH, 2009a), which are mainly sited in provinces and districts levels. VCT services have expanded across the country with the support from donors, namely USAID (FHI-ASA), Global Fund- AIDS, TB, Malaria (GF-ATM) and AusAID (IHPCP) (WHO, 2007c). VCT is conducted in health services, mobile VCT in some areas, within STI clinics at SW location, and also by NGOs (MoH, 2009b).

These VCT services, however, are often underutilized by the population because of various reasons. Overall access and use remain low and only few clients come by their own initiative (WHO, 2007c; MoH, 2009b). Up until December 2006, the number of people tested is 8.197, or around 4% out of 193.030 PLHIV estimated number (MoH, 2009b). Stigma and discrimination are the major barriers for increasing HIV testing and counselling services' access and coverage (WHO, 2007c). Despite of these circumstances, commitment to scale up HIV testing and counselling services exists at all levels. The government is planning to make VCT available in *Puskesmas* in every district to provide better access for people who want to know their status (MoH, 2009b).

#### **4.2.2 Provider Initiated Testing and Counselling in Indonesia**

Following the WHO recommendation with respect to PITC of 2007, the government is trying to promote PITC model in health care setting. PITC implementation is expected to increase the number of people knowing their HIV status through case findings in health services. There are missed opportunities because HCT is not offered by health professionals to patients who come to seek for health services, especially HIV-related health service, i.e. TB, STI, and ANC clinics. HCT is recommended to be offered as routine part of health services to catch these opportunities so that those who agree to take HIV test would get benefits from the prevention, care, support, and treatment services. The national guidance for PITC is still on going process under the facilitation of MoH.

Some hospitals are adopting PITC approach as part of their care, support and treatment (CST) services. Hasan Sadikin hospital which operates in West Java province is one of those hospitals. A questionnaire was sent to the hospital to get some information about PITC implementation in that site. In the last few years, they experience increased of HIV case findings by applying PITC approach implementation (see annex 3).

### **4.2.3 Mandatory Testing in Indonesia**

In some specific groups, HIV tests are conducted on mandatory basis, such as migrant workers and armed forces (Bateganya et al., 2008). Migrant workers must take HIV test to be eligible for working abroad. There are about two to three million people each year who apply for overseas jobs undergo testing organized by Ministry of Labour. The receiving countries are the ones who are asking for HIV testing and only those who are tested negative could apply to work abroad. These migrant workers are often low educated and have little information about HIV and AIDS. Some health centres arrange mass pre-counselling for this group before they take HIV testing. However, they will not refuse the test because they need it to get the job.

HIV testing in armed forces is done for two purposes, which is for pre-recruitment and for testing personnel fitness. Pre-recruitment HIV testing is regulated by the Ministry of Law and Justice. Military personnel who want to join a peace keeping mission will undergo HIV test before and after the mission. Counselling is provided if necessary (TNI, 2004).

Blood safety is included in national HIV prevention programme, in coordination with Indonesian Red Cross. Unfortunately, blood safety is not available in all areas, especially where the Indonesian Red Cross is not actively involved. Across the country, The Red Cross only operates in 185 of the 447 districts (WHO, 2007c).

### **4.2.4 Diagnostic Testing in Indonesia**

As mention before in sub chapter 4.2, many PLHIV are late diagnosed because they were tested when they were admitted in health care for HIV-related diseases or illness. Wortley et al. (1995) found that illness is the strongest reason for someone to seek or accept HIV testing. The health professionals prescribed HIV testing for the patients when he/she has symptoms related to HIV infection. HIV testing is requested with other diagnostic tests that are needed for treatment management.

### **4.3 Most at Risk Population (MARP)**

HIV modes of transmission based on cumulative reports are through heterosexual, IDU and homosexual (MoH, 2009a). Estimation on 2006 number of sex workers are 177,200-265,000 women and 21,000-35,000 transgender, Male have Sex with Male (MSM) are about 384,000-1,148,000 men. Client's estimation numbers are even higher, 2,435,000-3,813,000 for female sex workers and 62,000-104,000 for transgender (NAC, 2007). Sex workers (SW), transgender, IDU and MSM are most-at-risk population. However, we should not overlook the clients of SW and transgender.

The HIV burden in Indonesia is different in various geographical area. In the provinces of Bali, Java, Sumatra, West Kalimantan and South

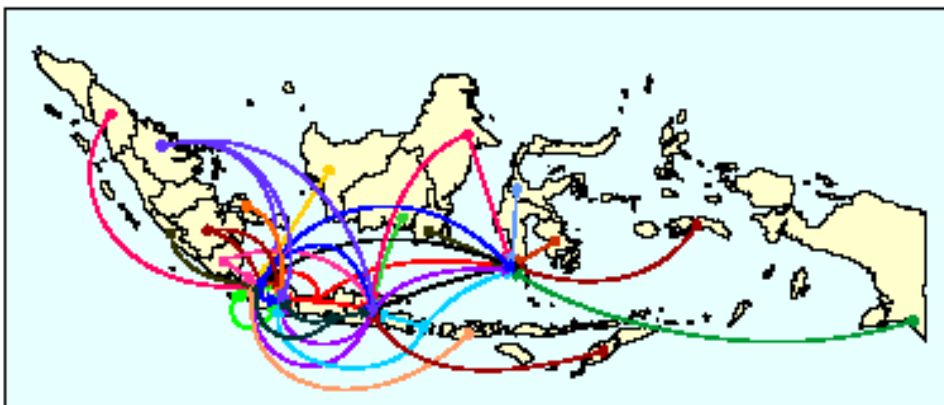
Sulawesi needle sharing among IDUs is the predominant mode of transmission. Different trend found in Papua province where the predominant mode of HIV transmission is through unprotected heterosexual (MoH, 2009a).

#### 4.3.1 Sex Workers

There are female, male, and transgender SWs. SW are mobile, moving from one province to the others. As seen in the figure below, sex workers are mobile throughout the country. Female SW has the low percentage of mobility (16-19%) compare to transgender (31%) and male SW (35%). Their clients number range from 4-13 clients in a week (Statistics Indonesia/MoH, 2005).

STI services do not always reach the most important target groups and condom use rates remain low among populations at high risk for HIV and STI infections such as SW. Condom are not always available or promoted in health facilities. Peers, volunteers and outreach workers do not always carry condoms or promote their use (WHO, 2007c).

**Figure 3. Sex Worker Mobility 2004/2005**



Source: Sub Directorate AIDS & STI, MoH, Republic of Indonesia

Building and maintaining trust between SW and project staffs are the lesson learnt from Eastern Europe and Central Asia. SWs are involved in planning, implementation, monitoring and evaluation process. The project also see different needs and specific vulnerability of sex workers (UNAIDS, 2006a). Program implemented for Sex Worker in Indonesia includes outreach, condom promotion, STI testing and treatments. One of outreach programme are aimed to reach SW and refer SW to VCT clinics to get HCT. In the health facilities, PITC could be conducted to find possible HIV positive SWs during their visit in STI clinics. It is necessary to avoid stigma and discrimination against SWs.

