HP+ POLICY *Brief*

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Legal and Regulatory Review to Support Strategic Health Purchasing for HIV in Indonesia

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Introduction

The Government of Indonesia plans to rapidly scale-up access to HIV services to meet newly established minimum service standards and achieve ambitious targets for identification, treatment, and viral load testing. The Ministry of Health's Antiretroviral Therapy (ART) Acceleration Plan aims for 40 percent of people living with HIV to be on ART by the end of 2020 and 90 percent by 2027 (Circular Letter No. 1822/2019). As of May 2020, of approximately 640,443 people living with HIV, 62 percent (394,769) knew their status but only 21 percent (133,551) were on treatment. Most people living with HIV (91 percent) who received viral load testing in 2019 have reached viral suppression, however viral load testing coverage is low (1 percent) and varies widely across Indonesia. The significant scale-up of the HIV response, combined with projected declines in external financing support for HIV and stable domestic resource availability, require the government to consider strategic purchasing reforms for HIV service provision to ensure optimal use of resources to achieve targets and successfully curb the HIV epidemic.

The Health Policy Plus (HP+) project—funded by the U.S. Agency for International Development—conducted several financing analyses and stakeholder consultations to inform recommendations for implementing strategic health purchasing reforms. This was conducted in coordination with Indonesia's HIV Strategic Health Purchasing Technical Working Group, led by the Ministry of Health's Center for Health Financing and Insurance and the Ministry's HIV Sub-directorate. As part of this support,

This brief presents findings undertaken to:

1. Analyze current laws, regulations, and additional national/local policy documents that apply to the provision and financing of HIV services by national and local governments
2. Identify HIV service delivery and financing-related laws and regulations that can potentially be targeted for strategic health purchasing reforms

HP+ conducted a literature review to identify regulations, laws, and policy documents related to financing and implementing HIV programming in Indonesia. In addition, key informant interviews were conducted with policymakers, program implementers, and bilateral/multilateral partners to gather officials' perspectives on current laws and regulations.

HP+ also conducted a legal and regulatory review of current legislation and guidelines governing HIV program implementation, management, and financing in Indonesia. Identifying laws and regulations related to the HIV program in Indonesia is important to understand which laws and regulations must be targeted for reform when implementing health financing and purchasing system adjustments. The following policy brief summarizes findings from this legal and regulatory review.

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Laws and Regulations on HIV Service Delivery

The Health Ministerial Regulation on HIV Prevention (No. 21/2013) is the legal umbrella of all HIV programming in Indonesia. Article 9 defines HIV prevention as consisting of (1) health promotion, (2) HIV prevention, (3) HIV screening and testing, (4) care, support, and treatment, and (5) rehabilitation. More detail on each HIV program area is described in Table 1, including the relevant laws, regulations, and guidelines under each category.

Table 1. Laws, Regulations, and Guidelines Relating to HIV Service Delivery by Program Area

