Evidence Action[1]
October 2019

Scoping Visit to Indonesia - Summary of Findings[2]

[Executive Summary](#)

[Stakeholders](#)
- [Background on Identified Stakeholders](#)
  - [Government Actors](#)
  - [Professional Organizations](#)
  - [UN or Other Major International Organizations](#)
  - [Additional Health NGOs or Programs](#)
  - [Other](#)
- [Mapping the Stakeholder Interactions](#)

[Syphilis Prevalence](#)

[What Does it Look Like to Get Screened and Treated for Syphilis If You Are a Pregnant Woman?](#)
  - [Where Are Women Going for ANC and What Services Are Offered?](#)
  - [Roles of Different Health Care Providers](#)
  - [National Health Insurance Scheme (JKN)](#)

[Government's Activities on Triple Elimination](#)
  - [Progress on HIV Screening and Treatment](#)
  - [Progress on Syphilis Screening and Treatment](#)
  - [Progress on Hepatitis B Screening](#)

[Other Background on the Government](#)
  - [Decentralization](#)
  - [How Procurement Works](#)

[Views on the Dual Test](#)

[1] Questions can be sent to Anna Konstantinova, Research Manager, Accelerator, at Evidence Action (anna.konstantinova@evidenceaction.org).

[2] All of the findings laid out in this report represent the best summary of information shared by the Indonesian government and local stakeholders during an in-country visit in June/July 2019. It is possible that some of the information provided was misinterpreted, and so further engagement with stakeholders should occur before critical program decisions are made based on the content of this report.

Executive Summary

Based on the numerous conversations with governmental and non-governmental stakeholders and the information they shared, there are several opportunities for a non-profit organization to meaningfully support the Government of Indonesia on expanding maternal syphilis screening and treatment. While our understanding is still tentative, there appear to be existing, actionable gaps in syphilis screening and treatment, interest from the government in addressing the issue via further scale up of rapid testing (either the single syphilis rapid test or the dual HIV/syphilis rapid test), and almost no external stakeholders engaged directly on syphilis. Given these, it is plausible that a technical assistance program to address the identified gaps would be well received by the Ministry of Health.

In this report, we detail: (a) the stakeholders which may be involved in potential maternal syphilis efforts; (b) estimates of syphilis prevalence in Indonesia; (c) description of the ongoing state of care-seeking among pregnant women; (d) the government's activities in regard to triple elimination; (e) additional relevant background on the government, and; (e) the government's views on the dual test.

Stakeholders

Background on Identified Stakeholders

Government Actors

The triple elimination strategy implementation is a collaboration between the Sub-Directorate of Maternal and Child Health, the Sub-Directorate of HIV and STIs, and the Subdirectorate of Hepatitis and Gastrointestinal Infectious Disease.

Sub-Directorate of Maternal and Child Health, Directorate of Family Health, Ministry of Health. The Directorate of Family Health is run by Dr. Erna Mulati who was newly installed in her role in April 2019. Dr. Nida Rohmawati is the Head of the Sub-Directorate of Maternal and Child Health, and under her, Dr. Mularsih Restianingrum is responsible for maternal health. As part of their maternal health responsibilities, this Sub-Directorate is accountable for all services provided in antenatal care (ANC), including prevention of mother-to-child transmission (PMTCT) activities.

Sub-Directorate of HIV and STIs, Directorate of Control and Prevention of Infectious Diseases, Ministry of Health. In the context of triple elimination, the Sub-Directorate of HIV and STIs is responsible for setting guidelines/policies/regulations as to which provider types and facility types can provide screening and treatment services for HIV and syphilis and what the services consist of. This Sub-Directorate also controls all of the government funding for HIV and

STIs and procures all non-ARV commodities (rapid tests for HIV and syphilis and BPG). In addition, the Sub-Directorate of HIV and STIs conducts training for providers in screening and treatment. Within this Sub-Directorate, Trijoko Yudopuspito is the person in charge of triple elimination and Dr. Helen Pameswari is the person in charge of syphilis.

Sub-Directorate of Hepatitis and Gastrointestinal Infectious Diseases, Directorate of Control and Prevention of Infectious Diseases, Ministry of Health. As the third pillar of the triple elimination program, this Sub-Directorate is responsible for setting policy and doing procurement as it relates to Hepatitis B.

Indonesian Ministry of National Development and Planning (Bappenas). Bappenas's role is to create a national 5-yr plan and indicative budget for all ministries and levels of government (central, provincial, and district/city) to use as a guideline for establishing their annual work plans. The upcoming plan will span from 2020 to 2024. Bappenas is also responsible for evaluating how well programs are implemented and to measure progress against a set of objectives and goals. In health, the current priority areas are HIV, TB, malaria, maternal health (anemia and access to care), and child health (pneumonia and diarrhea).

National Public Procurement Agency. The National Public Procurement Agency (LKPP) is a non-ministerial body that is responsible for conducting the Indonesian government's annual bidding process for products across sectors. The Agency creates a public bidding process for all new goods that programs indicate they want to procure, looking for manufacturers who can meet specific price and volume requirements.

Center for Health Financing and Budgeting, Ministry of Health. The Center for Health Financing and Budgeting is responsible for deciding on the per-unit cost of the reimbursement that goes to health facilities for different types of health visits, including ANC.

Family Health Section, Jakarta Health Agency. The Jakarta Health Agency is the provincial team responsible for managing health programs in the city of Jakarta. Given the existing decentralization, this body is the one responsible for implementing central government policy. Jakarta is leading the way among provinces making progress on triple elimination, with a screening rate of 77% and a treatment rate of 62% in 2018.

