

# GLOBAL SURVEY

access to and quality of  
HIV CARE & TREATMENT

RESULTS FROM

Indonesia ■ Viet Nam

JANUARY 2021



## About ITPC

The International Treatment Preparedness Coalition (ITPC) is a global network of people living with HIV and community activists working to achieve universal access to optimal HIV treatment for those in need. Formed in 2003, ITPC actively advocates for treatment access across the globe through the focus of three strategic pillars:

- Treatment education and demand creation ([#TreatPeopleRight](#))
- Intellectual property and access to medicines ([#MakeMedicinesAffordable](#))
- Community monitoring and accountability ([#WatchWhatMatters](#))

To learn more about ITPC and our work, visit [itpcglobal.org](http://itpcglobal.org).

## About this Report

ITPC's 2019 *Global Treatment Access Survey*, available [here](#), focused on barriers to quality HIV care and treatment across 14 low- and middle-income countries, covering seven regions of the world. This brief summarizes findings of our peer-led research, which was conducted between April and December 2018, focusing on two Southeast Asian countries: Indonesia and Viet Nam. To view or download this report on the ITPC Global website, [click here](#).

## Acknowledgements

ITPC recognizes the tireless efforts of all partner organizations in implementing the activities highlighted in this report. We express our particular thanks to all of the people living with HIV, health workers and community activists who were involved in data collection. ITPC also appreciates support from the Robert Carr Fund, Open Society Foundations and the Bridging the Gaps Programme.

## Regional and National Partners for Southeast Asia

- ITPC South Asia / Delhi Network of Positive People (DNP+)
- Persaudaraan Korban Napza Indonesia (PKNI), Indonesia
- Viet Nam Network of People Living with HIV (VNP+), Viet Nam

## Coordination

### Project and Research Managers

Pedro Garcia

*ITPC Monitoring & Evaluation and Research Manager*

Wame Jallow

*ITPC Director of Global Programs & Advocacy*

Helen Etya'ale

*ITPC Program Coordinator*

Maxime Inghels, Elise Nédélec  
*Consultants*

## Report Writers

Caroline Thomas

*Consultant*

Tracy Swan

*ITPC Treatment Education Co-Lead*

Pedro Garcia

*ITPC Monitoring & Evaluation and Research Manager*

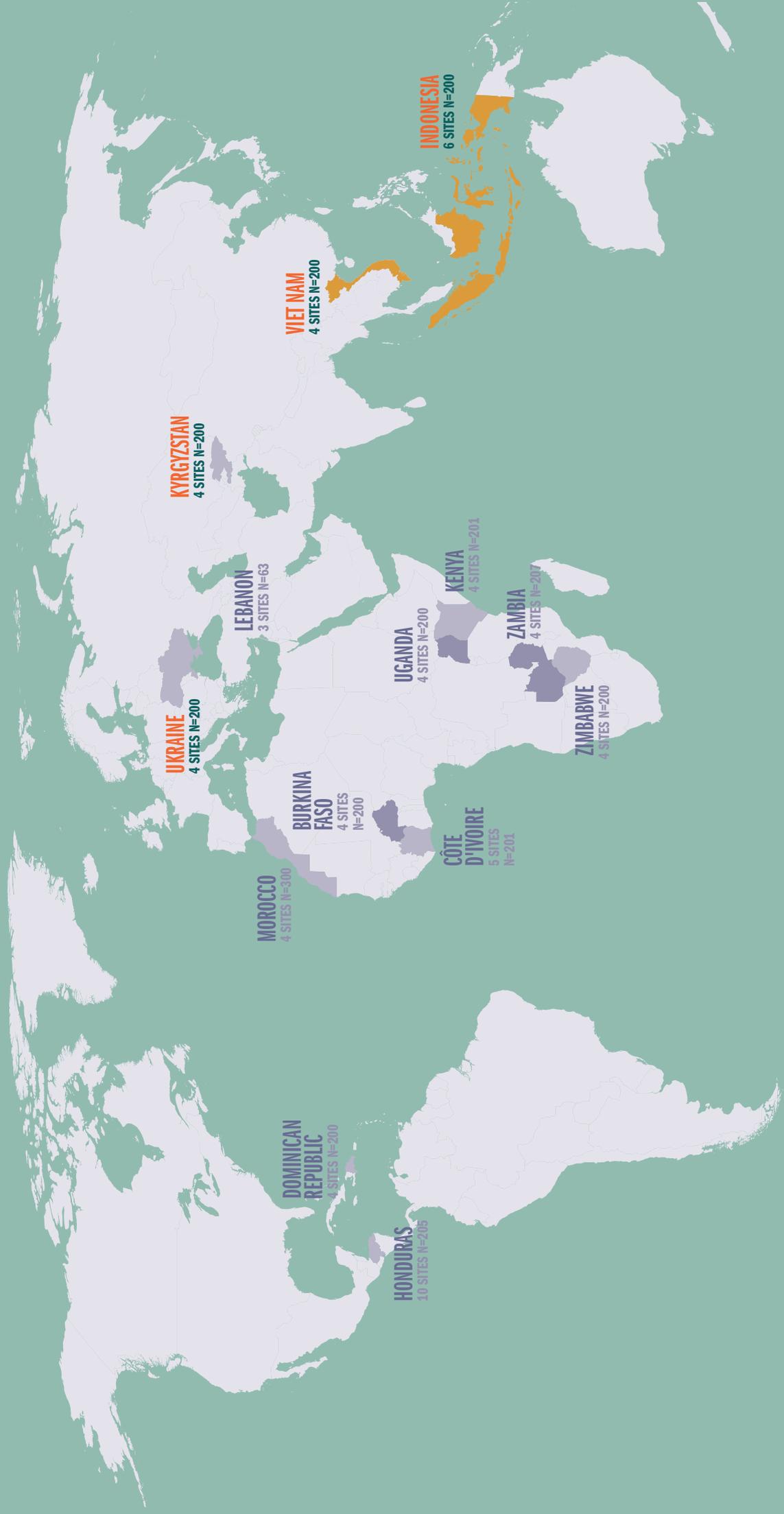
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# ABBREVIATIONS AND ACRONYMS