#### 4.3.2 Sex Workers' Clients

Mobility and HIV/ AIDS is linked and also well-documented (ADB, 2007). As in other parts of the world, the three "Ms"-Men, Mobile with Money-are

key components for the spread of HIV. Being away from home for a long time is significantly associated with engaging in commercial sex. HIV and AIDS risk in Indonesia is linked to men who work away from home. HIV Behaviour Surveillance on 2005 shows that men tend to buy sex, regardless of their marriage status. This condition will cause a wider spread of HIV infection, bridging to lower risk populations (Statistics Indonesia/MoH, 2005).

Recently, there is an effort to mainstream HIV by the Ministry of Public Works (MPW) (ADB, 2007). The MPW wants to have a workplace programme for public workers who could be considered to have high risk of HIV infection due to their long time away from their home for working. The result of this project is not available yet because the technical assistance for workplace policy was due in June 2009 but is not yet ready. Programmes aiming at sex worker's clients are usually carried out indirectly through work place programmes in public and private sectors. HCT promotion should be integrated in the work place programme to increase their knowledge and refer to VCT or other HIV related services. A "Tripartite Declaration on Commitment to Combat HIV/AIDS in the World of Work" was signed by the Ministry of Manpower, the chairmen of the Indonesian Chamber for Trade and Industry and the Indonesian Employers Association and several chairmen of trade union in February 2003. This commitment recommends the use of the ILO Code of Practice on HIV/AIDS and the World of Work, prioritize prevention programmes on HIV/AIDS, and support an effort to deal with stigma and discrimination against workers with HIV/AIDS. A copy of this declaration is attached in annex 5. About 200 Indonesian companies participated in HIV work place prevention (NAC, 2003)

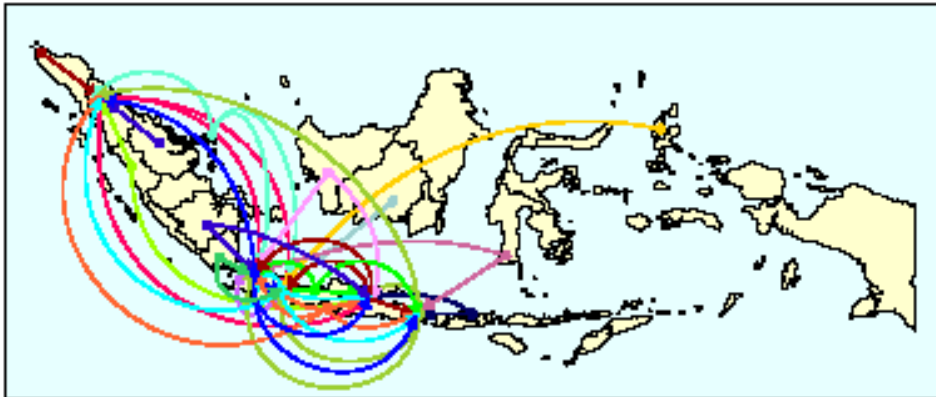
#### **4.3.3 Injection Drug Users (IDUs)**

IDUs has the highest rates of HIV infection, about 40% of IDUs are HIV positive (MoH, 2009a). Harm reduction programme has started, includes Needle Exchange Programme (NEP) and methadone substitution therapy. Methadone maintenance treatment was available in 2003, in 3 treatment sites in two provinces. NEP operating in 57 sites in four provinces, more than half are in Jakarta.

In 2003, NAC and National Narcotics Board (NNB) signed a Memorandum of Understanding (MoU) with Coordinating Minister of Social Welfare and Chief of the National Police on harm reduction. A draft law on harm reduction is proposed to be stipulated in the national legislative. A comprehensive prevention and care programme including prison is set up. Coverage of harm reduction programme is much lower than expectation. Many IDUs does not have access to clean needles, syringes and condoms (WHO, 2007c).

IDUs are mobile and they share needle outside their origin city (Statistics Indonesia/MoH, 2005). Figure 4 shows IDUs mobility across the country. IDUs are sexually active and usually have permanent partner or husband/wife. Nevertheless, they also buy sex. However, their condom use rate remains low, about 24-45% are using condom. These unprotected sex behaviour makes HIV epidemic among IDUs grow even faster.

**Figure 5. IDUs mobility 2004/2005**



Source: Sub Directorate AIDS & STI, MoH, Republic of Indonesia

IDU is also a hard-to-reach group as the laws in Indonesia are against the use of drugs. Although the MoU has been signed on harm reduction programme, in the reality there have been police harassments against IDUs on NEP programmes. They arrested people who are caught with syringe needle. This situation make IDUs stay hidden and reluctant to come to harm reduction programme. Outreach programme are conducted by NGOs to reach this group by involving their peer group. Mobile VCT may be a good choice to scale up HCT among this group. HCT could be offered near the site where IDU usually gathered. Methadone clinic is a place to approach IDUs for HCT. PITC approach could be applied in methadone clinic to reach IDUs.

#### **4.3.4 MSM**

Homosexuals and bisexuals are marginalized groups in Indonesia (NAC, 2007). These issues are not talked openly in the community. Most of them are hidden and living according to heterosexual values that are accepted by community. That is why it is hard to reach this population. There are only a few of prevention efforts given specifically for this group, such as condom package with extra lubricant for MSM.

This chapter elaborate HCT practices, in particular for Indonesian setting. Various HCT models are conducted in Indonesia, including VCT, PITC, mandatory and diagnostic testing. MARPs are the target groups of HCT because HIV infection in Indonesia concentrated in high risk population. They are hard-to-reach population which need specific approach to get



them to HCT. However, enabling environment seems to have significant contribution to motivate people for HCT.

## **Chapter 5. Considerations around PITC model**

PITC model is a reaction to the low uptake of the standard VCT model. In this chapter, determinants of VCT low uptake are described. After that, the recent debates on PITC model, is discussed.

### **5.1 Determinants of VCT Low Uptake**

Low uptake of VCT is caused by the same factors that limit uptake of other HIV-related services (WHO/UNAIDS, 2007). Those factors are low perception of risk of oneself, stigma and discrimination, limited access to treatment, care and services in general, as well as gender issues (WHO/UNAIDS, 2007; Ma, et al., 2007; Pulerwitz, et al, 2008). Those are common factors that are related to the low uptake of VCT in Indonesia.

#### **5.1.1 Accessibility**

In the Indonesia national programme, it is targeted to make VCT services available in all districts and cities by 2010 (WHO, 2007d; MoH, 2009b). VCT services are available in 236 locations in almost 100 of 457 districts/cities in Indonesia. MoH recorded 2,000 VCT counsellors had been trained for 468 VCT clinics (MoH, 2009b)

More VCT sites will be built in order to bring the services more available for the population. Although the number of the services is limited, some of them are underutilized by the population. The geographical situation with poor road facilities and lack of means of transportation limit people's access to the nearest facilities. Economic factors also have significant influence. There are related service fees, such as administrative cost, lab tests, and other opportunity costs, that are burdening those who want to access the services. However, the accessibility to that information is known to be a barrier for people to come to the services, especially for those who live in remote area. Language barrier is another challenge commonly faced in Indonesia where people speak different local languages (MoH, 2007c).

Accessibility is a challenge for PITC implementation in health facilities. Although *Puskesmas* reach in rural areas, people are experiencing difficulties to access them. PITC in health services may scale up the number of HCT but not in great number as most health services are not easily accessible by the whole population. Other than that, human resources in health settings also need to be considered. PITC may burden health care professionals with secondary task, especially when they have limited resources. Health care professional – having their job descriptions – will get additional assignments, such as identify patients that have HIV related symptoms, give counselling/information, offer HIV test to the patient, to refer patients to HIV-related services.