Laboratory Working Group. The laboratory working group is made up of approximately 30 clinical pathologists and medical doctors of varying specialties. The group meets at the behest of the Sub-Directorate for HIV and STIs and provides technical advice for executing specific programs in the areas of guidelines, how to allocate limited resources, what content should be included for provider training, and how to manage testing reagents. The group also participates in training providers (general practitioners, dermatology specialists, midwives, and laboratory staff).

STI Working Group. The STI working group consists of approximately 60 dermatologists who practice at academic hospitals across Indonesia. The working group meets when the MoH requests their advice, largely meeting with the Sub-Directorate of HIV and STIs, the Directorate of Family Health, and the Sub-Directorate of Cancer. In addition to these meetings, the group supports the government in writing guidelines and training providers, and holds its own symposiums for dermatologists.

Professional Organizations

Indonesian Obstetrics and Gynecology Association (POGI). POGI works with the government in advocacy and promotion of particular policies, including triple elimination. POGI's focus is on reducing maternal mortality via a focus on PPH, pre-eclampsia, and sepsis, and on reducing neonatal mortality. POGI also supports the government in training health care providers.

Indonesian Midwives Association (IBI). The Indonesian Midwives Association is a professional organization for midwives which currently has about half of Indonesia's 800,000 midwives enrolled as members. Their work includes developing guidelines and professional standards for midwives, conducting continuing medical education for midwives, and encouraging adherence to professional ethics. IBI partners with other professional organizations and with the Ministry of Health and the Ministry of Women and Child Protection. IBI is a strong platform for reaching midwives across Indonesia.

Indonesia Society of Dermatology and Venereology. Professional organizations play a very large role in Indonesia, and as dermatologists are the ones specifically trained to address syphilis, this group will be important to changing policies around syphilis.

UN or Other Major International Organizations

UNICEF. UNICEF has been working to advance PMTCT of HIV in Indonesia since 2012 and currently operates in nine provinces. In 2014, UNICEF supported increased screening and treatment of HIV and syphilis during ANC in three demonstration regions in partnership with the government: West Jakarta, Surabaya, and Sorong. More generally, UNICEF provides technical assistance and support in training, logistics, and communication from the central level to the district level.

UNAIDS. UNAIDS works in three main areas in Indonesia: supporting the government in estimating HIV and AIDS prevalence and mortality due to AIDS among at-risk groups, pregnant women, and the general population; influencing policy development in the area of improved access to HIV prevention, screening, and treatment; and communications to the general public on HIV/AIDS. Although their work does not directly touch maternal syphilis, they are aware of the workings of the government, their data collection and reporting, and the presence of services among health facilities.

WHO. The WHO's Indonesia office does work in the areas of: communicable diseases; noncommunicable diseases; promoting health throughout the life-course; health systems; preparedness, surveillance, and responses; and emergencies. The WHO lobbies the government to engage on international agreements in regard to health advancement, including the Asia-Pacific commitment to triple elimination. The WHO also provides technical assistance to the government and has engaged closely with the MoH on ongoing activities regarding triple elimination.

Global Fund. Global Fund is the main external funder of HIV/AIDS activities in Indonesia, which includes funding UNICEF, supporting government training activities, and partially funding PMTCT service delivery. We also believe some of the Global Fund resources are set aside to address syphilis, including an interest in procuring the dual test, but we are not sure of where all of these efforts stand beyond that they have not procured the dual test thus far (see explanation below).

World Bank. The World Bank has various health programs in Indonesia, although the specific programs in their portfolio are not clear.

Additional Health NGOs or Programs

Planned Parenthood International - Indonesia (PKBI). PKBI has 25 provincial chapters which have a good level of autonomy from the national office and decide what programs they are going to operate as long as the activities advance the overall objectives. The chapters are direct recipients of Global Fund money and the objectives of their HIV work include increasing awareness of HIV and AIDS among at-risk populations, distributing preventive products (condoms and safe needles), encouraging local governments to deliver programs that prevent HIV, and supporting the capacity of local NGOs. PKBI also operates 31 reproductive health clinics and some unknown number of mobile clinics.

Save the Children. Save the Children is focused on improving the lives of children via advancing health, education, wellness, livelihood generation for their parents, and disaster relief. Their current health work includes strengthening health systems via a focus on ICCM, promoting health seeking behavior, improving service delivery within facilities, and working on advocacy to translate policies from the central level to the district level.

GKIA. GKIA is a coalition of Indonesian civil society organizations and individuals whose work focuses on improving the health status of mothers, children, and adolescents. Its current advocacy is largely focused on issues of universal health coverage. The Presidium of GKIA (its governing body) is made up of six organizations: PKBI, Muhammadiyah, Pelkesi, Yayasan Sayangi Tunas Cilik (Save the Children), Wahana Visi (World Vision), and Perinasia (The Indonesian Society of Perinatology). GKIA is well connected to the Ministry of Health, in particular the Sub-Directorate of Maternal and Child Health.

USAID Jalin. Jalin is the third iteration of USAID's maternal and child health program. Jalin is focused on reducing maternal mortality via a focus on hemorrhage, pre-eclampsia, and sepsis, and on reducing neonatal mortality via a focus on low birth weight, asphyxia, and immunizations. The program's intention is to create multi-stakeholder commissions at the national and local level and to provide catalytic funding for locally created solutions aimed at addressing maternal and child health challenges.

CHAI. CHAI's current operations in Indonesia are largely focused on scaling usage of the PCV vaccine and on scoping the potential of working on assistive technologies. In 2018, CHAI did some scoping work to see whether their office would work on screening and treatment for maternal syphilis via the dual test but ultimately rejected that work when the government was not interested in a pilot on the dual test (at the time, their concerns were that it was not registered, was expensive, and training would need to take place to enable its usage).

