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STIs and HIV service availability in primary care settings: findings from health facility survey in Bali Province, Indonesia

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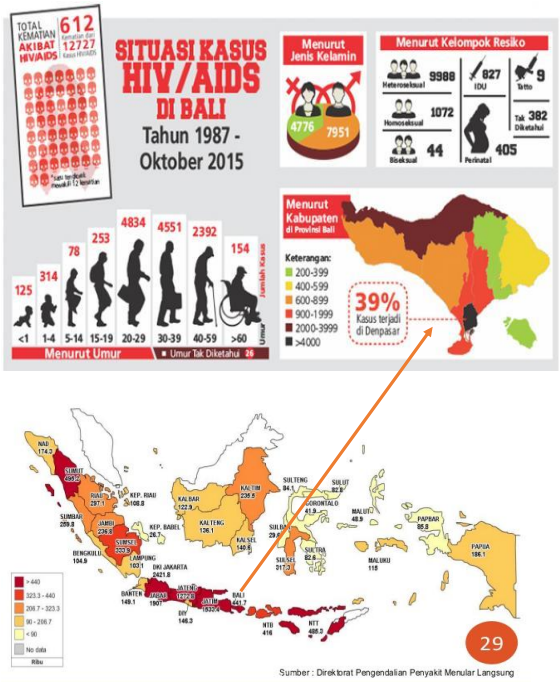

INTRODUCTION

- One among the 29 priority nations that experienced an increased incidence
  - Third highest prevalence rates in Indonesia (100.2 per 100,000 adult populations
- The fastest HIV epidemic progression in Asia
  - Estimated PLWHA is 13,235, concentrating at Denpasar, Buleleng and Badung Districts
- Contributing to 4% of newly infected cases and 2% of HIV-related death globally
  - Reported cases from 1987-2017 was mainly transmitted via heterosexual contact and IDUs, but new increasing trend was also evident from MSM and transgender
- Contributing to 23% of total cases and 12% HIV-related death among the Asia and Pacific countries
- Second highest contributor after India
  - High prevalence of HIV among FSWs and MSM subpopulations

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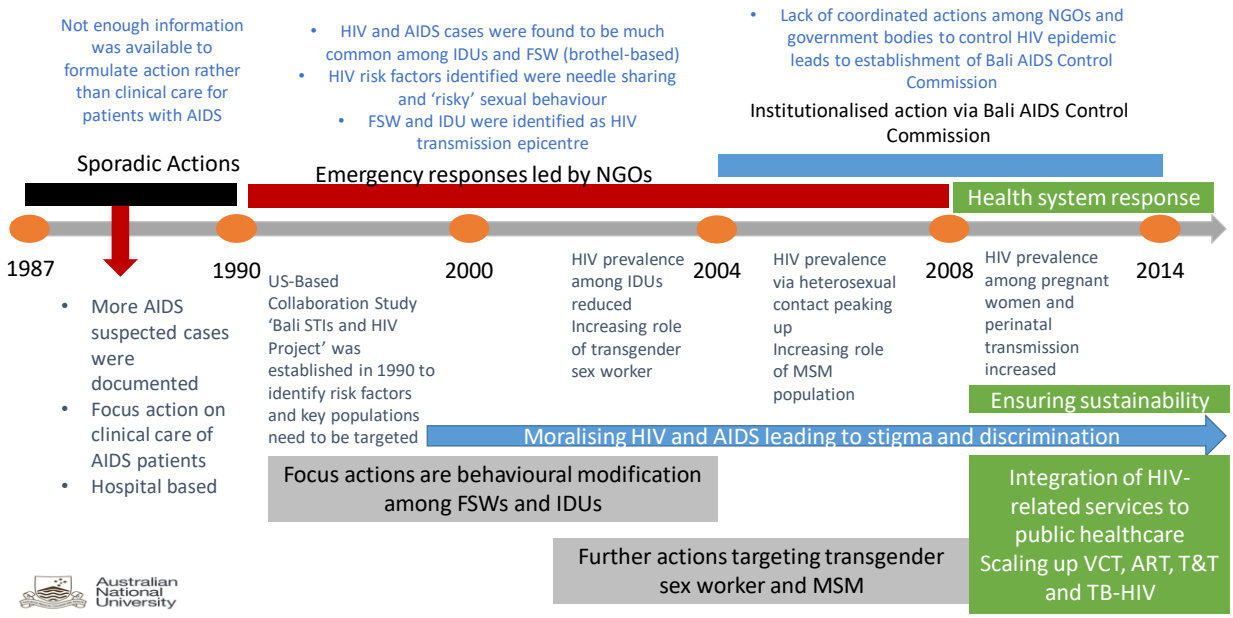

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DECENTRALISATION OF HIV and STIs SERVICES

National and local health actors, encouraged by the funding structures from the international landscape, aims at improving access and coverage by making HIV-related health services available at the primary care level (Cohen et al. 2015).