Since 2004, Indonesia provides free ARV for PLHIVs. By the end of 2007, Indonesian government targeted to provide free ARV to 26,000 people

considered eligible. Until June 2009, out of 28,050 PLHIVs eligible for ARV, only 21,653 (77.19%) are ever on treatment (MoH, 2009a). The proportion of people ever received ART are high, but among these patients there are 2,508 (12%) lost follow up and 989 (5%) stop ARV treatment.

Indonesia follows the agreement on Trade Related Aspect of Intellectual Property Rights (TRIPS) as a member of WTO. Several ARVs are manufactured by Kimia Farma and several of these ARVs are under patent in Indonesia. There are two main sources of procurement for HIV related health products: the Government of Indonesia and GF-ATM. The GF-ATM supports 17 out of 33 provinces for ARV provision. There is also small third supply of ARVs from the NNB to selected prisons, purchased independently from the system of MoH (WHO, 2007c). In 2006, however, stock out of ARVs had occurred in almost all provinces.

### **5.1.2 Stigma and Discrimination**

In reality, stigma and discrimination continue to hinder people from having an HIV test (UNAIDS/WHO, 2004; NAC, 2007). In low prevalence countries, where most of HIV comes from marginalized groups, PLHIV experience rejection from families and communities (UNAIDS, 2000). Stigma and discrimination may occur everywhere: school, work place, family, community, etc. The real lives stories, i.e. PLHIV lost their job, rejected by family members, or even experienced violence, are common in everywhere of the country. The children born to parents who are tested positive often experience discrimination, such as banned from school. It happens both in the cities and remote areas (WHO, 2007c).

Reports of discrimination by health workers in government health care facilities against members of vulnerable communities and PLHIVs are also common in Indonesia. It can be found both hospitals and *Puskesmas* settings. Health care providers most likely discriminate IDUs, poor people, transgenders, people without national identification cards, migrants, and PLHIVs. Unnecessary disclosure of a patient's serostatus, being ask to stop narcotic use before initiating ART, and police detaining IDUs for legally carrying needles and syringes as part of harm reduction services are some examples of those discriminative actions (WHO, 2007c). There are some hospitals continue to refuse to treat known PLHIV (Busza, 1999).

In a study of four Asian countries on Thailand, Indonesia, India, Philippines, it was found that discrimination coming from the health sector is higher than the ones that coming from family and community (Paxton et al., 2005). It was found that 54% of HIV positive respondents had experienced some forms of HIV-related stigma and discrimination in the health sector. PLHIV experienced refusal of treatment and delay in the provision of health care. This study also found that only small percentage

of respondents received pre-test counselling. Breaches of confidentiality by health care workers were common. Within the family and community, women are more likely to experience discrimination compare to men.

Learning from that experience, HCT scale up efforts must consider how stigma and discrimination will affect the life of those who are tested positive, moreover for PITC that takes place in health facilities where stigma and discrimination are high. Necessary actions should be taken to ensure that people who are going to be tested are protected from the possibility of experiencing stigma and discrimination from health facilities, family and community.

### **5.1.3 Gender issues**

Most HIV and AIDS data are disaggregated by sex, but there is little information on gender dimensions of HIV epidemic (WHO, 2007c). HIV epidemic progress is influenced by violence against women, socio-economic and emotional dependency (NAC, 2007). Some field workers in the field of addiction recognize that female IDUs have limited access to health services due to stigma and discrimination. Transgender maybe refused inpatient care, as there is ambiguity whether they are accommodated in male or female wards (WHO, 2007c). Women who are tested positive are often blamed of bringing HIV infection into the relationship and often experience violence. Men are less likely to visit health facilities compare to women (Csete et al., 2004). These examples represent failures of diagnosis, prevention, treatment and care in relation with gender issues.

It is clear from the foregoing that HTC model should be gender sensitive, moreover for PITC model as it is conducted in sites where women are most likely come to search for health services, such as STI and ANC clinics. PITC implementation in those clinics should be gender sensitive, covering women's and transgender issues. It is not about knowing HIV status alone, but also about the persons and the effects to their lives.

## **5.2 Recent Discussions on PITC**

Discussions around PITC are rolling since opt-out routine testing idea came out. When WHO give recommendation for its implementation and provided the guidelines, debate occurred worldwide. There is no consensus on this approach. The debate is divided into two points of view, the public health and the human rights perspectives. In this sub chapter, we will see several critical points that come out and being discussed.

### **5.2.1 Universal Access**

Globally, the 3 by 5 initiative was able to reach only around 50% of its target. The nations then made a commitment to reach "Universal Access" in 2015. Client initiated approach was not giving result as much as it was expected. The need to scale up HCT was responded by WHO

recommendation on PITC approach in health services (WHO/UNAIDS, 2007). Provider initiated goes beyond client initiated approach because it is actively reaching out people coming to health services who might be infected by HIV but do not know their status yet. Once they know their status, PLHIVs should have access to care, support and treatment. Provider initiated approach implementation should be accompanied with access to HIV related services. However, concern has been expressed that universal access may not be a reality in the near future for the large number of PLHIVs (Grover, 2006).

Access to treatment is one of the issues being discussed. Although PLHIVs have a right to affordable ART (Grover, 2006), the availability is in question. This concern is related to the agreement on TRIPS by members of World Trade Organization (WTO). In 2000, Indian generic companies were able to force the reduction of prices of ARV drugs. In that time there was no protection for product patents in India, which means more generic producers, competition and lower prices. Indian generics supply about 50% of the ARVs in the developing world. Even with this condition, the majority of PLHIVs around the world are unable to access affordable ART in their respective country. In January 2005, India joined in TRIPS agreement. This means that Indian generic companies will not be able to supply the drugs at affordable process domestically or to other developing countries. This applies to both the existing first line and second line ARVs and other drugs.

The above condition will limit affordable ARV, but provision of ARV must continue for PLHIVs. Huge efforts have to be made to close funding gap for ARV provision. Throughout the world, Global Fund provides most of ARV funding. Even though 2007 funding was increased to US\$ 8.1 billion, it is not enough to provide ART for entire PLHIVs population. This means that ARV treatment may not be available to a vast majority of the PLHIVs (Gruskin, 2008). In this case, opt out routine testing is not really a practical option at all because treatment will not be available.

The implementation of PITC should be accompanied by the provision of a minimum package of HIV services. Testing services should be connected with long-term access to appropriate HIV and health-related services. Attention to the individual's right to privacy must be described in as detailed as possible. WHO will need to decide on how to implement referral system in resource-constrained settings, for the general population and for specific population, such as pregnant women (Gruskin, 2008).

### **5.2.2 Informed Consent**

It is now accepted that consent means informed consent. Informed consent implies at least informing the patient about the benefits, risks, and alternatives. In reality, informed consent does not exist in many of

major interventions, as well as in HIV intervention. If opt-out routine testing is recommended globally, it requires a careful guidance to implement such testing without coercion and how to limit the negative social consequences. It is feared that people will be tested without consent, which will make this testing model appear as mandatory testing. The necessity of taking consent is not restricted only to treatment. It also applies to diagnostic testing (Grover, 2006). Patients need to receive necessary information to enable him/her to give consent and make a decision.