Chemonics Global Health Supply Chain Program - Procurement and Supply Management. Funded by USAID-PEPFAR, this program began in 2017 and aims to provide the government technical assistance to improve its supply chain management for HIV and TB commodities, with special focus on HIV. Chemonics supports the central government and two provinces, Jakarta and Papua. Their technical assistance focuses on improving forecasting and creating guidelines for proper procurement at all levels of government. As part of their work, Chemonics also holds biannual reviews with key government officials to evaluate progress made on projections, procurement, and distribution.

Muhammadiyah. Muhammadiyah is a Muslim faith-based organizatons that operates the largest chain of private health facilities in Indonesia.

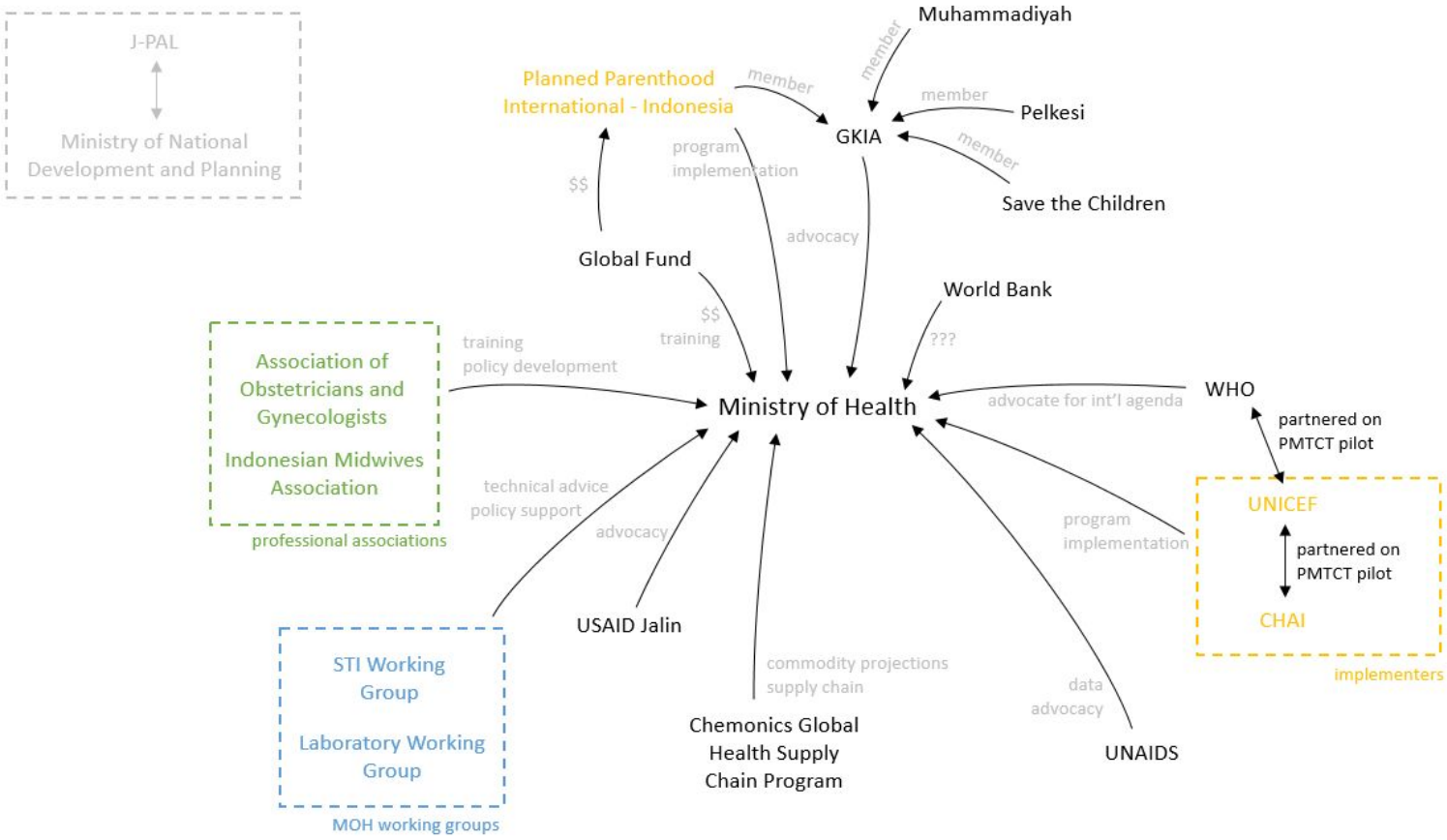
Pelkesi. Pelkesi is a Christian faith-based organization that operates the second largest chain of private health facilities in Indonesia.