HIV Program Area	Description	Relevant Laws and Regulations
Health promotion	Activities consist of public service advertisements, condom use campaigns, health promotion for youth and adolescents, capacity building for harm reduction and HIV prevention programming among medical staff, and training for non-medical staff, among other programs.	Health Ministerial Regulations: No. 21/2013; No. 585/MENKES/SK/V/2007; No. 74/2015; No. 44/2018
HIV prevention	Includes (1) prevention of HIV infection through sexual intercourse, (2) prevention of HIV infection through non-sexual intercourse, which includes donor blood screening and harm reduction for people who inject drugs, and (3) prevention of HIV infection from mother to child, which includes prevention of HIV infection among reproductive-age women, prevention of unplanned pregnancy among women living with HIV, prevention of HIV infection from pregnant women to their infants, and providing psychological, social, and treatment support for mothers living with HIV, their children, and families.	Health Ministerial Regulation No. 21/2013 Ministry of Health Regulation No. 55/2015 Sexually Transmitted Infection National Guideline
HIV screening and testing	Activities are aimed at the early detection of HIV based on principles of confidentiality, consent, counseling, documentation, reporting, and referral. HIV testing can be carried out through voluntary counseling and testing and provider-initiated counseling and testing. Testing requires the patient's consent unless the patient has a specific appointment in the army or police force, there is a medical emergency to treat a patient with clinical manifestation of HIV/AIDS, or there is a request from authority based on existing regulations.	Health Ministerial Regulation No. 21/2013 Ministry of Health Regulation No. 74/2014
Care, support, and treatment	HIV/AIDS treatment is carried out through therapeutics, prophylaxis, and support. Antiretroviral therapy must be used for people living with HIV with stage 3 or 4 clinical infection or with a CD4 count less than or at least 350 cells/mm^3, pregnant women living with HIV, and people living with HIV with tuberculosis. The *Test and Treat All Policy* is based on the concepts that (1) early diagnosis and immediate treatment initiation will reduce morbidity and mortality among people living with HIV, both due to HIV and other causes, and (2) reducing the amount of HIV viral load will significantly reduce HIV transmission. A test and treat all approach must include identifying people living with HIV as soon as possible, starting with high-risk groups, and immediately linking identified people living with HIV with hospitals or providers that provide antiretrovirals, adherence counseling, and health education.	Health Ministerial Regulation No. 21/2013 Ministry of Health Regulation No. 87/2014 Test and Treat All Policy

HIV Program Area	Description	Relevant Laws and Regulations
Rehabilitation	Refers to medical and social rehabilitation within the HIV/AIDS prevention activities carried out for key populations, especially sex workers and people who inject drugs.	Health Ministerial Regulations: No. 21/2013; No. 2415/2011 Ministry of Social Affairs Regulation No. 6/2018

Note: Laws, regulations, and guidelines presented above may not be comprehensive of all laws, regulations, and guidelines that apply to HIV service delivery.

Role of Provincial and District Governments in HIV Service Delivery

The role of provincial and district/municipal governments in the AIDS response is outlined in the Health Ministerial Regulation on HIV Prevention (No. 21/2013). For provincial and district/municipal governments, this includes coordinating and carrying out HIV program implementation efforts, organizing information systems for reporting and evaluation, determining the HIV situation at the local level, and ensuring availability of referral and primary level health services for prevention and control of HIV. For medical procurement and medicines availability, however, responsibility lies mostly with the central government.

Among HIV service delivery regulations, HP+ found differences in the defined responsibility of local governments for implementing HIV programming. In particular, there are differences between the Clinical Practice Guidelines for Doctors at Primary Health Care Facilities (Health Ministerial Regulation No. 5/2014) and the Technical Standard for Fulfillment of Basic Services Quality in Minimum Health Services Standard (Health Ministerial Regulation No. 4/2019) (see Table 2). Furthermore, at the subnational level, the Minimum Health Services Standard does not include HIV treatment and several program areas that are mentioned in the Health Ministerial Regulation on HIV Prevention (No. 21/2013). Instead, local government requirements are limited to health promotion and HIV screening. Although the Minimum Health Services Standard does not include HIV treatment and care and support performance targets, local governments can and should still offer these services at the primary care level per the Clinical Practice Guidelines for Doctors (Health Ministerial Regulation No. 5/2014).

National ART Acceleration Plan

Another important guideline relating to HIV service delivery is the ART Acceleration Plan (Centers of Disease Control and Prevention, Ministry of Health Circular Letter No. 1822/2019), which defines HIV program scale-up targets for Indonesia. The plan's directives for provincial and regency/municipal departments of health are shown in Table 3. These directives are intended to increase ART coverage, which will also increase the cost of providing care for people living with HIV. Strategic purchasing approaches and increasing integration of HIV services within the national health insurance scheme (Jaminan Kesehatan Nasional or JKN) may be key strategies for Indonesia to finance this ambitious scale-up strategy.