- Targeting single health systems function or multiple for

However, improving coverage and access to HIV-related health services by heavily reliant upon service expansion strategies overlooks the underlying socio-political, institutional, and structural determinants of health service utilisation.

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Premise

Service availability represents the potential access to health services but it may or may not be realised due to numerous structural or institutional barriers to access appropriate and quality health services – preventing service utilisation especially for the poor and the key population groups

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Objectives

This study aimed to examine STIs and HIV service availability and readiness in primary care settings, and to explore barriers to utilisation of STIs/HIV services within the health decentralisation contexts

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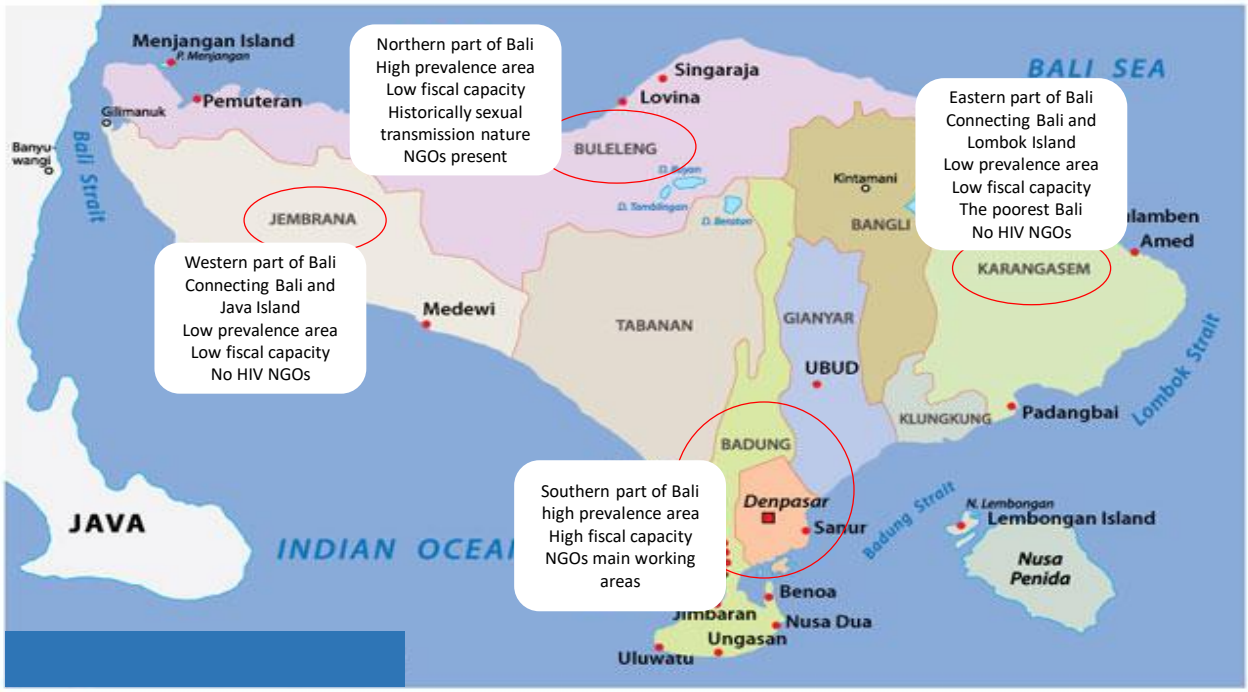

Organisation/affiliation	Position/role	Number of participant
Bali AIDS Control Commission	Head of Bali AIDS Control Commission	1
Provincial health office	Head of Communicable Disease Control	1
	Head of HIV Program	1
	Head of Maternal and Child Health Program	1
District health offices (5 districts)	Head of Communicable Disease Control	5
	Head of HIV Program	5
	Head of Maternal and Child Health Program	5
Local NGOs	Executive staff member or director	3
Peer support group for PLWHA	Facilitator (as well PLWHA)	2
	HIV patients	4
Health providers (hospital settings)	District hospital (VCT and/or CST clinic)	2
	TB-HIV Program	2
	PMTCT Program	2
Health providers (at community health centres)	Head of community health centres	5
	HIV Program Division	5
	TB Program	5
	Maternal and Child Health Program	5
Community members	Seeking general health services	5
	Accessing HIV related services	3
Total Participants		62