There is power differential between doctor and patient (Gruskin, 2008). The doctor-patient relationship is inherently unequal for reasons of knowledge, skill that doctor have, and trust given by patient to the doctor. In many cultural setting, patients do not question the medical advice of their doctor. This situation is even harder for women. The opportunity to decline testing will remain beyond the reach of many women if adequate strategies are not available to ensure informed consent. There are reasons why patients fail to oppose health provider's recommendation to take an HIV test. Some of the reasons are the high social status ascribed to medical professionals, the belief that a doctor might negatively impact on health care provision, and the perception of HIV testing as something that has been institutionally sanctioned and is therefore 'right' thing to do. In this context, women's self perceived inability to refuse an HIV test will be further worsen by gender dynamics that make it difficult for women to say no.

In the PITC guidance, WHO/UNAIDS (2007) lists all the issues that a patients need to know about HIV on pre-testing counselling to be discussed with patients, but the concrete steps that would need to be taken in order for this to become possible require specific consideration. The PITC guidance also recommends verbal communication as an adequate means for obtaining informed consent. The implication of this practice in different contexts and different groups needs further research (Gruskin, 2008).

Additional areas of concern are raised with respect to consent when the pregnant woman is an adolescent. Legal frameworks usually ask for parental consent before HIV testing made available. In some circumstances, this is not practical. Gruskin (2008) suggests that informed consent shall be obtained from the adolescent him/herself, if the adolescent is sufficient maturity.

De Cock argued that the use of opt-out testing conform to human rights principles, including the rights to privacy and personal autonomy (De Cock et al., 2002; De Cock, et al., 2003). PITC guidance recommended that HIV testing could be included in general consent, without need for a separate written consent. HIV and AIDS should carry the same process as

other diseases. This practice of opt-out routine testing promotes the normalization of HIV and AIDS (WHO/UNAIDS, 2007). However, specific circumstances, as discussed above, challenge the implementation PITC approach.

Opt-in approach, traditionally was a part of client-initiated counselling and testing, should be considered to be applied on routine testings. Rather than automatically having HIV testing unless patients refuse directly, patients are given option to accept whether he/she wants to have HIV testing. Compared to opt-out testing, the opt-in model gives more possibility for patients to make their own decisions and less pressure from the side of the health provider. This approach worth to be consider for high vulnerable population (WHO/UNAIDS, 2007).

### **5.2.3 Confidentiality, Stigma & Discrimination**

Issue on confidentiality is usually related to stigma and discrimination. People do not want others to know their status because they are afraid of the community reaction. In many countries, stigma and discrimination exist. Therefore, routine testing for HIV should be able to guarantee confidentiality and protection against discrimination (Grover, 2006). However, it is hard to control stigma because it operates in silent, secretive and subversive ways. Efforts at dealing with stigma and discrimination should be focused within communities.

It appears that women are more likely than men to experience stigma associated with HIV (Gruskin, 2008). Women, and especially pregnant women, are often diagnosed with HIV before their male partners because they use health services more frequently than men. Therefore, women have risk of being blamed for bringing HIV into the relationship, even in situations where their partners may have contracted the virus first. Without support, PITC may unconsciously make worse a women's risk of stigma from her partner, family and community. Many of these women who are suspected or tested positive are likely to face violence (Csete et. al., 2004). One way to alleviate some of the stigma experienced within a couple is by providing couples counselling. Nevertheless, even as many health service providers think that it is a good idea, they feel ill-equipped to provide it.

In scaling up PITC for pregnant women, privacy and confidentiality must be carefully considered (Paxton et al., 2005; Gruskin, 2008). A pregnant woman may well be accompanied by relatives, including her male partner, at the health facilities. If she tests positive, efforts must be made to ensure she has the space and time to understand her diagnosis and its potential implications, both immediate and longer-term. In this process, they will need the support of health professionals and away from the engagement of any relatives she has not chosen to bring into this process. This is a particularly acute situation if testing takes place during

labour. The situation will be more complicated where the patient herself is still legally considered minor.

Gruskin (2008) suggested that step by step practical direction is required on how this can be assured, particularly in resource-constrained settings. Health care staffs are often responsible for direct breaches of confidentiality. It is important to remember that women in antenatal settings appear to be least likely of any population to choose to disclose their status to partners. This situation likely relates to fear of stigma, discrimination and violence. Without neglecting the importance of HIV status disclosure to partners and relatives, pregnant women's risk of adverse outcome from disclosure can not be ignored. Physical violence has been reported as a result of disclosure. It occurs in many settings and disproportionately affects women.

#### **5.2.4 Counselling**

##### **a. Pre-test Counselling**

Pre-test counselling is essential because it is the entry point of information for person who may test negative and positive. Patients will receive messages on prevention, treatment availability and adherence (Grover, 2006). Pre-testing counselling was a key component in HIV testing, but now it is minimized in the PITC guidance. Pre-test counselling has been replaced with simplified pre-test information. Although a minimum standard of information is exists, when this should be done and how long it should takes requires explicit attention (Gruskin, 2007). Pre-test counselling which was meant to help PLHIVs to cope with life. But it can become a tool of terror in the hands of the health provider. Simplified pre testing counselling may not achieve the objective of behaviour change because those who come for test do not get comprehensive information to evaluate their personal risk behaviour.

Pre-testing counselling is also important in PMTCT setting. Women are accessing pregnancy-related services to check their pregnancy and wanted to know that their pregnancy is safe and healthy. Without appropriate pre-test counselling, they may be mentally unprepared to undergo HIV testing let alone to receive positive test result (Gruskin, 2008).

##### **b. Post-test Counselling**

The WHO/UNAIDS guidance highlights post-test counselling as an 'integral component of the HIV testing process' and something that everyone should receive irrespective of their test result. Careful consideration should be taken for pregnant women. As examples, women who are tested during labour, when the test result should be disclosed and post-test counselling provided-during labour? Should it be done soon as the child is born (Gruskin, 2007)



VCT access and coverage in Indonesia are limited and underutilized. Stigma and discrimination seems to be the major barrier for people to get HIV test. PITC model is on the process to be adopted in Indonesian HIV prevention programme. Debate on PITC implementation in health services has not come into consensus. Both public health and human rights perspective need to be accommodated to serve the best interest of people health.

## Chapter 6. Discussion

PITC implementation in Indonesia should be done with some consideration. The ongoing debate on PITC informs policy makers who plan to scale up HCT with PITC model in different settings. The foregoing chapters give insights on steps to be taken to implement PITC model. Easy access to HIV-related services, readiness of human resources, and an enabling environment are crucial to be met. In Indonesian setting, these conditions are still to be satisfactory met.

ARVs are provided freely by the government of Indonesia. It has been a global concern that ARV may not be available for all PLHIV. This issue is closely related to the TRIPS agreement by the member of the WTO (Grover, 2006). Even though ARVs are available in Indonesia, there are barrier for access to treatment. It is seen from the occurrences of ARVs stock outs, number of PLHIV who lost follow up and stop ARV (WHO, 2007c; MoH 2009a). The limited number of HCT centres and staffs will not be able to serve population that need HCT (WHO, 2007c; MoH, 2009b). Looking at these conditions, government need to consider the readiness of access to treatment and other HIV related services for PITC implementation in health facilities. Universal access to treatment should be guaranteed for those who are tested positive, which is estimated around 193,030 PLHIVs, if HCT is scaled up. However, currently this does not seem likely in Indonesia.