Down-Referral System for People Living with HIV

People living with HIV may need to be referred to advanced care facilities (hospitals) by primary care facilities to access more specialized services or advanced health infrastructure not available at the primary care level.[1] Currently, people living with HIV can continue to receive care at the hospital level without a new referral letter within a certain period of time and according to hospital physician advice even if they are classified as a stable patient.

[1] Further details on overall referral guidance can be found in *Practical Guidance: Tiered Referral System* published by the national health insurance agency, Badan Penyelenggara Jaminan Sosial-Kesehatan.

Table 2. Differences Between Two Health Ministerial Regulations

Clinical Practice Guidelines for Doctors at Primary Health Care Facilities (Regulation No. 5/2014)	Minimum Health Services Standard (Regulation No. 4/2019)
Each region, district, or city is expected to provide all HIV service components consisting of: • Informed consent for HIV testing and other medical actions • Documenting all service activities in the provided form • Anamnesis and full physical examination by doctors • Tuberculosis and opportunistic infections screening • Counseling for sexually active women living with HIV on family planning and sexual and reproductive health, including pregnancy planning • Administering cotrimoxazole as prevention for opportunistic infections • Administering antiretrovirals for eligible people living with HIV • Administering antiretroviral prophylaxis for infants born to HIV-positive mothers • Administering immunization and preventive cotrimoxazole for infants born to HIV-positive mothers • Recommendation for routine HIV, malaria, syphilis, and other sexually transmitted infection tests during antenatal care visits • Counseling to start antiretroviral therapy • Counseling on nutrition, prevention of infection, narcotics, and other necessary counseling services • Recommendation of HIV test to tuberculosis patients, sexually transmitted infection patients, and high-risk groups and their intimate partners, as per the existing regulation • Accompaniment by non-health organization based on the needs of the patient	The regency/municipal government must provide healthcare services according to the standard for anyone bearing the risk of being infected by HIV within their area in a year's time. The definition of health services provided to people at risk of being infected with HIV according to standards includes: 1. Educate risky behavior 2. Screening People at risk of being infected with HIV include: 1. Pregnant women 2. Tuberculosis patients 3. Sexually transmitted infection patients 4. Sex workers 5. Men who have sex with men 6. Transgender/waria 7. Injecting drug users 8. Citizens of correctional assistance

Table 3. Directives under the ART Acceleration Plan

Directives for Provincial Governments	Directives for Regency/Municipal Governments
• Divide the regency/municipal ART acceleration targets based on nationally determined targets • Ensure all regencies/municipalities implement the test and treat policy • Monitor monthly recording and reporting in the HIV/AIDS information system	• Implement the test and treat policy • Reactivate comprehensive continuum of care to accelerate ART by involving district health offices, health service providers, HIV counselor organizations, HIV community organizations, HIV-focused nongovernmental organizations, existing District AIDS Commission, and peer supporters of people living with HIV • Increase the quantity and quality of care, support, and treatment • Scale up regular antiretroviral adherence counseling by trained medical staff and/or an HIV counselor • Provide clinical mentoring at health facilities in collaboration with the local expert team • Monitor monthly reporting and recording in the HIV/AIDS information system • Ensure successful referral of people living with HIV to ART services by involving peer supporters, primary healthcare workers, families, community organizations, and AIDS care communities/cadres • Ensure all health facilities strengthen implementation of HIV testing, partner notification, and collaboration with all parties to increase ART coverage and scale-up of viral load testing

However stable patients could be referred down to a primary care facility for ongoing monitoring and management instead of staying at the hospital level, which carries hospital-level costs for HIV service delivery. Ministry of Health Decree No. 32/2014 regulates a "down referral program" in which services provided to patients with chronic diseases in stable condition are obligated to receive treatment or long-term care at first-level health facilities (i.e., at the primary healthcare level) on the recommendation or referral from specialist doctors. The decree explicitly applies the down referral program to certain non-communicable diseases, but does not include HIV.[2]