Other

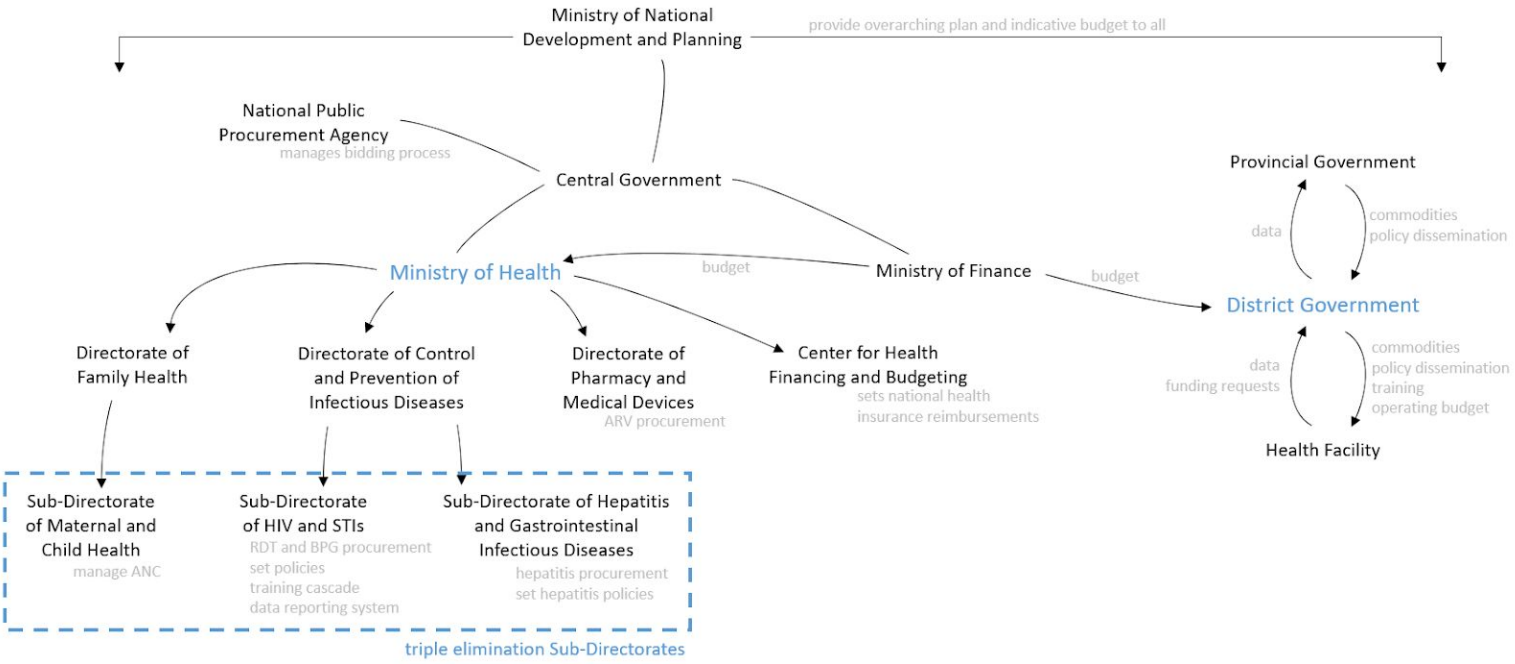
J-PAL Southeast Asia. J-PAL opened its Southeast Asia office in 2013. They conduct research programs in partnership with economists, the government, and occasionally with donors. Their current portfolio does not include any active health programs but they have been involved in health-focused evaluations in the past.

Mapping the Stakeholder Interactions

To the best of our understanding, the following diagram maps the relationships among health sector stakeholders and the government, including some mapping of the relationships among the different organizations. The diagram does not differentiate among the Directorates or Sub-Directorates of the Ministry of Health.



Within the government, the actors who are involved in the triple elimination regulation are mapped as follows:



Syphilis Prevalence

To the best understanding of the sector experts we spoke with, the estimate of syphilis prevalence in Indonesia available in the Global AIDS Monitoring System (GAMS)[3] is based on the number of people who test positive divided by the number of people who are screened, and whose test results are reported as part of the monthly reporting system that tracks HIV among pregnant women, called SIHA.[4]

Recent government data[5] shared during the trip indicates the prevalence may be either 1.4% or 1.7%. According to this data, in 2018, 214,179 out of 5,291,143 pregnant women were screened for syphilis (screening rate = 4.05%). Of those screened, 3,081 tested positive, suggesting the prevalence rate may be 1.44%. 1,593 of those who tested positive were treated with BPG (treatment rate = 51.7%). When the government estimated[6] the expected syphilis burden for 2018, a 1.7% prevalence rate was assumed, in line with the prevalence reported by

[3] Global AIDS Monitoring System publicly available data on syphilis prevalence among ANC attendees. In 2017, according to GAMS, 1.7% of pregnant women were screened (approx. 8,500 women) and the reported prevalence was 3.2%.
[4] Based on conversations with the USAID Jalin program, CHAI, UNICEF, UNAIDS, and WHO.
[5] From a presentation titled, “Action Plan: Workshop for Facilitators of the Prevention of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B” from June 24-25, 2019.
[6] In the same presentation where actual data for 2018 was reported (see previous footnote).

the Ministry of Health in its 2017 Regulation[7] for the Triple Elimination of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B.

The government data shared was likely taken from the SIHA database and may be either an over- or under-estimate. It may be an overestimate because those being screened have a reason to be suspected of having syphilis, given how few women are screened in total across the country. On the other hand, it may be an underestimate because there may be underreporting as some screening cases are captured within the maternal and child health reporting system rather than the HIV reporting system.[8]

There are two additional sources of data that may be used in the future to estimate syphilis prevalence, but both would require some application of modelling. The first is the **Integrated Behavioral and Biological Survey (IBBS)** which measures sex practices and the rates of HIV and other STIs among high risk populations, namely transgender individuals, men who have sex with men, female sex workers, and people who inject drugs. There is publicly available data from 2015 and there will be data upcoming from the survey done in 2018.

The second is the **HIV Sentinel Surveillance (HSS)** which measures HIV prevalence among the same high risk populations as the IBBS, though it is meant to occur on a more ongoing basis as compared to the every 2-yr frequency of the IBBS.[9] Earlier implementations of the sentinel surveillance have not included measures of STI prevalence, though the government is planning to alter this in the future.