Stigma and discrimination is a major barrier to HCT in Indonesia. Many PLHIVs in Indonesia find that their status is being disclosed to others against their willingness (Paxton et al., 2005). Health care professionals often stigmatize and discriminate on the basis of HIV. As in many countries, they are the ones who breach the patients' confidentiality. Women are in vulnerable situation before and after they take HIV test. Violence against women are frequently happens in Indonesia, as it also happens related to HIV issues. Domestic violence may not appear so frequently because it is hidden, but we it's existence in the community cannot be denied. Women are more likely to experience stigma and discrimination compared to men (Csete et al, 2004; Paxton et al., 2005; Grover, 2006; Gruskin, 2008). The use of PITC approach in health care setting will push more women and girls into HIV testing, than men and boys. Consideration must be made on how to protect women and girls from the possibility of getting harmed. The fact that there is no national legislation to protect the rights of PLHIVs in Indonesia makes this situation more difficult (WHO, 2007c). If these conditions continue, people will not access health services. It is better for them not knowing their status. Government needs to put effort on reducing stigma and discrimination, especially for women, and how to ensure confidentiality inside health care setting. A national anti-discrimination law should be advocated and formulated.

If access to comprehensive health services is available and people no longer need to fear stigma and discrimination, then PITC can be implemented. National guidance needs to be formulated and disseminated. Three Cs principles remain the core of HCT (UNAIDS/WHO, 2004). Simplified pre-test counselling will limit patient's access to information that they need to make an informed consent. Unequal relationship between doctor and patients will influence patient's decision because in practice, patients will not question on doctor's advice (Gruskin, 2008). This situation certainly will effect patients' decision to take HIV testing. The patient will do what the doctor tells him/her to do. Consent from patient will be doubtful in practice. It may become some kind of formality in the health service facilities.

In PITC guidance, ANC clinic is one of the sites that are recommended for PITC model. This clinic is mostly visit by women and accompanied by their partner. In this case, couples counselling may be good to be conducted. This effort can reduce the possibility of violence against women that are likely happen when women are known to be HIV positive prior to their male partner (Gruskin, 2008)

Opt-in approach could be consider to adopted as it gives patients more power to decide whether he/she wants to take HIV test. This approach should be done where vulnerable population, such as women and children, may come to health services (WHO/UNAIDS, 2007), such as in ANC clinic. Women will have more power to decide if they wanted to have an HIV testing or not.

The questionnaire that was replied by Hasan Sadikin Hospital, one of hospital which implements PICT in Indonesia, shows that health provider gives patients pre-testing information. Patients did not receive pre-test counselling after agreed to have HIV testing. Number of people who received treatment increased, but there is no research yet done to know the impact of PITC (see annex 3). Further research need to be conducted to evaluate PITC implementations that currently take place in Indonesian health care setting.

## **Chapter 7. Conclusion and Recommendation**

### **7.1 Conclusion**

This thesis intends to describe current HCT models in Indonesia; to discuss considerations on PITC model implementation; and to use the findings to provide recommendations for scaling up HIV counselling and testing in Indonesia. This effort is made as a response to the Indonesian government's plan to adopt PITC model in health facilities in order to scale up HCT in Indonesia. Scaling up HCT is related to the commitment to achieve universal access and the availability of treatment. Because VCT uptake and coverage is below expectation, PITC model is proposed to pick up possible HIV positive patients that come to health facilities seeking health care services.

As described in previous chapter, the various HCT models that have been implemented in Indonesia are VCT (free-standing, integrated, and mobile VCT), diagnostic testing, mandatory testing, and PITC. Each of these models aims to serve different populations with different models.

There are different ways to scale up HIV counselling and testing with context-specific consideration. PITC in health facilities is feasible to be implemented in Indonesia. However, this should be done only after ensuring that certain requirements are met, including universal access to prevention, care, support, and treatment; readiness of human resources in health facilities; and anti-discrimination law and human rights principles based on the Three C's. The Three C's principles should remain at core of PITC, as it is for other HCT models. Counselling, consent and confidentiality have to be applied by PITC model.

Target groups for the Indonesian HIV programme are MARPs because Indonesia is a low prevalence country with concentrated HIV epidemic. The epidemic is largely driven by MARPs through unsafe drug injection and unprotected sex. PITC in health services may not be able to reach MARPs. PITC should be introduced to these groups. It could be integrated in health facilities that serve or are closely connected to MARPs, such as STI and Methadone clinics. Various models are needed to reach MARPs with their specific needs.

Considering the Indonesian epidemiology and setting, PITC will be able to scale up HCT to certain extent only. Unless the requirements mentioned above are fulfilled, people – including MARPs – will hesitate to come to HCT services. PITC will complement other HCT models that already exist in Indonesia. VCT will continue to be implemented in Indonesia to serve general population who want to know their HIV status.

For any HCT model to function effectively, it is necessary that HIV programming as a whole is strengthened. This means that the national

policies, strategies, and agreements on harm reduction and workplace anti discrimination have not been consistently implemented. These policies, strategies, and agreements are an advantage, but they need to be put into action. Additionally, concern around women's issues should also be addressed in order to mitigate violence, stigma and discrimination.

Also it is important to mainstream HIV and AIDS into various sectors in order to reach wider population, such as young people, workers, etc. Awareness on HIV and AIDS should be spread to as many people as possible, so that they will get tested and have access to treatment or any other HIV-related services that they need.

## **7.2 Recommendations**

The following sub chapter consists of recommendations that are aimed for HIV national programmes. These recommendations are made in assumption that those requirements mention above are present (universal access, readiness for human resources and anti-discrimination law). The recommendations are divided into 2 parts: for PITC model and for ongoing VCT models.

### **7.2.1 Implementing PITC model**

These are recommendations for PITC implementation in Indonesia:

- Research is necessary to evaluate current PITC implementation and to know the impacts on the people who undergo the process. Based on the result of this research, scaling up HCT should be considered.
- Develop National anti-discrimination legislation to guarantee protection of human rights of PLHIV.
- Antiretroviral treatment and other HIV related treatment must be available for all PLHIV who are eligible to receive treatment.
- National PITC guidance should integrate consent, counselling and confidentiality in Indonesia's health care setting. It is necessary to consider patient-doctor power relation, gender issues, youth and high-risk groups needs, and stigma and discrimination in health facility as well as in family and community.
- Pre-test counselling, individually or in group, have to make sure that client has sufficient information to make an informed consent for HIV testing.
- Health care workers are ready –in terms of quality and quantity- to give HIV services. Trainings for health care staffs to implement PITC according to the National guidance and HIV and AIDS sensitization should be provided. The sensitization is needed to build health care

staff awareness to ensure Three C's principle in the process of PITC and to interact appropriately with MARPs.

- PITC should be available in health services which are easily available by the community, up to district level.
- PITC information and promotion should be done outside the health facilities to create public awareness of PITC and to reduce stigma and discrimination in the society.
- Introduce PITC to MARPs in health facility settings. PITC model may be integrated in sites that are in close contact with MARPs, such as STI and Methadone clinics.
- "Opt-in approach" for vulnerable groups, such as pregnant women in ANC, to give them more power to decide whether or not they want to undergo an HIV testing.
- Couple counselling should be encouraged in ANC settings to avoid stigma and discrimination and possibility of violence against women.
- Patients' health records and referral system should be maintained to ensure patient's confidentiality.
- Up scale "Tripartite Declaration on Commitment to Combat HIV/AIDS in the World of Work", as a step to guarantee protections of human rights for PLHIV.