Clinical management of people living with HIV in Indonesia was initially introduced at the hospital level due to limited primary healthcare capacity, and this has resulted in many stable people living with HIV still being treated at the hospital level, where costs are higher. To increase efficiencies in management of people living with HIV under JKN, Ministry of Health Decree No. 32/2014 should be revised to include HIV as a case that can be referred to the primary healthcare level once the patient is in stable condition. The implementation of down-referral should consider health system context, however, and ensure primary healthcare facilities are properly equipped and capable of managing people living with HIV before down-referral is implemented.

Laws and Regulations on HIV Financing

Funding Sources for the HIV Program

The total budget for the HIV program in Indonesia has increased every year since 2011. The latest National AIDS Spending Assessment report indicates that the total allocated budget for HIV in fiscal year 2016 was around USD 177 million (Wahyuniar and UNAIDS, 2019). There are three main sources of funding for the HIV program in Indonesia: international (bilateral/multilateral) donor funding, public government (central and subnational, including JKN) funding, and private funding. In 2016, government funding accounted for 74 percent of HIV program funding while donor funding accounted for 26 percent (contribution by private sources was negligible).

Both central and local government contribute a critical portion to HIV financing, mostly for care and treatment, and especially for procurement of drugs and consumables. Most government allocation to HIV comes from non-JKN sources, however JKN does cover some services, such as drugs for sexually transmitted infections (STIs), consultations for HIV/STIs, and inpatient care for any opportunistic infection as well as HIV care as covered through Indonesia Case-Based Groups (INA-CBGs) at the hospital level (National AIDS Commission et al., 2015).[3]

Financing from National and Subnational Governments

Subnational governments receive intergovernmental fiscal transfers from the national government budget that go toward the subnational budget along with locally generated revenue. Transfers to subnational governments include special allocation funds that can be used for physical infrastructure (regulated under UU No. 33/2004; PP No. 141/2018; PP No. 12/2019; and Permenkes No. 2/2019) and non-physical operational improvements (regulated under UU No. 33/2004; PP No. 12/2019; and Permenkes No. 3/2019), as well as deconcentration funds for non-core functions such as planning, technical assistance, and training (regulated under UU No. 23/2014; PP No. 7/2008; Permenkes No. 55/2018), among other transfers. Special allocation funds for non-physical improvements can be used for HIV

[2] Non-communicable diseases for which the down referral program applies include diabetes mellitus, hypertension, cardiovascular disease, asthma, chronic obstructive pulmonary disorder, epilepsy, schizophrenia, hepatitis cirrhosis, and lupus syndrome.

[3] INA-CBGs are tariff payments to hospitals based on diagnosis groups.

prevention and treatment, while deconcentration funds can be used for health promotion and activities that work toward reaching universal health coverage. Locally generated revenue (regulated under UU No. 28/2009; PP No. 12/2019; and Perpres No 82/2018, as well as additional local-level policies) also funds universal health coverage efforts as well as local priority health programs.

Subnational government funding is intended to support implementation of the Minimum Health Services Standard, as mentioned previously. Districts and provinces are responsible for financing education on risky behaviors and HIV screening among their catchment populations under the standard. Subnational governments are expected to use locally generated revenue and intergovernmental fiscal transfers, including from special allocation and deconcentration funds, to finance implementation of the standard. The national government funds antiretroviral drugs (ARVs) and consumables, which accounted for 88 percent in 2015 and 93 percent in 2016 of government spending on HIV (Wahyuniar and UNAIDS, 2019).