<b>AIDS</b>	Acquired immunodeficiency syndrome
<b>ART</b>	Antiretroviral therapy
<b>ARV</b>	Antiretroviral
<b>DSD</b>	Differentiated service delivery
<b>EFV</b>	Efavirenz
<b>HBV</b>	Hepatitis B virus
<b>HCV</b>	Hepatitis C virus
<b>HIV</b>	Human immunodeficiency virus
<b>HPV</b>	Human papillomavirus
<b>IRIS</b>	Immune reconstitution inflammatory syndrome
<b>ITPC</b>	International Treatment Preparedness Coalition
<b>LGBT</b>	Lesbian Gay Bisexual and Transgender
<b>MSM</b>	Men who have sex with men
<b>PLHIV</b>	People living with HIV
<b>PrEP</b>	Pre-exposure Prophylaxis
<b>PWID</b>	People who inject drugs
<b>RVLT</b>	Routine Viral Load Testing
<b>TB</b>	Tuberculosis
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>WHO</b>	World Health Organization

FIGURE 1. NUMBER OF SITES AND PEOPLE LIVING WITH HIV INCLUDED IN THE SURVEY FROM INDONESIA AND VIET NAM





# EXECUTIVE SUMMARY

## To document the various challenges and barriers people living with HIV encounter across the HIV care continuum, the International Treatment Preparedness Coalition (ITPC) published its first Global HIV Treatment Access Survey in 2019.

The Global Survey assessed the state of HIV/AIDS treatment efforts in fourteen low- and middle-income countries, among 2,777 people living with HIV and other stakeholders. This report provides an overview of the Global Treatment Survey's major findings from two South East Asian countries—Indonesia and Viet Nam. The data was gathered from 200 respondents from each country.

Despite efforts to improve access to HIV testing and treatment and access to CD4 testing and viral load monitoring, these remain challenging in both countries. In terms of timely diagnosis, Indonesia in particular is lagging behind. Notably, in both countries, there is a critical need for overall improvement in overall access and ease of access to HIV services. A more comprehensive, integrated care system should be available across different settings and for key population groups. In both countries, confidentiality of HIV status and medical records need to be protected. It is also critical to address stigma (including internalized forms) and discrimination in HIV-related healthcare facilities and the national healthcare system.

### Key Findings

- Access to viral load testing was a particular challenge; only 32.5% of respondents in Indonesia (n=65/200) and 50.5% in Viet Nam (n=101/200) reported getting a viral load test after initiating antiretroviral therapy (ART).
- Study findings suggest that providing timely viral load monitoring was a profound challenge for both countries, as a very low percentage of study participants received their first viral load test results within six months of starting ART (Indonesia, 12.8%; Viet Nam, 4.8%). As many as 63.2% of the respondents from Indonesia were diagnosed when their CD4 cell count was already less than 200 cells/mm<sup>3</sup>. As a comparison, 18.5% of Vietnamese respondents had a CD4 cell count of less than 200 cells/mm<sup>3</sup> at diagnosis.
- In terms of preventative therapies, co-trimoxazole was provided to 69.5% of study participants in Indonesia and 46.5% in Viet Nam. Isoniazid preventative therapy (IPT) was provided to 31% of study participants in Indonesia and 17% in Viet Nam. In both countries, all respondents reported either never receiving or being unsure whether they had received insecticide-treated bed-nets. A very small percentage of respondents reported having been offered a vaccine for at least one preventable disease (e.g. hepatitis B virus [HBV], influenza, pneumococcal disease, tetanus, or human papillomavirus [HPV]) (Indonesia, 14.5% and Viet Nam, 1%).
- Access to contraception was remarkably low in Indonesia, with only 39.6% (n=78) of respondents reporting access to modern contraception (injectable or oral pills). In Viet Nam, 52.5% (n=105) of respondents reported having access to modern contraception. A similar pattern was observed in with access to condoms: 44.3% of respondents from Indonesia (n=86) could get condoms when they needed them, vs. 51.5% in Viet Nam (n=103).
- Confidentiality breaches, internalized stigma, as well as stigma and discrimination from healthcare providers and communities were evident across different settings in both countries.