### **7.2.2 Improving the Ongoing VCT models**

VCT model is able to serve general population who wants to know their HIV status. It is important to continue to encourage public awareness and self- initiation to be tested. The following are recommendation for VCT models that are in place in Indonesia:

- Research on VCT effectiveness to know which VCT models work in Indonesian settings.
- Increase people's access to VCT services by making services closer to the community. The government's plan to have VCT in every district needs to be made into reality. VCT services need to be affordable and information access about HIV and AIDS should be available. Young people require special attention to their needs that could be met by providing youth friendly health services.

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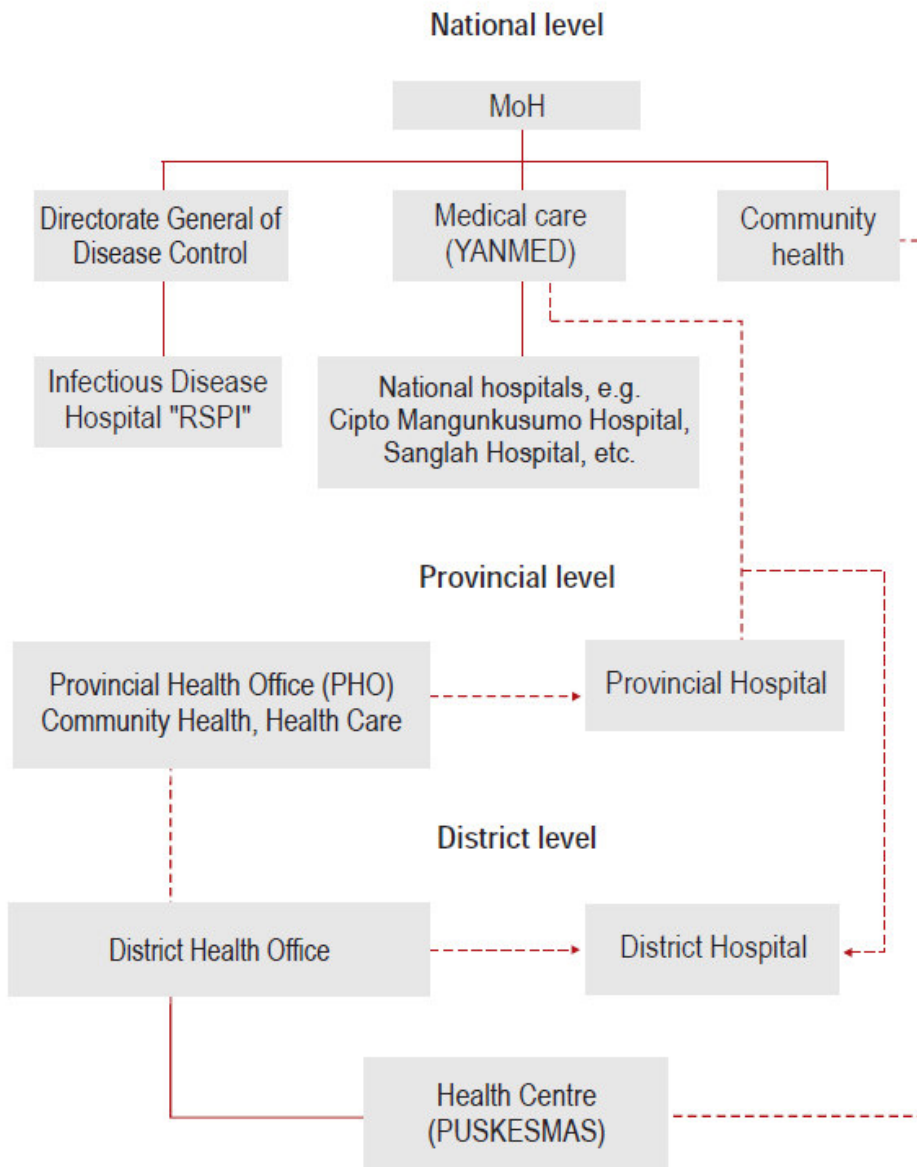
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## Annexes

### Annex 1. Organizational of Health Services at the Provincial and District Level



Source: WHO, 2007c

## Annex 2. Political and Health Structures in Indonesia

Political Structure		Health Structure	
Level	Position	Level	Position
Central (Pusat)	Government of Indonesia (Pemerintah Indonesia)	Ministry of Health  (Departemen Kesehatan)	Minister of Health (Menteri Kesehatan)
Provincial (Propinsi)	Governor= Gubernur	Provincial Health Office (Dinas Kesehatan Propinsi)	Head of Provincial Health Office (Kepala Dinas Kesehatan Propinsi)
District / Municipality (Kabupaten)	Head of District / Major= Bupati / Walikota	District Health Office (Dinas Kesehatan Kabupaten)	Head of District Health Office (Kepala Dinas Kesehatan Kabupaten)
Subdistrict (Kecamatan)	Head of Subdistrict= Camat	Health Center (PUSKESMAS)	Head of HealthCenter (Kepala PUSKESMAS)

### Annex 3. Questionnaire to Hasan Sadikin Hospital

1. What are the reasons for implementing PITC in Hasan Sadikin Hospital?

- ◆ *Increase case findings. Data from Hasan Sadikin Hospital found that more than 2/3 HIV patients know their status when admitted to Hasan Sadikin hospital, while in the last one year more than half of them visited hospital or other health facilities but not offered HIV test.*
- ◆ *Limited VCT counsellor number. PITC could increase health staff role in the hospital to increase HIV test.*
- ◆ *Increase awareness Hasan Sadikin hospital health staff in active case findings.*

2. Could you mention and explain the procedure of PITC? (The process from entering hospital until the patient had the health care they needed)

- a. How to include a patient to attend HIV counseling and testing? *PITC does not replace VCT. As VCT, PITC also have indication criteria. Inpatients, for example, we are using indicators that comes from Rosie and Nirmala research on 2008 as mention below:*

	VCT (N=107)			PITC (N=69)		
	HIV- (N=65)	HIV+ (N=42)	p	HIV- (N=38)	HIV+(N=31)	p
weight loss	17%	38%	*	76%	87%	ns
chronic diarrhea	6%	21%	*	21%	58%	**
chronic fever	0%	19%	**	66%	61%	ns
persistent cough	9%	29%	**	42%	19%	*
skin problems	11%	29%	*	11%	13%	ns
white patches tongue	12%	31%	*	11%	61%	**
urethral discharge	6%	7%	ns	5%	0%	ns
genital wounds	11%	14%	ns	3%	3%	ns
mean number of symptoms (0-8)	0.7	1.9	**	2.3	3.0	**