Financing from the National Social Health Insurance Scheme

Based on Health Ministerial Decree No. 52/2016, payments from Indonesia's national health insurance scheme, JKN, is based on capitation and non-capitation rates. Antiretroviral drugs are excluded from JKN coverage, per Presidential Decree No. 82/2018 (Article 52, Clause 1, Letter U), which states that interventions/treatments already covered by another program will not be covered by JKN. Thus, ARVs and any related consumables are not covered by JKN as Health Ministerial Regulation No. 199/2004 delegates responsibility for the distribution of free ARVs to the central government.

Reimbursing for ARVs through JKN may be possible through regulatory changes (Prabhakaran et al., 2018). According to Ministry of Health Decree No. 32/2014, certain classes of medicines can be reimbursed outside the tariffs for INA-CBGs at the hospital level. These include medicines for chronic care of patients with chronic conditions. One option is for the Ministry of Health to classify ARV regimens as chronic care drugs, as provision of ARVs for patients responding to therapy requires lifelong treatment (Deeks et al., 2013). This would allow JKN-affiliated facilities that purchase ARVs for patients under their care to be reimbursed by the national health insurance agency based on the INA-CBG claim for ARVs dispensed. Further consideration is needed on how primary care and private facilities could access ARVs under this potential JKN-reimbursed model and whether this would improve timeliness of ARV procurement (Prabhakaran et al., 2018).

JKN payments still cover inpatient and outpatient services for people living with HIV as mentioned in Health Ministerial Regulation No. 52/2016, which refers to INA-CBGs regulated in Health Ministerial Regulation No. 59/2014. Viral load testing can also be covered by JKN but only if it is part of inpatient care. Revisions to INA-CBG rates that include discouraging retention of people living with HIV at hospitals (especially Type A and Type B hospitals) for stable patients will require revisions to Health Ministerial Regulation No. 59/2014.

Some of JKN's regulations make certain HIV interventions challenging to offer through the scheme. Needle and syringe exchange programs and methadone maintenance treatment (a form of opioid substitution therapy) are not currently appropriate for coverage under JKN due to limitations on coverage allowed for health issues caused by drug dependence or self-harm (Presidential Regulation No. 19/2016, Article 25). Methadone maintenance treatment is currently provided in select hospitals and financed by the central government (Prabhakaran et al., 2018).

Mapping of Funding Sources

Table 4 maps each HIV intervention and service component to the current funding source/ mechanism and identifies the specific use of funds for services where more than one funding source is used.

Table 4. Financing and Service Delivery Point for HIV/AIDS Prevention, Case Finding, and Clinical Management Services

Prevention Interventions	Service	Provider Level		Funding Source					
		Primary Care	Referral Care	JKN	Public, National Budget	Public, Sub-national Budget	Public, Health Operational Fund	External, Donor or Private	Patients, Out-of-Pocket
Prevention information and services	Information, education, and communication	✓	✓		✓	✓		✓	
	Condom provision and distribution	✓	✓		✓	✓		✓	
	Outreach for key populations							✓	
	Tuberculosis prophylaxis	✓	✓		✓	✓			
Harm reduction for people who inject drugs	Information and education on risk reduction	✓					✓		
	Opioid substitution therapy	✓	✓		✓	✓			
	Sterile needle and syringe exchange program	✓			✓	✓	✓	✓	
STI prevention	STI detection and management	✓	✓	✓[1]	✓[3]	✓[3]			
	Counseling	✓	✓	✓					
	Outreach for key populations	✓	✓				✓	✓	
	Condom provision	✓	✓		✓	✓		✓	
Prevention of mother-to-child transmission	Maternity care	✓	✓	✓			✓		
	ARVs for prophylaxis	✓	✓		✓				✓
	Family planning	✓		✓			✓		
	Counseling	✓	✓	✓[2]			✓		
	HIV treatment and care for women living with HIV and their babies and family	✓		✓	✓[3]				

[1] Health care fee only. [2] Primary care only. [3] Consumables only.