UNAIDS mainly relies on IBBS data when modelling the HIV prevalence among pregnant women. When possible, UNAIDS attempts to compare IBBS estimates to those obtained in the HSS and triangulate the size of key populations and the HIV incidence among them to model the prevalence among the general population and among pregnant women.

According to UNAIDS, the national prevalence for HIV is 0.3%. The population prevalence in Papua and West Papua is 1.3%, and many believe that area also has a high syphilis rate. Among high-risk populations, the HIV prevalence is 28% among injection drug users, 30% among men who have sex with men, and 30% among transgender people. Many of the stakeholders we spoke with suggested syphilis is likely to have a variable prevalence across provinces which may also be an area worth further investigation.

[7] Translation of the regulation can be found here.
[8] The government is in the midst of improving the coordination and data collection mechanisms across the maternal and child health branch and the HIV/AIDS branch.
[9] See UNAIDS report on the relative data provided by the HSS and IBBS in Indonesia.

What Does it Look Like to Get Screened and Treated for Syphilis If You Are a Pregnant Woman?

Where Are Women Going for ANC and What Services Are Offered?

According to DHS data, 95.4% of Indonesian women attend at least one ANC visit and 97% of occur at or before the 24th gestational week. Based on the 2016 National Health Indicator Survey (Sirkesnas), of those attending ANC:

- **41.8% go to a private midwife practice.** Midwives are allowed to screen women for syphilis but are not allowed to provide treatment. There may be issues of test availability at midwifery practices.
- 15.1% go to a puskesmas (public primary health center). Providers at a puskesmas can do syphilis screening and treatment.
- 11.7% go to a posyandu (public mother and child village-level healthcare center). These are often staffed by community health volunteers, with rotating visits for nursing staff, so it is likely neither screening nor treatment are available.
- **10.1% go to a private doctor, private polyclinic, or private hospital.** Private doctors are allowed to screen and treat pregnant women.
- 12.0% go to a polindes or poskesdes (public village polyclinics or health post) or a pustu (public auxiliary health center). These are often staffed by community health volunteers, with rotating visits for nursing staff, so it is likely neither screening nor treatment are available.
- 2.4% go to a public hospital. Screening and treatment services are available at hospitals.

Of the different types of government facilities, only the puskesmas (of which there are about 10,000) and public hospitals (of which there are about 2,500) are regularly equipped with diagnostic services for syphilis; lower level public facilities cannot do syphilis screening and there is no intention to change that in the policy as of yet. All public hospitals have laboratories and so they have both rapid testing and lab-based tests for syphilis. There are puskesmas with laboratories and ones without -- those without only offer rapid testing whereas those with laboratories may offer both rapid testing and lab-based tests.

For all private practices regardless of the type or staffing, it is at the discretion of the private facility whether they want to offer testing services for syphilis, but they are required to deliver the basic package of ANC tests which currently includes only hemoglobin, proteinuria, glucose, and blood-typing. Should they offer syphilis testing, the private facilities must procure all of the commodities themselves (thus far, they do not have access to the e-catalogue system though that is likely to change). Private facilities can eventually be reimbursed for syphilis screening though there may be delays in the payments that make procurement cycles more difficult at private facilities. In certain areas, the puskesmas can also decide to supply rapid tests to private clinics, though it’s not clear how often this happens in practice.

Taking this information together, 76.5% of initial ANC appointments occur at facilities where the presence of rapid or lab-based syphilis screening is not guaranteed, and in many cases, is prohibited.

Roles of Different Health Care Providers

In Indonesia, there are the following types of health care providers:

- Specialists, such as dermatologists, pediatricians, obstetricians and gynecologists, etc.
- General practitioners, or GPs
- Nurses
- Midwives (bidan)
- Community health workers (kader)

The village-based public facilities (posyandu, pustu, polindes, and poskesdes) are often staffed by community health workers on a day-to-day basis but have midwives and nurses come to provide services on a specific schedule.[10] In most cases, the community health workers in the village-based facilities report to a given puskesmas. At a puskesmas, one can find general practitioners, nurses, midwives, and community health workers. Specialists are often only found at hospitals and most prefer[11] working in urban areas.

In regard to syphilis, midwives are being trained to conduct rapid syphilis testing, though it's not clear the extent to which the training includes public *and private* midwives.[12] Private midwives are supposed to refer pregnant women to a puskesmas to be screened if they are not trained in rapid testing or do not procure the rapid tests themselves. If a woman tests positive for syphilis, historically, she would need to be referred to a hospital to be treated by a dermatologist. In 2018, the government passed a new regulation to allow general practitioners to treat women for syphilis in order to enable the treatment to occur at a puskesmas. The government is in the midst of rolling out a training curriculum for general practitioners on how to do syphilis treatment. **These trainings are focused on combating GP fears/unwillingness to provide BPG injections due to fears of allergic reactions**.[13]

In Indonesia, "task shifting" refers to a system in which the set of activities a given provider can do is expanded in areas where there is an absence of higher skilled health professionals. For example, in a remote village where the only provider is a midwife (called a bidan desa), she is specifically trained to provide more services than a typical midwife and regulations can be passed at the district level to allow for this. At this time, we are unclear whether this would allow midwives to eventually treat pregnant women for syphilis (though this seemed unlikely based on responses to our queries), or to what extent this role expansion specifically affects triple

[10] Additional information can be found in this MCC report.
[11] According to the Indonesian Society of Obstetricians and Gynecologists.
[12] The Indoneisan Midwives Association indicated private midwives may have to pay to attend trainings to conduct syphilis testing.
[13] Based on conversations with UNICEF, the MoH laboratory working group, and CHAI.

elimination, particularly around testing capacity. There is a particular task shifting regulation that concerns this area, which may be worth further investigation to be sure we understand what is possible. It seems likely that this is an important point of leverage in increasing testing and treatment rates in remote areas.