Methods

- Service Availability and Readiness Assessment using a modified SARA Instrument (WHO 2015)
- In-depth Interviews
- Focus Group Discussions (2 FGDs)

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FINDINGS

Table 1. Distribution and the participation rates of CHCs in the SARA study

No	City/district	Community Health Centre		
		Total	Participated in the survey	Participation rate (%)
1	Badung	13	13	100
2	Buleleng	20	18	90
3	Denpasar	11	11	100
4	Karangasem	12	12	100
5	Negara	10	9	90
6	Total	66	63	95.45

(Analysed from the survey data)

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FINDINGS

Table 2. Characteristics of community health centres

Variables	Priority Districts			Non-priority Districts	
	Denpasar (n=11)	Badung (n=13)	Buleleng (n=18)	Jembrana (n=9)	Karangasem (n=12)
Type of CHC (in-patient)	2	3	3	5	6
LKB status Comprehensive HIV services	11	13	18	0	0
Functional internet access	10	12	10	9	12
Availability of selected guidelines					
Opportunistic infection treatment	8	7	16	8	5
VCT	11	13	16	9	8
PMTCT	11	13	14	7	1
TB-HIV	11	13	18	9	12
STIs	11	13	14	9	7
MCH	11	13	18	9	12

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FINDINGS

Table 3. Availability and readiness of selected health services

Variables	Priority Districts			Non-priority Districts	
	Denpasar (n=11)	Badung (n=13)	Buleleng (n=18)	Jembrana (n=9)	Karangasem (n=12)
Availability of outreach worker (HIV and STIs)	11	7	18	0	0
Availability of VCT services	11	13	11	9	12
Availability of HIV testing for pregnant women	11	13	11	9	12
Availability of ART services	5	3	3	0	0
Availability of STIs services	10	10	6	3	1
Partnership with local NGOs	11	8	16	0	0
Availability of funding from external stakeholders	11	13	16	0	0
HIV testing for TB patients	11	13	10	9	12
Availability of TB treatment	11	13	18	9	12
Availability of full-range of PMTCT services	0	4	1	0	0

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FINDINGS

Table 4. Availability and readiness of drugs, laboratory, and other materials

Variables	Priority Districts			Non-priority Districts	
	Denpasar (n=11)	Badung (n=13)	Buleleng (n=18)	Jembrana (n=9)	Karangasem (n=12)
Ciprofloxacin (500 mg)	11	13	18	9	12
Fluconazole (150 mg)	8	7	8	0	0
ARV	5	3	3	0	0
TB drugs	11	13	18	9	12
Male condom	11	13	18	9	12
HIV antibody testing	11	13	11	9	12
CD4 count testing	2	2	1	1	0
Full blood counts	11	13	13	9	9
RPR or VDRL	7	2	5	0	0

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It's not my choice…

- Lived experience of 'LD' – female transgender diagnosed with TB milier due to late diagnosis of HIV (passed away April 2018)
- Lived experience of 'VV' – female transgender currently on ART in Denpasar and supported by 'Gaya Dewata' – local NGO funded by HCPI and GF to provide services for TG and MSM groups

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DISCUSSION

- HIV and STIs health services are disproportionally distributed following the intensity of donor interventions in priority areas and fiscal capacity of different districts
- HIV and STIs service availability and readiness constitute the potential access, however, it can only partially explain the inequity in access to health services

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DISCUSSION

Potential access to health services are impeded by structural and institutional barriers to access:

- Unresponsive health services to unexpressed demand from marginalised population
- Structural and social determinants of access to quality health services are inequitably distributed across population
- Moral pathology around key population groups held by policy makers and providers
- Local socio-religious narrative around social anomaly
- Risk discourse and categorisation promoted by biomedical and public health institutions also contribute to the reproduction of moral pathology leading to social stigma and exclusion

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CONCLUSION

- Access to STIs and HIV health services is a complex reality dealing not only with the availability of services but also with institutional and structural determinants that impede or facilitate the actual utilisation of such services
- Inequity in access to health care is not random but it is a product of structural violence

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ACKNOWLEDGEMENTS

- Department of Social Foundation of Medicine, ANU Medical School
- Department of Community and Preventive Medicine, Faculty of Medicine Udayana University
- Bali Province and district health offices of Badung, Buleleng, Jembrana, Karangasem, and Denpasar City
- Bali Province AIDS Control Commission
- Indonesia Endowment Fund for Education through the Indonesian Presidential Scholar for funding the study
- All gate keepers, head of health centres, and all key informants who had participated in this study

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