Case Finding Interventions	Service	Provider Level		Funding Source					
		Primary Care	Referral Care	JKN	Public, National Budget	Public, Sub-national Budget	Public, Health Operational Fund	External, Donor or Private	Patients, Out-of-Pocket
HIV testing	Active case finding including voluntary HIV testing and provider-initiated testing	✓	✓	✓ [1]	✓ [2]	✓ [3]		✓	
	Early detection in adults, infants, and children		✓	✓	✓ [2]	✓ [2]			
HIV counseling	Counseling	✓	✓	✓					

[1] Administrative fee only. [2] Consumables only. [3] Consumables and operational, management, and treatment only.

Interventions for Clinical Management of People Living with HIV	Service	Provider Level		Funding Source					
		Primary Care	Referral Care	JKN	Public, National Budget	Public, Sub-national Budget	Public, Health Operational Fund	External, Donor or Private	Patients, Out-of-Pocket
Treatment	ART	✓	✓	✓ [1]	✓ [3]			✓ [3]	
	Psychosocial and peer support to people living with HIV							✓	
Laboratory monitoring	Basic and advanced tests	✓	✓	✓					
	Viral load testing	✓	✓	✓ [2]	✓ [4]	✓ [6]		✓	✓
	CD4 testing		✓	✓ [2]	✓ [5]				
	Specimen transport							✓	
Management of opportunistic infections and comorbidities	Treatment	✓	✓	✓ [2]				✓	
	Imaging	✓	✓						✓
Other management	Tuberculosis–HIV integrated care	✓		✓ [2]	✓ [3]	✓ [7]			✓
	Palliative care		✓	✓					✓
	Nutritional support	✓	✓		✓	✓		✓	

[1] Consultation fee only. [2] Service fee only. [3] Medicines only. [4] Consumables and reagents only. [5] Reagents only.
[6] Consumables only. [7] Operational, management, and treatment only.

Financing Civil Society Organizations to Deliver HIV Services

Although civil society organizations (CSOs) play a key role in HIV outreach and prevention in Indonesia, Health Ministerial Regulation No. 21/2013 does not guarantee financial support for the HIV prevention program by civil society. The Ministry of Health is only obliged to carry out budgeting without any obligation to actively partner with or involve civil society (e.g., nongovernmental organizations, academicians, and key population communities) (see Box 1 for details from the regulation).

When it comes to procuring services from CSOs, there are two types of public procurement: self-management funds and competitive bidding (defined in Presidential Decree No. 16/2018). CSOs can participate in competitive bidding if they have the required skills, experience, and organizational capacity, however one type of regulated self-management government fund (type three) has been identified as most applicable for CSOs (World Bank, 2019). This type of self-management fund for organizations or community groups is an expansion of a type of fund mentioned in Presidential Decree No. 54/2010. However, there is a lack of delegation from the Presidential Decree to the respective ministry to compile technical guidance on type three self-management funds, which may add challenges for implementing this specific granting mechanism. In Jakarta province for example, type three self-management funds are not yet implemented due to a lack of operational and technical instructions for the funds. The Provincial Health Office, however, has been mandated to allocate budget for these funds in 2021 (via Jakarta Governor's Instruction No. 1/2019) and recognizes the added value of CSO contracting in reaching HIV program targets.

Separate from the public procurement process, there is also a grant mechanism option for channeling funds to CSOs. This mechanism is divided into programmatic central and regional government or regional social assistance/emergency response grants. Different than public procurement schemes, grants have already been allocated by direct assignment from budgetholders because there is no vendor in the commercial market. Under this scheme, public health facilities could contract with CSO staff through a memorandum of understanding between the two parties, however, this only allows individual staff to be contracted and not the organization as a whole. Because of the nature of this

Box 1. Health Ministerial Regulation No. 21/2013 on Local Government Budgeting and Civil Society Collaboration for the HIV Prevention Program

Article 48: Local government is obliged to allocate budget for financing HIV and AIDS prevention activities.