Further, the 2016 National Health Indicator Survey reports that **85.0% of ANC appointments are conducted by a midwife**, 13.8% are conducted by an obstetrician, 0.5% are conducted by a general practitioner, and 0.5% are conducted by a nurse. **As a whole, this information suggests that while many women are seeing an ANC provider who is able to screen them for syphilis, in principle, they are not able to receive treatment from that same provider and so must be referred onward for treatment.**

National Health Insurance Scheme (JKN)

On 1 January 2014, the Indonesian government launched a national health insurance scheme called Jaminan Kesehatan Nasional (JKN). The intention of the program is to have all people in Indonesia covered by the end of 2019. Under this program, households are required to pay monthly premiums; the minimum monthly premium is approximately $2 per person and the maximum is approximately $6 per person. Pregnant women are not required to pay an additional copayment[14] for any of their ANC services at public health facilities. Certain private health facilities, including midwife clinics, can also apply to be included as a reimbursable facility for JKN such that pregnant women do not need to pay additional fees when seeking ANC care.

For pregnant women, the shift to JKN posed one specific challenge that the government is in the midst of addressing. Prior to the introduction of JKN, there was a different program called Jampersal that covered the costs of pregnancy services (ANC and delivery, possibly postnatal too) for all pregnant women in Indonesia. Women did not have to enroll specifically in this program. Rather, facilities had to request reimbursement for the services as they were provided. Once JKN was introduced, the government eliminated Jampersal which left many women uncovered as they had to go through a registration process to obtain JKN and there are premiums associated with JKN that did not exist with Jampersal. This issue has been identified for some time and is unlikely to be a major problem in the future as 81% of the population has been covered by JKN since January 2019.[15]

The transition to the JKN scheme poses a unique challenge for private facilities, especially midwife clinics. The JKN scheme reimburses a facility of any type approximately $4 per ANC visit. For public facilities, this reimbursement is sufficient because the infrastructure, commodities, and salaries are funded separately by the government. For private midwife clinics in particular, they have two choices:

1. Register to get reimbursed by the JKN scheme. In this case, the policy is ambiguous as to whether the midwives can charge a copayment. If not, then a midwife must rely solely

[14] We do not know what the copayment scheme is for other populations or visit-purposes.
[15] https://www.thejakartapost.com/academia/2019/01/09/taking-jkn-for-granted.html

on the $4 reimbursement per ANC to cover their facility costs, wage bill, and commodities -- this reimbursement is may not be enough especially given potential repayment delays and the need to procure commodities in advance.

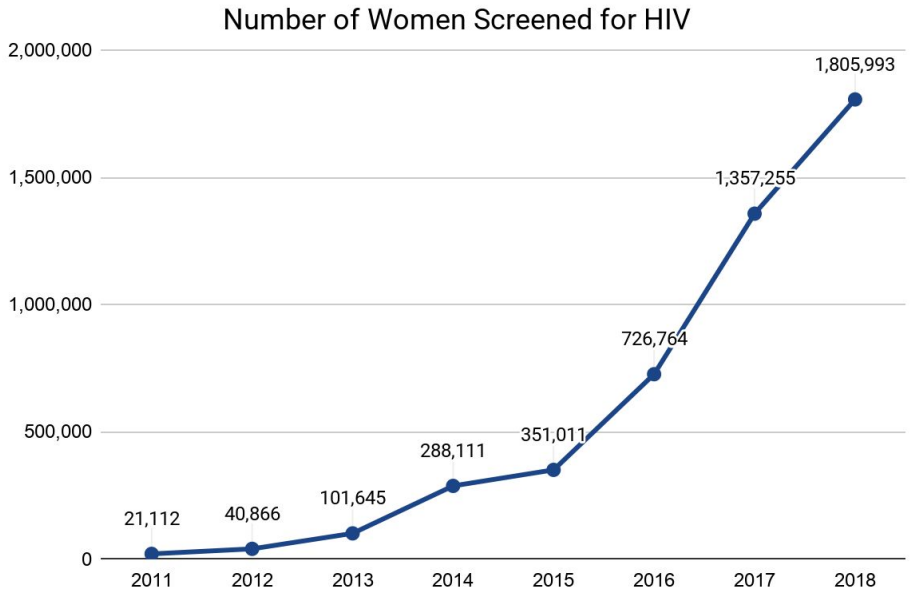
2. Charge pregnant women for services.

As the above data demonstrated, many women are going to private midwife clinics, which poses an issue of cost and access under the health insurance scheme.

Government's Activities on Triple Elimination

Progress on HIV Screening and Treatment

Since 2011, the number of women screened rate for HIV during antenatal care has nearly doubled each year, and an upward trend in the screening rate is likely to continue.[16,17] As of 2018, roughly a third of pregnant women received HIV screening.



The government released an official regulation calling for the elimination of mother-to-child transmission (EMTCT) of HIV in 2014. With the focus put on prevention of mother-to-child transmission of HIV, the government initiated a policy to allow rapid testing during ANC at lower

[16] Data is taken from two government presentations: (1) "Action Plan: Workshop for Facilitators of the Prevention of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B" from June 24-25, 2019; (2) "Policy for the Prevention of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B" from November 6-9, 2017.