Rosie, 2008

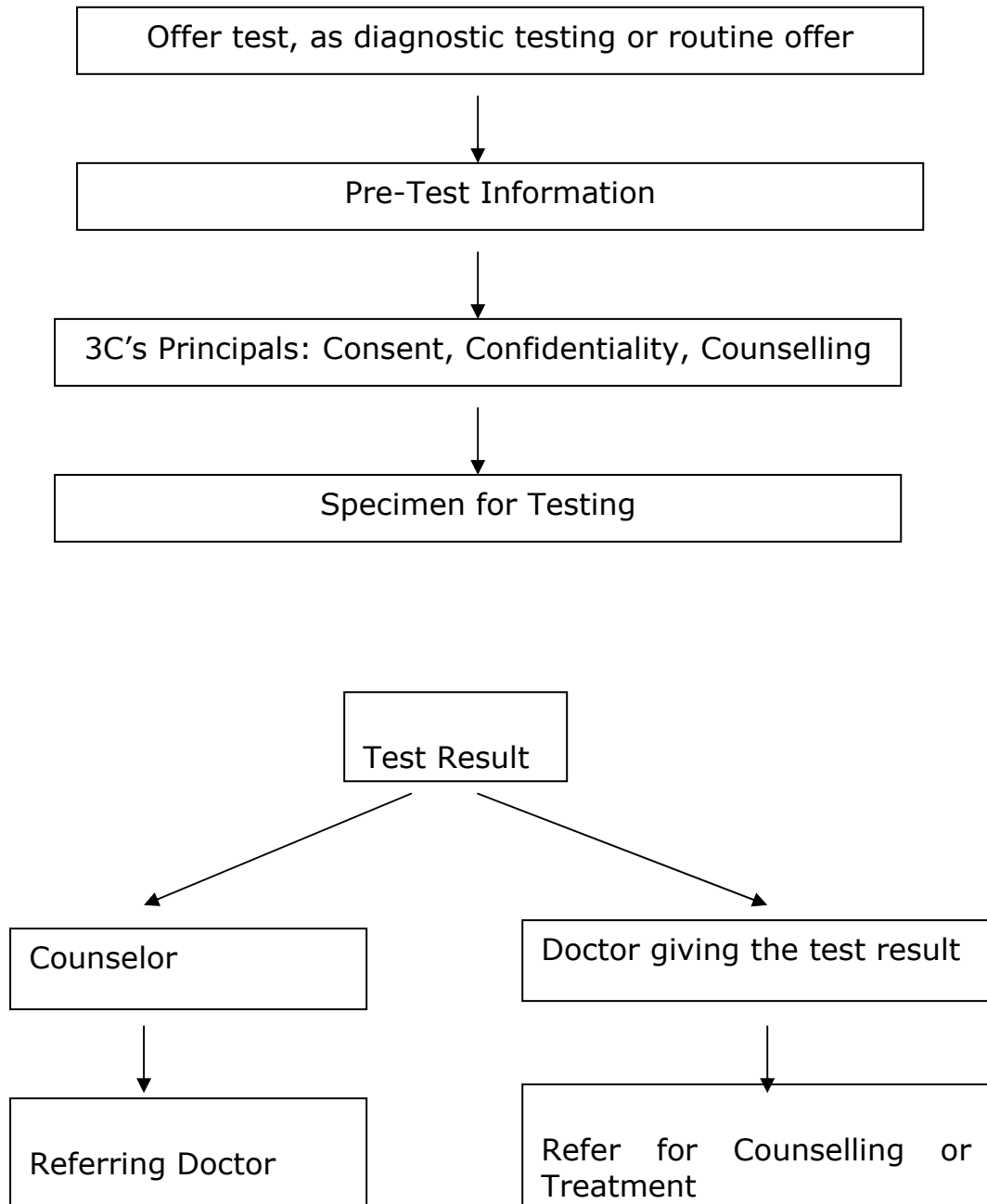
*We can see that we will initiate HIV testing when clinical symptoms are found in Hasan Sadikin hospital patients. In other setting like ANC, TB clinics, etc there are different indicators.*

- b. Is it opt-in or opt-out? Opt-out  
 c. Where are the sites for PITC entrance? *In-patient, internist, neurologist, child, TB out-patient clinic, ANC, etc.*

d. How do you ensure Consent, Counseling, and Confidentiality (3C's)?

This are the pathways that we use:

PITC protocols:

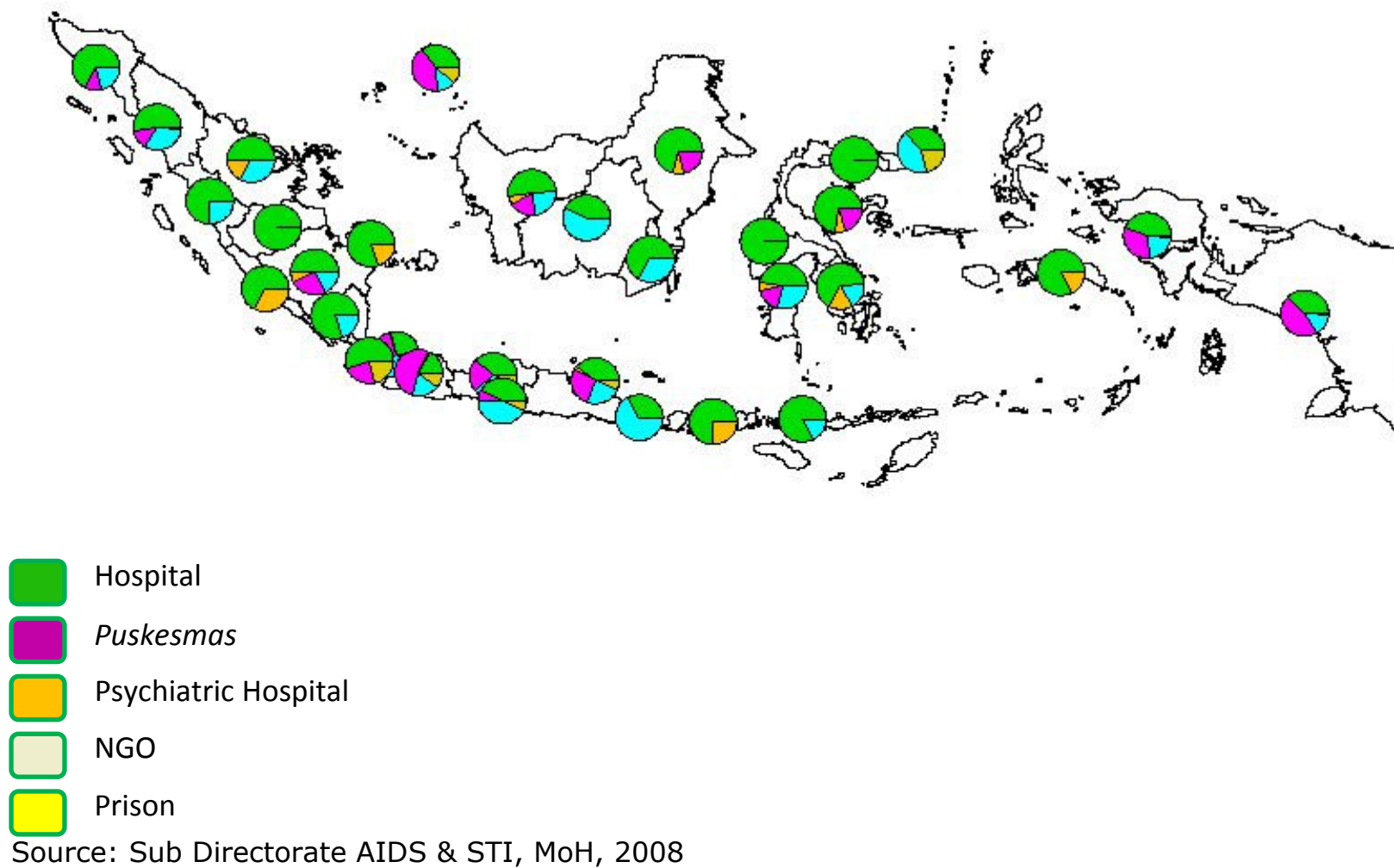


*Health staff who initiated the test is fully responsible for #C. For example, blood sample taken by the provider so that only that provider had access to the test result. In the lab there are no remarks about patient's name, only the health staff that asked for the test.*