**Effective ART has proven to reduce HIV-associated morbidity and mortality dramatically<sup>1</sup>. In resource-abundant settings, life expectancy of PLHIV with access to early ART is approaching that of the general population<sup>2</sup>. A number of randomized clinical trials have demonstrated the benefits of ART in reducing HIV-related morbidity and mortality, irrespective of the degree of immune suppression at treatment initiation<sup>3</sup>. Because of these benefits, the World Health Organization (WHO) recommends ART for all PLHIV, regardless of age, CD4 count or clinical conditions<sup>4</sup>.**

In spite of the 90-90-90<sup>5</sup> UNAIDS goal (by 2020, 90% of people living with HIV will know their HIV status; 90% of people who know their status will be accessing ART, and 90% of people on ART will have a suppressed viral load), globally, only 70% of PLHIV are aware of their HIV status, only 77% of them are on treatment and, of this group, 82% are virally suppressed<sup>6</sup>.

In Asia, sustained and focused efforts to reach key populations have led to major reductions in HIV infections in Cambodia, India, Myanmar, Thailand and Viet Nam since 2010. However, many countries in Asia are still falling short in achieving the 90-90-90 targets<sup>7</sup>. According to Indonesia's March 2020 National HIV and STI Quarter Report, only 60% of PLHIV knew their status; only 34% of them were on ART and only 1% of PLHIV on treatment had a suppressed viral load.<sup>8</sup> The 2019 data from Viet Nam suggests that 85% of the estimated number of PLHIV had been diagnosed. Of that number, 54% were on treatment, and 95% of people on ART were virally suppressed<sup>9</sup>.

Barriers to HIV services have been well documented over the past decade. Studies have shown different obstacles that prevent or make it difficult for people living with HIV to seek care and treatment:

- **Individual characteristics:** such as gender<sup>10</sup>, age<sup>11</sup>, being a member of a key population<sup>12</sup>, socioeconomic status,<sup>13</sup> perception of

health status<sup>14</sup>, HIV treatment literacy<sup>15</sup>, attitude toward medical services<sup>16</sup>, and social environment—e.g. stigmatization<sup>17</sup>, social support<sup>18</sup>, substance use<sup>19</sup>, and violence<sup>20</sup> may lead PLHIV to refrain from seeking HIV services.

- **Health system characteristics** such as long distances to health centers,<sup>21</sup> negative interactions between healthcare providers and PLHIV,<sup>22</sup> stockouts of antiretrovirals (ARVs) or test kits<sup>23</sup>, understaffed healthcare facilities<sup>24</sup> and provider attitudes<sup>25</sup> may also create barriers to quality HIV-care<sup>26</sup>.

- **Discriminatory laws and policies** such as mandatory testing, criminalization of sexual behaviors, drug use, gender expression and perceived sexual orientation limit access to HIV services and diminish their effectiveness and quality<sup>27</sup>.

- **Stigma and discrimination** are facts of life for people living with and affected by HIV, with very real consequences for their health, safety and ability to access services. For key populations—including men who have sex with men (MSM), sex workers, people who inject drugs (PWID) and transgender individuals—violence and criminalization are further barriers to accessing care. It was estimated that among adult people living with HIV in Southeast Asia in 2018, 8% are

sex workers, 13% are people who inject drugs, 30% are MSM, 2% are transgender women, 25% are clients of sex workers and sex partners of other key population, and 22% are members of the general population<sup>28</sup>.

The changing context of HIV care created by the advent of WHO ‘treat-all’ guidelines, recommendations for ARV regimens and implementation and expansion of innovative services and policies (e.g. promoting community ART delivery) have reshaped the HIV access to care environment. These advances call for refreshing the current state of knowledge about access to and quality of HIV-care, including related barriers.

Thus, this study aims to assess access to and quality of HIV/AIDS care and treatment, highlighting remaining challenges and answering the following questions:

1. Who is—and isn’t—able to access quality HIV services along each step of the HIV treatment cascade?
2. What are the remaining barriers encountered by both PLHIV and healthcare professionals at each step of the HIV treatment cascade? What are the differences by world region?
3. In countries that have adopted the 2015 WHO ‘treat-all’ guidelines, are the recommendations actually implemented? What barriers have been encountered to their implementation?

To identify and document the numerous challenges and barriers PLHIV experience at each step of the HIV care continuum, the three objectives of the survey were:

1. To measure access to quality HIV care and treatment among PLHIV;
2. To identify barriers to each step of the care cascade experienced by PLHIV;
3. To describe the challenges encountered by health care workers and other stakeholders involved in HIV care.

In 2018, over 2,700 PLHIV from 14 low- and middle-income countries<sup>29</sup> and seven geographic regions<sup>30</sup> participated in this survey. This report presents a subset of the survey’s overall findings to provide a snapshot of two countries in the Southeast Asia region—Indonesia and Viet Nam.

The report will focus on findings from Indonesia and Viet Nam about access and barriers to, and quality of HIV care and treatment. Furthermore, the report focuses on the challenges that health care workers and other stakeholders encountered while delivering HIV services in Indonesia and Viet Nam.