[17] It is possible that even more women are being screened each year. The commodities data suggests between 2.5 and 3 million rapid tests were used in 2018 although only 1.8 million tests were reported in the MoH SIHA reporting system. This may be due to either: (1) underreporting or, (2) provincial and district governments are keeping tests as buffer stock (according to the WHO and the Chemonics Global Health Supply Chain Program).

level health facilities rather than restricting HIV screening to hospitals or only those puskesmas with a laboratory. In fact, **according to UNICEF and UNAIDS, the main reason the government has been able to increase screening is by steadily expanding the number of puskesmas that are equipped with rapid testing**. Currently, of the approximately 10,000 puskesmas in Indonesia, at least 7,000 are able to do initial rapid screening for HIV. In high prevalence areas, puskesmas also have the rapid tests for confirmation and tie-breaking. In low prevalence areas, women who test positive via screening most often have to go to a higher level facility to get further testing. To enable its commitment to EMTCT of HIV, the government is procuring 7 million rapid tests each year. Each test costs between 11,000 and 12,000 Indonesian rupiah ($0.79-$0.86) and the brands procured in Indonesia include SD Bioline, Focus, Oncoprobe, and Vikia.

Ongoing challenges faced in further increasing HIV screening, which the government is working to address, include:

- Continuing to train staff to use rapid HIV tests and ensuring the supply of rapid tests reaches health facilities in a timely manner.
- Ensuring staff, particularly midwives, are properly trained in providing counseling in order to encourage women to consent to being tested.
- Providing health care providers with the skills needed to communicate HIV test results so they are less reticent to initiate screening for their patients.
- Improving follow up for women who are referred to a puskesmas or other facility for HIV screening if they had their ANC visit at a midwife clinic or other place where rapid tests are not available.

Indonesia also has a low treatment rate for HIV. Among pregnant women who tested positive for HIV during ANC, only 13% were on ARVs as of 2017.[18] According to UNAIDS, the reason behind this gap is two-fold. First, the government has only recently begun implementing the test-and-treat approach where women get immediately put on ARVs regardless of what their CD4 count is; the policy was approved in July 2018. Second, approximately 50 of the 10,000 puskesmas in Indonesia are capable of providing ARV treatment. A new policy was passed in 2018 to allow puskesmas to dispense ARVs whereas previously it was restricted to hospitals. The MoH is now in the midst of implementing it by training and equipping puskesmas with Global Fund[19] support.

[18] UNICEF report, “PMTCT of HIV and Syphilis in Indonesia.”
[19] Global Fund has given the MoH and Spiritia a $90 million grant over 3 years. The mandate for the funding is to have at least 40% of those living with HIV on treatment by 2020.

Progress on Syphilis Screening and Treatment

	2017[20]	2018
Screening rate	2.1%	4.05%
Treatment rate	21.1%	51.7%

The government is attempting to increase screening and treatment rates. In regard to screening, the government procured 1.5 million syphilis-only rapid tests in 2017 and 2.5 million in 2018. There are plans to procure 2 million rapid tests in 2019 and these should be distributed to provinces from the central government by September of this year. For 2020, the government is currently planning to procure 2.3 million syphilis RDTs. The manufacturers of the syphilis RDTs procured by the government include SD Bioline, Focus, Hexagon, and InTec, and the price of a single RDT is between 15,000 and 20,000 Indonesian rupiah ($1.07-$1.43 USD). **Overall, the government is exhibiting a willingness to procure RDTs, despite their usage rate remaining stagnant.**

The government is also moving forward with training to implement the new policies its set forward as part of the triple elimination approach. This training focuses on three main areas as it relates to syphilis:

1. Sensitizing local government teams as to the goals, activities, and timelines of the triple elimination regulation.
2. Training general practitioners on treating pregnant women who test positive for syphilis.
3. Training midwives and other relevant health care providers, including laboratory personnel, on the use of the syphilis rapid test.

In order to do this training and sensitization, PMTCT teams have been created at the provincial level that include a general practitioner, a nurse, a laboratory technician, a dermatologist, a gynecologist, an internal medicine specialist, a pediatrician, and a midwife. These teams are brought in by the central government annually to report on the progress they've made in triple elimination and are also responsible for disseminating the new regulations to district teams and arranging for trainings at the local level.

While there is interest and ongoing activities regarding triple elimination occurring at the central level, the ultimate implementation of the program depends on activities taking place at the district level.

[20] On this visit, the government did not provide data prior to 2017. There is data in the Global AIDS Monitoring System going back to 2011.

Progress on Hepatitis B Screening

Between January and September 2017, only 5.4% of pregnant women were screened for syphilis. The regulation including hepatitis B as part of the triple elimination strategy was published sometime in 2017. **By the end of 2018, 29% of pregnant women had been screened for the infection during their pregnancy.**

Other Background on the Government

Currently, the government's broader health priorities for 2020 are stunting, TB, and improved immunization rates for children. As top priority areas, these will have faster mobilization of resources. Although syphilis and PMTCT is not specifically listed among the health priorities, there is political will in achieving the goals set forward in the triple elimination regulation.

Decentralization

There are three levels of the government: central, provincial, and district/city. At the national level, the government responsibilities in regard to triple elimination include:

- Creating policies and guidelines to facilitate triple elimination activities.
- Disseminating information down to the *provincial* level.
- Procuring rapid tests, ARVs, and BPG, and distributing the commodities down to the *provincial* level.
- Monitoring progress and bringing together provincial PMTCT teams annually to discuss challenges and successes on PMTCT.
- Engaging with professional associations to initiate training-of-trainers cascades to train providers in doing rapid testing and identifying and treating maternal syphilis and syphilis in infants.