- e. Is it integrated with VCT? How? *Integrated, if PITC has barriers than patients will be refer to VCT.*
  - f. How is it connected to treatment, care and support? *It is connected automatically, because CST is the one who asked for HIV testing.*
3. a. How many people has been counseled trough PICT?
  - b. How many people has been tested trough PICT? *In 2008, from 666 HIV testing there are 113 tested and counselled through PITC*
4. a. Is there any significant difference before and after the implementation PITC regarding to the number of people counseled and/or tested?  
*Number of HIV case findings increase each year.*
  - b. If any, are there any other differences?  
*Number of people enter CST increase each year*
5. a. What are the advantages of PITC implementation?
    - ◆ *Increase test range*
    - ◆ *Counsellor task and role efficiency*
    - ◆ *Increase health staff awareness*
  - b. What are the disadvantages of PITC implementation?  
*Nothing so far.*

### Annex 4. Proportion of VCT Services in Indonesia



## Annex 5. Tripartite Declaration Commitment to Combat HIV/AIDS in the World of Work

### Tripartite Declaration Commitment to Combat HIV/AIDS in the World of Work

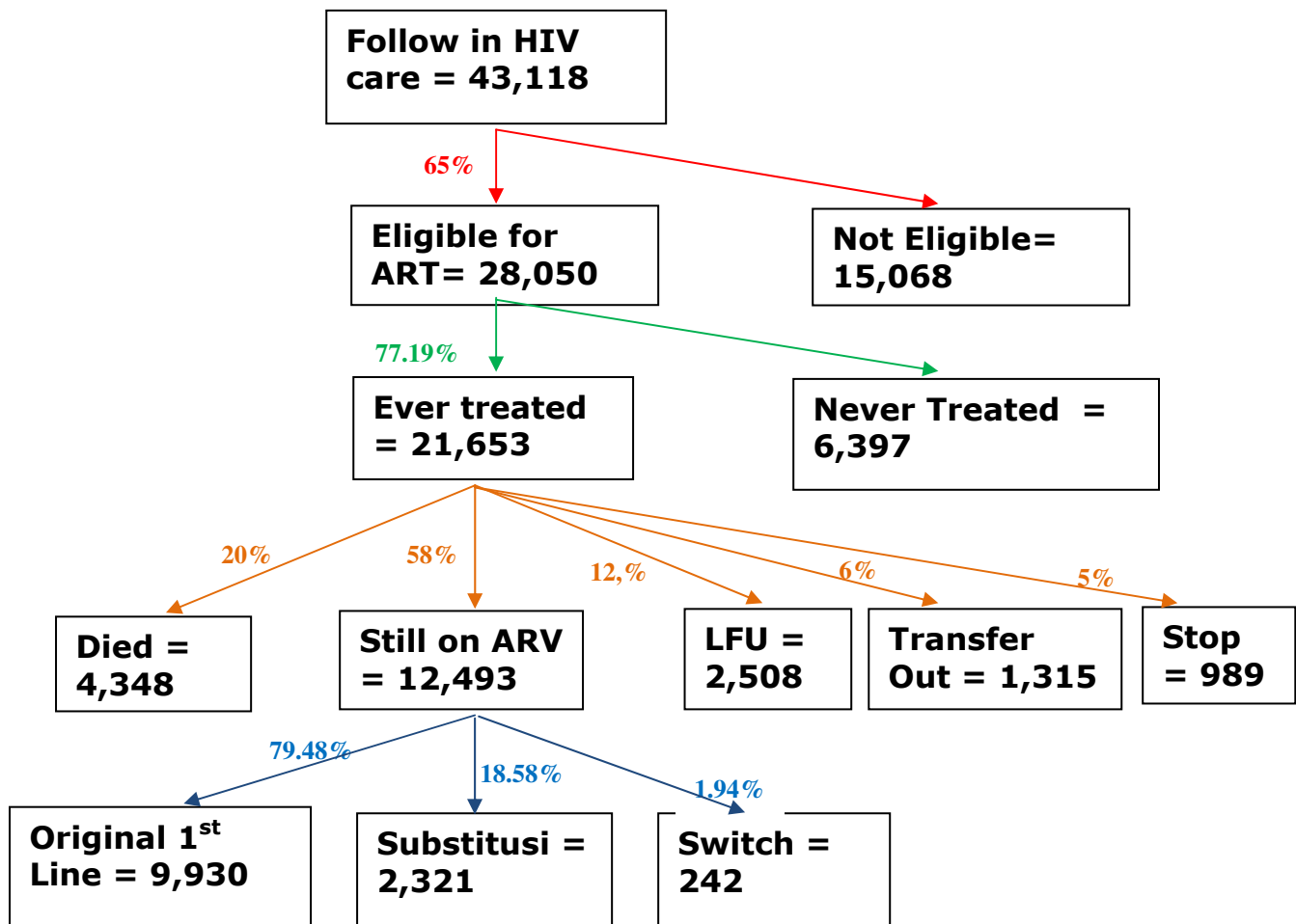
We, the Government of Indonesia, Coordinating Ministry for People's Welfare and Ministry of Manpower and Transmigration, Indonesian Chambers of Commerce and Industry (KADIN), Indonesia Employers' Association (APINDO) and Workers' Organization representative: SBSI (Indonesian Prosperous Trade Union), KSPI (Indonesian Trade Union Congress), and KSPSI (Confederation of the All Indonesian Worker Union) hereby:

- RECOGNIZE that the transmission of HIV/AIDS in Indonesia will potentially threaten business' profitability and productivity, workers' occupational health and society;
- EXPRESS our deep concern that the threat of HIV/AIDS impacts on sustainable national development;
- URGE all parties to collaborate with other efforts among the society especially in the private sector to prevent the spread of HIV/AIDS;
- URGE all parties at the workplace to work together under a tripartite framework with emphasis on the following:
  1. To use the principles of the ILO Code of Practice on HIV/AIDS and the World of Work as a basis for implementing workplace programme on prevention, care and support;
  2. To give priority to prevention programmes on HIV/AIDS including encouraging business and unions to support these programmes;
  3. To encourage and support an effort to deal with stigma and discrimination against workers with HIV/AIDS.

The image shows six handwritten signatures, each followed by a blacked-out name. The signatures are arranged in two columns of three. The first column contains three signatures, and the second column contains three signatures. The signatures are in various styles, including cursive and semi-cursive.

Source:  
<http://www.hsph.harvard.edu/population/aids/indonesia.aids.04.pdf>

**Annex 6. HIV Care and Antiretroviral Therapy Report, June 2009  
(154 hospitals)**



LFU: Lost Follow Up

Source: MoH, 2009a