# 2

## METHODS

**The study is composed of two surveys, quantitative and qualitative. The quantitative survey evaluated access and barriers to HIV services among PLHIV. The qualitative survey described challenges to accessing care among PLHIV and among healthcare workers in delivering it (objectives 2 and 3).**

At least four health care facilities were selected in each country.<sup>31</sup> We based our inclusion criteria for healthcare facilities on the type of structure (e.g. hospital, small health center), area (urban, semi-rural and rural) and type of facility (public, private, governmental, NGO) to reflect various setting and contexts. In each setting, 50 PLHIV were randomly selected using systematic sampling. Every third recipient of care was interviewed until the goal of including 50 recipients of care was achieved at each setting.

The survey population was adults (ages 18 and above) who received their HIV diagnosis at least three months prior. A quantitative survey evaluated access and barriers to HIV services, and qualitative interviews were organized with recipients of care and health care providers to describe the various challenges they encountered in accessing and delivering HIV care, respectively.



A health worker takes blood to detect a patient's disease in Surabaya, Indonesia.

PHOTO: SHUTTERSTOCK

# 3

# COUNTRY CONTEXTS

The Asia and Pacific region is home to an estimated 5.9 million people living with HIV<sup>32</sup>. China, India, and Indonesia account for almost three-quarters of region's total number of people living with HIV<sup>33</sup>.

It is increasingly clear that the Asia and Pacific region is falling behind in its HIV response. In 2018, 69% of people living with HIV in this region were aware of their status. Among those diagnosed with HIV, 78% were on treatment; 91% of them were virally suppressed<sup>34</sup>. In terms of treatment coverage this equates to only 54% of all people living with HIV being on treatment and just of them 49% being virally suppressed<sup>35</sup>.

Indonesia, the world's fourth most populous country, also has the fourth largest number of new HIV infections per year: the WHO estimates<sup>36</sup> that 73,000 people acquire HIV each year in Indonesia, behind only China, India and Russia. It is also the only country in the Asia-Pacific region where HIV prevalence is still increasing, up from a very few people in 2000 to an estimated current total of 640,000 people. HIV prevalence among the general population

(people ages 14-49 years) is still low, at 0.4%. It is much higher among people who are members of key populations: it is an estimated 39% among people who inject drugs (PWID), 12.8% among men who have sex with men, (MSM) 7.4% among transgender women and 7.2% among female sex workers.

According to UNAIDS, in 2018 only 51% of PLHIV in Indonesia knew their status<sup>37</sup>. Of all adults aged 15 years and over

living with HIV, only 17% were on treatment, while only 22% of children aged 0–14 years living with HIV were on treatment.

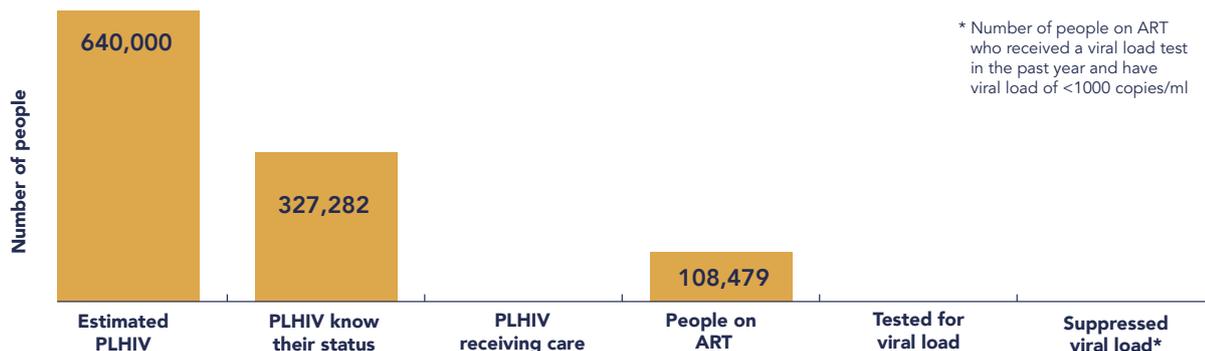
Figure one represents Indonesia's treatment cascade (from Global AIDS Monitoring 2019 and UNAIDS 2019 estimates<sup>38</sup>).

In 2019, Indonesia's treatment guidelines recommended ART for all people with HIV, regardless of CD4 cell count.<sup>39</sup> They specified that ART should be started as soon as possible (at least within 7 days following an HIV diagnosis), and should be accompanied by education about its benefits and risks, and the importance of adherence to ART<sup>40</sup>.