The mandate for provincial governments is to disseminate the information and distribute the commodities received from the central government down to the district governments, and to report data from the districts up to the central government. We have been told that **in general, provinces have a minimal role to play in the functioning of the decentralized government because they do not have ultimate decision making authority at either the central or the local level** and have small operating budgets.

District governments have their own budgets, often relatively large, set by the Ministry of Finance. Districts have autonomy in deciding how to utilize their budgets, as long as they are in line with broader national objectives. In general, districts choose what health commodities to procure, but in the case of triple elimination, it was decided that the procurement will take place centrally (that is why the central MoH is procuring 7 million HIV RDTs and approx. 2 million syphilis RDTs annually). District governments are responsible for disseminating information and distributing commodities received from the provincial government down to facilities and health care providers; district governments need to set aside funding for training health care providers

as part of fulfilling the TOT cascade. Districts are also responsible for reporting on various indicators up to the provincial government.

There are a few coordination mechanisms between the national and district levels that we might leverage. At the national level, there are annual (or biannual) MoH planning meetings where the central government brings provincial governments to disseminate information, set program targets, and make procurement projections. At the tactical level, there is a WhatsApp group, on which several of the key national stakeholders - and possibly relevant district officials - discuss issues related to Triple Elimination.

Overall, the existing decentralization suggests efforts may need to take place simultaneously at the national and local levels. Further discussions with key stakeholders in this regard are necessary.

How Procurement Works

Typically, the Indonesian government begins its annual bidding and procurement process in March or April each year. If there are any new products requested by a given ministry, the National Public Procurement Agency (LKPP) puts out a bid request that sets performance specifications, price bounds, and quantities needed. Manufacturing firms can then bid to secure the rights to be the supplier of the product. LKPP chooses the supplier who is best able to meet the price goal, has the capacity to deliver the volumes needed, and can demonstrate a commitment to fulfilling the tender.

All products that have gone through bidding and have a supplier are entered into the e-catalogue. The bidding process is not repeated every year for products that are already in the e-catalogue unless there is some global market shift and the program makes a specific request to LKPP to repeat it. The government is in the midst of implementing a new approach to LKPP's structure wherein its activities are divided by sector. There is also a shift to allowing multiple winners for each bid, but this is only being allowed for certain products right now.

Most procurement of health commodities in Indonesia takes place at the district level via the e-catalogue. The districts use whatever budget was allocated to them from the Ministry of Finance to buy what is needed for their facilities. The health facilities make proposals for what they will need each year. Jakarta Province is one exception to this in that the health facilities have their own allocated budgets and can procure directly in the e-catalogue as they wish.

Unlike general practice, **for the triple elimination program, commodities are procured centrally**. The Sub-Directorate of HIV and STIs projects how much of the rapid tests, BPG, and ARVs will be needed for the coming year. This is done during bi-annual forecasting workshops organized by the Chemonics Global Health Supply Chain Program. Once the quantities are set, the Sub-Directorate of HIV and STIs issues a tender and completes procurement of the rapid

tests and BPG. ARVs are procured separately by the Directorate of Pharmacy and Medical Devices.

Once the central government has the HIV and syphilis commodities, it is responsible for distributing them to the provinces by September. Provinces are then expected to deliver the commodities to districts which deliver it to facilities. Facilities can expect to receive the commodities by December.

Central procurement and distribution to provincial governments takes place once a year. In rare circumstances, it can take place twice a year. The provinces distribute commodities to districts approximately twice a year. Districts then distribute commodities to facilities once a month or once every three months.

If districts are anticipating stock outs or want more commodities than the central government is planning to supply, they are within their rights to use their locally allocated budget to purchase additional HIV and STI commodities.

According to the Chemonics Global Health Supply Chain Program, there are generally no stock outs for HIV commodities, which they were more familiar with. The last stock out issue occurred in 2017 for HIV rapid tests because the central procurement took place late in the year; that issue has not resurfaced since.

Views on the Dual Test

During our single meeting with the MoH, Trijoko Yudopuspito, the person in charge of triple elimination, mentioned that he has been approached several times about switching to the dual test but has yet to undertake the transition. CHAI has told us that the government's main concerns in making the switch are:

1. **The cost of the dual test is higher in comparison to the single tests.** The dual test currently registered in the government's e-catalogue is upward of $3.00 USD[21] whereas the HIV screening test is 11,000-12,000 IDR or $0.79 to $0.86 and the cost of the syphilis rapid test is 15,000 to 20,000 IDR or $1.07 to $1.43.
2. **There are existing stocks of single rapid tests (both HIV and syphilis) that have not been used.**
3. **Switching to the dual test would require training providers** in new protocols which may be costly and time-consuming.

The Global Fund has sought to procure the dual test on the global market because they believe they can get a much lower price than the Indonesian domestic price. However, they are unable to do so under current Indonesian procurement regulations. Since the product has already been registered in Indonesia and is included in the e-catalogue, the policy

[21] According to CHAI.

states it must be procured from *that* manufacturer. The Global Fund can request a “special access scheme” to be able to procure overseas. In this case, a recommendation from the program and strong evidence about why the product must be procured in the global market are needed. The Global Fund has done this for other commodities, so it’s conceivable that with the right political will, this could be achieved for the dual test.

Other non-governmental stakeholders that we’ve spoken to have seemed especially interested in the potential of the dual test in simplifying ANC by having only one fingerstick test rather than two. These stakeholders have repeatedly mentioned that **the government’s preference for assessing new technologies is to pilot them in specific demonstration regions with explicit plans for how to scale nationally once the pilots are successful**.