Article 49: HIV and AIDS prevention efforts can be carried out by each institution and/or by collaborative efforts with two parties or more in the form of HIV and AIDS prevention-specific activities or integrated into other activities. Nongovernmental organizations, universities, health profession organizations, key population communities, and the private/business sector can actively partner up with institutional/government bodies in HIV and AIDS prevention efforts. International development partners can contribute to fighting HIV and AIDS according to the existing law and regulations. Collaboration and special partnership for implementing HIV and AIDS programming as mentioned in clause 1, clause 2, and clause 3 is led and coordinated by the National AIDS Commission, Provincial AIDS Commission, and Municipal AIDS Commission.

mechanism—between individual facilities and CSO staff—such contracting may not be well positioned to strategically contribute to reaching HIV program goals.

It is worth noting that CSOs require training and capacity building in order to successfully submit applications to local governments for domestic grant funding as grant application requirements can be complex and are not always publicly announced (World Bank, 2019).

Recommendations

In order for the legal and regulatory landscape to allow for strategic purchasing reforms to be implemented in a way that promotes efficient, effective, and integrated HIV service delivery, HP+ recommends the following actions.

Align national and subnational service delivery targets and funding for HIV. There is an opportunity for Indonesia to streamline laws and regulations around HIV service delivery that will align incentives and allow for greater progress toward reaching treatment targets and ultimately epidemic control. For example, the Minimum Health Services Standard for local governments requires setting HIV screening targets, however, these district-level targets do not necessarily align with the national-level ART Acceleration Plan targets. Ways to link subnational HIV service delivery requirements with indicators that represent true achievement along the HIV care cascade—i.e., targets for identification of people living with HIV instead of targets for screening under the standard—could be very beneficial to improving HIV program outcomes in the country while promoting efficiency in service delivery. Such linkages should be considered in future revisions to the Minimum Health Services Standard. Subnational governments should also consider the potential role of subnational budget funds and funding from national sources (like non-physical special allocation funds) to fund additional incentives for health providers to actively find cases in the community and to link and retain people living with HIV on ART.

Include HIV in down-referral regulations and adjust INA-CBG reimbursement accordingly. To increase efficiencies in management of people living with HIV under JKN, Ministry of Health Decree No. 32/2014 should be revised to include HIV as a chronic condition and thus a case that must be referred to be managed at the primary healthcare level once the patient is in stable condition. Regulating and encouraging down-referral for stable people living with HIV can reduce costs to the national health insurance agency while maintaining and/or improving outcomes among people living with HIV who can be successfully managed at the primary care level. Before changing down-referral regulations, the capacity for primary care facilities to provide high-quality care for people living with HIV should be assessed and strengthened. Once HIV is included in down-referral regulations, INA-CBG reimbursement can be adjusted to impose limits on the number of visits stable patients can have at hospitals within a certain time frame.

Begin integrating HIV benefits into JKN by designating ARVs as medicines for chronic conditions. Further integrating HIV benefits, including covering ARVs, into the JKN benefits package is feasible and could lead to efficiency gains and cost savings (Prabhakaran et al., 2018). Further integration of HIV benefits under JKN can leverage health insurance budgets and pooled funding for sustainable financing of HIV program components, especially ARVs, which account for a significant portion of Indonesia's domestic contribution to the HIV program.

Implement CSO contracting for community-based services to complement facility-based services. Current mechanisms for local governments to contract with CSOs for HIV service delivery exist, however, it seems these mechanisms are underutilized due to a lack of technical and operational direction as well as limited capacity among CSOs to apply for government grants. Operationalizing CSO contracting mechanisms under the

law and publicizing deadlines and requirements for CSOs to apply for funding may prove very beneficial for reaching HIV targets as CSOs can complement facility-based testing and treatment with community-based outreach. CSOs can also conduct lost-to-follow-up tracing in the community as well as conduct adherence support and follow-up.

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