## INDONESIA



**FIGURE 1. Indonesia's Treatment Cascade (2018)**



\* Number of people on ART who received a viral load test in the past year and have viral load of <1000 copies/ml

Source: Global AIDS Monitoring 2019 and UNAIDS 2019 Estimates

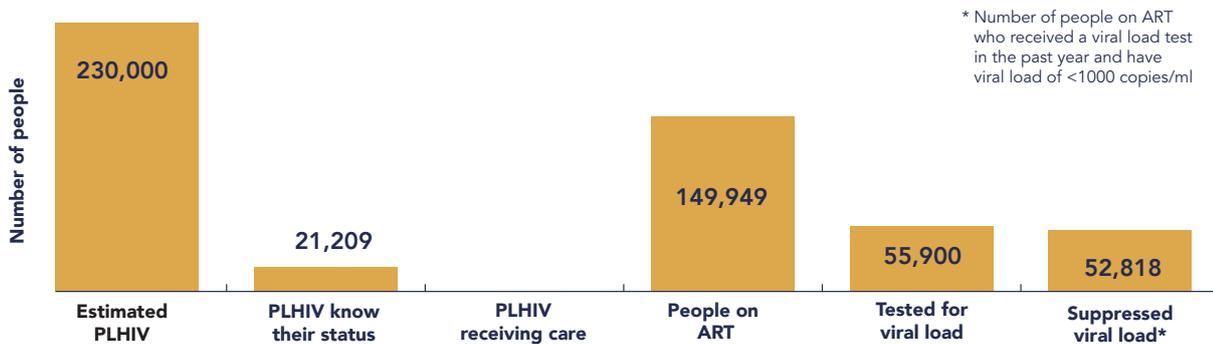
Viet Nam is one of the largest and densely populated countries in Southeast Asia. In 2017, the population was estimated to be 96 million people. As of 2018, Viet Nam was home to an estimated 230,000 PLHIV. According to UNAIDS, HIV prevalence among adults age 15–49 years old is 0.3% <sup>41</sup>. There has been progress in reducing mortality: the number of AIDS-related deaths has decreased by 45% since 2010, from 8,500 to 4,700. During the same period, new HIV infections have also decreased, from 16,000 to 5,700. By 2018, 65% of all PLHIV aged 15 years and above were on ART.



Figure two, Viet Nam’s HIV treatment cascade (from Global AIDS Monitoring 2019 and UNAIDS 2019 estimates) shows drop offs in viral load testing <sup>42</sup>.

In the revised country operational plan (COP) 2017 strategy<sup>43</sup>, PEPFAR Viet Nam developed and implemented same-day ART initiation procedures. The rollout began in Q3 of 2018 in clinics across Ho Chi Minh City and Hanoi. The plan resulted in a minimum of 40% people initiating ART on the same day as their HIV diagnosis.

**FIGURE 2. Viet Nam’s Treatment Cascade (2018)**



\* Number of people on ART who received a viral load test in the past year and have viral load of <1000 copies/ml

Source: Global AIDS Monitoring 2019 and UNAIDS 2019 Estimates

## 4

## SURVEY FINDINGS

The table below summarizes characteristics of the survey population in Indonesia and Viet Nam. The subsequent sections describe their experience in accessing HIV services across the continuum of care.

TABLE 1. Demographics

Demographics and Other Characteristics of Survey Population (n=400)		INDONESIA		VIET NAM	
		n=	%	n=	%
GENDER IDENTITY	Male	140	70	98	49
	Female	60	30	102	51
	Transgender	0	0	0	0
	Total	200	100	200	100
AGE	Median	36		38	
	18 - 24	6	3	4	2
	25 - 49	187	93.5	193	96.5
	> 49	7	3.5	3	1.5
AREA	Rural	21	10.5	40	20
	Semi/peri-urban	103	51.5	104	52
	Urban	76	38	56	28
RELATIONSHIP STATUS	Married	80	40	97	48.5
	Not married, living with partner	5	2.5	10	5
	In a relationship, not living with partner	7	3.5	16	8
	Single	60	30	27	13.5
	Divorced/separated	15	7.5	18	9
	Widow/widower	33	16.5	32	16
EDUCATION	No formal education	0	0	0	0
	Primary	4	2	62	31
	Secondary	123	61.5	126	63
	Tertiary	73	36.5	12	6
	Other	0	0	0	0

**TABLE 1.** Demographics (cont'd)

INCOME	Yes	160	80	194	97
	No	40	20	6	3
	Median	4		4	
HOUSEHOLD SIZE (Number of people)	1 - 3	86	43	75	37.5
	4 - 6	105	52.5	123	61.5
	7 - 9	8	4	2	1
	10 - 12	1	0.5	0	0
	>12	0	0	0	0
	Total	200	100	200	100
HEALTH INSURANCE	Yes	150	75	118	59
	No	50	25	81	40.5
	Don't know	0	0	1	0.5
HAS HAD SAME-SEX INTERCOURSE	Yes (total)	47	23.5	3	1.5
	No (total)	153	76.5	197	98.5
	Yes (male)	47	33.6	3	3.1
	No (male)	93	66.4	95	96.9
	Yes (female)	0	0	0	0
	No (female)	60	100	102	100
	Yes (trans)	0	0	0	0
	No (trans)	0	0	0	0
SEX WORKER	Yes (total)	6	3	15	7.5
	No (total)	194	97	185	92.5
	Yes (male)	5	3.57	1	1.02
	No (male)	135	96.43	97	98.98
	Yes (female)	1	1.67	14	13.73
	No (female)	59	98.33	88	86.27
	Yes (trans)	0	0	0	0
	No (trans)	0	0	0	0

**TABLE 1.** Demographics (cont'd)

SEX WITH SEX WORKER	Yes (total)	56	28	47	23.9
	No (total)	144	72	150	76.1
	Yes (male)	56	40	46	47.92
	No (male)	84	60	50	52.08
	Yes (female)	0	0	1	0.99
	No (female)	60	100	100	99.01
	Yes (trans)	0	0	0	0
	No (trans)	0	0	0	0
HAVE YOU EVER INJECTED ANY ILLICIT DRUG?	Yes, currently	3	1.5	1	0.5
	Yes, in the past	88	44	71	35.5
	No	109	54.5	128	64
IN LAST 3 MONTHS, DID YOU RECEIVE AND USE CLEAN SYRINGES FOR EVERY INJECTION?	Yes, every time I needed	0	0	0	0
	Most of the time	0	0	0	0
	Sometimes	1	33.3	1	50
	Never	2	66.7	1	50

**In this study, late diagnosis was defined as presenting with a CD4 cell count below 200 cells/mm<sup>3</sup>. Late diagnosis was more common in Indonesia than Viet Nam. Interestingly, respondents who were more knowledgeable about ART in Indonesia were not likely to get tested earlier. As many as 63.2% of Indonesian respondents were diagnosed late; the median CD4 cell count among survey respondents in Indonesia was 145.5 cells/mm<sup>3</sup>.**

The most common reasons for being tested among Indonesian respondents included: being ill or suspecting HIV symptoms (54%); exposure to HIV (26.5%); referral from a health professional (13.5%); having a spouse/partner/child who tested positive (8%) wanting to know their HIV status (7%) and illness or death of a husband/wife/partner/child (7%). Reasons for seeking an HIV test did not differ by area (rural, country, semi/peri-urban and urban).

In contrast, respondents from Viet Nam who had more knowledge about HIV were more likely to seek earlier testing: only 18.5% of survey respondents were diagnosed with a CD4 cell count below 200 cells/mm<sup>3</sup>. The median CD count at diagnosis was 286 cells/mm<sup>3</sup>. The most common reasons for being tested among respondents in Viet Nam included: exposure to HIV (51.5%); being ill or having suspected HIV-related symptoms (50.5%); having a spouse/partner/child who tested positive (36.5%); illness or death of a husband/wife/partner/child (17%); and wanting to know HIV status (6.5%). The main reasons for testing were similar among respondents from rural/country areas and large cities and towns in Viet Nam; survey respondents from semi/peri-urban areas were more likely to be tested because of exposure to HIV.

Subsequent to their HIV diagnosis, respondents reported having been tested or examined for co-infections and non-communicable diseases: HBV (Indonesia, 34.5%; Viet Nam, 34.5%); hepatitis C virus (HCV) (Indonesia 54%; Viet Nam 35.5%); cervical cancer (Indonesia 9.5%; Viet Nam 8.5%); cryptococcal infection (Indonesia 10%; Viet Nam 0.5%); cardiovascular disease

(Indonesia 17%; Viet Nam 0%); hypertension (Indonesia 60.5% ; Viet Nam 0.5%); and diabetes (Indonesia 53%; Viet Nam 0.5%). Furthermore, 24.5% of respondents from Indonesia and 18% of respondents from Viet Nam reported a positive HCV antibody test result. Alarming, HCV treatment has only been provided to 14% of co-infected study respondents in Indonesia and 5.6% in Viet Nam.

“ CD4 count and viral load (tests) are important in monitoring and treatment of patients but (the tests are) not yet available in my area. Samples have to be sent to the central government. The time from sending to receiving the result about 1 month.”

—Doctor, Viet Nam

When they received their HIV diagnosis, 85.5% of respondents in Indonesia and 82% of respondents in Viet Nam reported that doctors asked them about tuberculosis (TB) symptoms (cough, night sweats, weight loss or fever for over 3 weeks), and whether they had been in contact with a person with TB (Indonesia 85%; Viet Nam 80%). More than half of the respondents from Indonesia (52.5%) reported ever being diagnosed with TB and 97.2% of those diagnosed with TB received treatment for it. In contrast, only 14.5% of respondents in Viet Nam reported ever being diagnosed with TB, and 90.3% of them received treatment for it.

## Linkage to Care

### CD4

Of the 200 respondents in Indonesia, 95% (n=190) received a CD4 count after being diagnosed with HIV, while 4% (n=8) could not remember whether they had a CD4 cell count, and only 1% did not receive a CD4 count. In Viet Nam, 100% of respondents (n=200) received a CD4 count after being diagnosed with HIV. However, the amount of time between diagnosis and the first CD4 cell count ranged from 0 days to over 7 years in Indonesia (13.9% at the same day, 8% within a week, 48.1% from more than one week to one month, 20.6% from more than a month to 6 months, 4.1% from more than a month to 1 year, 5.4% from more than 1 year to more than 7 years) and from 4 days to over 11 years in Viet Nam.

Qualitative inquiry revealed that getting CD4 count and viral load test results in Viet Nam is still profoundly challenging, as there are only limited number of machines in the country. The theme seems to be consistent among health practitioners. One of them mentioned:

### ART

In both Indonesia and Viet Nam, the WHO treat-all recommendation has been adapted into current national treatment guidelines.

Currently, Indonesia's HIV treatment guidelines recommend ART for all people with HIV, regardless of CD4 cell count.<sup>44</sup> ART should be started as soon as possible (at least within 7 days following the diagnosis) and should be accompanied by education about the benefits and risks of ART and the importance of adherence<sup>45</sup>. The highest priority for offering same-day treatment is given to pregnant women<sup>46</sup>. No data is available on the number of PLHIV who had started at least within 7 days following the diagnosis.

### Viral load monitoring

National Guidelines in Indonesia and Viet Nam have adopted WHO recommendations for routine viral load monitoring.

Effective HIV treatment reduces the amount of HIV in body fluids; within three to six

months most people's viral load has become undetectable (below 50 copies/ml).<sup>47</sup> Routine viral load testing measures the response to ART; it is recommended by WHO<sup>48</sup> at 6 and 12 months after ART initiation and every 12 months thereafter for people who are clinically stable.

Based on current Indonesian HIV guidelines<sup>49</sup>, the definition of treatment failure is a viral load above 1000 copies/mL (based on 2 viral load tests within 3 to 6 months). The routine viral load monitoring strategy is testing 6 months after ART initiation, then every 12 months thereafter. In Viet Nam, at least one annual viral load test is recommended for 95% of PLHIV on ART<sup>50</sup>.

Qualitative HIV DNA and quantitative HIV RNA testing are both used for routine viral load monitoring. Currently, qualitative HIV DNA testing is more widely used in Indonesia to diagnose HIV in infants. In areas that do not have HIV DNA testing facilities, quantitative HIV RNA testing is used, or dried blood spot testing for HIV DNA is performed.<sup>51</sup>

In Indonesia, most people who are members of key populations are not keen to have routine viral load testing, since it is not government-funded and it is considered expensive (\$100; Indonesian's average monthly income was \$183 in December 2019)<sup>52</sup>.

Access to viral load testing is a particular challenge; only 32.5% of respondents in Indonesia (n=65) and 50.5% in Viet Nam (n=101) reported getting a viral load test after starting ART. Furthermore, the study's findings suggest that timely viral load monitoring after ART initiation was a challenge in both countries, as a very low percentage of survey respondents received their first viral load test within six months of an HIV diagnosis (Indonesia, 12.8% and Viet Nam, 4.8%).

Only 39.8% of survey respondents in Indonesia were informed by their healthcare provider that their viral load was undetectable. An alarming 44% of survey respondents from Indonesia did not know whether or not their viral load is undetectable. In contrast, 95.1% of Vietnamese survey respondents were informed by healthcare providers of their undetectable viral load test result.

## Quality of Comprehensive Package of Care

A comprehensive package of treatment and care is crucial for people living with HIV, as they are confronted with risks of infection. In addition to ARVs, WHO recommends offering comprehensive care, including prophylaxis and treatment for opportunistic infections, condom and contraceptive services, and counselling.<sup>53</sup>

In terms of preventative therapies, respondents reported receiving co-trimoxazole (Indonesia, 69.5% and Viet Nam, 46.5%), and isoniazid preventative therapy (IPT) (Indonesia, 31% and Viet Nam, 17%). All respondents in both countries reported either receiving or being unsure whether they received insecticide-treated bed-nets to protect them from malaria. A very small percentage of respondents reported being offered a vaccine for at least one preventable disease (e.g. HBV, influenza, pneumococcal disease, tetanus, or HPV) (Indonesia, 14.5% and Viet Nam, 1%).

A remarkable 92.5% of respondents from Viet Nam reported receiving their first consultation on the same day as their HIV diagnosis. In contrast, only about 33.5% of Indonesian respondents reported receiving a consultation on the same day as their diagnosis. For both countries, however, a large number of respondents visited government health structures for their first consultation (Indonesia, 65.5% and Viet Nam, 80.4%), followed by private health structures (Indonesia, 31.5% and Viet Nam, 18.2%). In Viet Nam, 98.5% of respondents reported having regular consultations, as did 68.8% of their Indonesian counterparts. Sadly, efforts to make clinics available for working people in Indonesia has not always resulted in routine check-ups for PLHIV. In Indonesia, 31.2% of survey respondents reported that they only consulted healthcare providers when they were sick.

Furthermore, although healthcare professionals did well in informing participants about the possibility of having a child after their HIV diagnosis (Indonesia, 92.5% and Viet Nam, 94.5%), counseling about safe methods for giving birth and safe infant methods feeding was consistently low in both countries. Only

45% and 47% of the respondents from Indonesia and Viet Nam, respectively, reported ever receiving counseling about safe birth-giving methods, and less than half of the participants in both countries (Indonesia, 43.5% and Viet Nam, 46.5%) were counselled about safe infant feeding.



*In the clinic, the working hour is 9am-9pm on Monday to Friday, and until 3pm on Saturday to accommodate the need of the working people.*

—Doctor, Indonesia

A mother in Indonesia raised concerns—apart from safe infant feeding and birth-giving methods—about the government giving more thought to the issues of expenses and ease of access, as well as disclosure and adherence, especially for young children living with HIV.



*I have to register my child 3 days before the appointment date. Having an HIV-positive child and also an HIV-positive partner, the number of visits to health services doubled in amount, and it means that double the travel expenses and the number of unproductive working days. The refill of drug prescription should be done not once a month. Adherence for children with HIV is a more challenging than for the adult, in addition to the difficulties of the issue of disclosure of HIV status to children. It affects the adherence of the child.”*

—Woman living with HIV, Indonesia

In the case of women with HIV, a small percentage of respondents reported access to pregnancy test (Indonesia, 16% and Viet Nam, 16.7%). Access to contraception was remarkably low in Indonesia, with only 39.6% (n=78) of

respondents reporting access to modern contraception (injectable or oral pills) when in need of it. In Viet Nam, 52.5% (n=105) of the respondents reported having access to modern contraception. A similar pattern was found for access to condoms: 44.3% of respondents from Indonesia (n=86) could get condoms when needed, versus 51.5% in Viet Nam (n=103).

During the qualitative research, additional issues that need to be addressed were raised, including follow up of PLHIV who are working abroad; incorporating ARV services into those for domestic violence, and making condoms and healthcare services available in prisons and other settings where they currently are unavailable.

“ So many patients are dropping out of treatment, including those who are sailing abroad as fisherman and ship’s attendant. Other than that, ARV services should also be equipped with services or link to domestic violence services because many female drug users are also experiencing domestic violence.”

—Woman living with HIV, Indonesia

“ HIV-related services are difficult in prison and the ratio of doctor to inmates is also not ideal. Doctors available in the prison are general practitioner and for more complicated cases, patients need to be transferred to the hospital with special security. I also think that condoms should be made available in prison. Other than that, TB prevention is also a challenge because a 3x3 meter cell is occupied by 10 people. Contracting TB is as easy as breathing.

—MSM, PLHIV, Indonesia

## Retention in Care

### Adherence

Almost all of the respondents in both countries are still on ART (Indonesia 99.5%; Viet Nam, 100%). Nonetheless, a number of study respondents (Indonesia, n=37 and Viet Nam, n=3) reported ever stopping ARV for a long period (more than a week) or more than once (Indonesia, mean=1.32 times and Viet Nam, mean=1 time). In Indonesia, reasons for stopping ART included: side effects (5.5%); treatment made them feel unhealthy (1%); the respondents felt healthy (3%), moving to another place (3.5%), and missing appointments with the ART clinic healthcare provider (2%). In addition, respondents noted fear of life-long commitment (n=1), boredom (n=2), being busy (n=1), distance from home to healthcare structure (n=1), being unable to afford transportation (n=1), and being upset with family members for forcing him/her to be in a rehabilitation clinic (n=1). Among respondents from Viet Nam, reasons for not taking ARVs were sample were side effects (n=1) and forgetfulness (n=2).

Apart from what was reported by the respondents, findings from the qualitative inquiry also pinpoint the issue of drug use and its impact on ARV adherence:

“ Patients are not ready for treatment because they are still using drugs. They do not adhere to treatment.

—Doctor, Viet Nam

Changing ARV regimens were also reported by respondents in both countries (Indonesia, 22% and Viet Nam, 20.5%). The most common reasons for changing ARV regimens in both countries were: side effects (Indonesia 15.5%; Viet Nam 19%) and drug resistance (Indonesia, 5%; Viet Nam 1.5%).

The majority of respondents from both countries reported high levels of adherence to ART (Indonesia 97.37%; Viet Nam 99.44). However,



about 10.1% and 4.5% of respondents from Indonesia and Viet Nam, respectively, admitted missing a dose approximately a month ago (Indonesia, mean of 31.41 days ago) and three months ago (Viet Nam, mean of 100.89 days ago).

## Legal and Other Barriers to an Enabling Environment

In general, Indonesia does not recognize same-sex relationships. As of 2019, no law exists to protect Indonesia citizens from discrimination or harassment based on their sexual orientation or gender identity. However, the Government of Indonesia is starting to enact anti-discrimination policies. In November 2019, for example, the National Human Rights Commission commanded that the Attorney General's Office withdraw their requirement of acceptance for civil servants which discriminates against gay and transgender people and those with a mental illness<sup>54</sup>.

Since January 2018, as part of revising the criminal code, lawmakers have been working on a criminal code draft. Despite international criticism and fears from human rights organizations, if passed, the law would criminalize consensual sex between two unmarried people, cohabitation and adultery, along with rape. It will also enable lesbian, gay, bisexual or transgender people to be taken to court for their sexual orientation. The draft of the code is still pending.

Article 469 Paragraph (1) of the draft code states:

*"Everyone who do the deed of fornication with others of the same sex below 18 years of age should be convicted for at most 9 (nine) years."*

Community members and activists argued that the draft code should generalize the sexual abuse of underage people, not be specific to same-sex abuse. The law should not target people with a certain sexual orientation as perpetrators of fornication; it should target all perpetrators, regardless of sexual orientation.

Article 2 Paragraph (1) of the draft code on the Living Law states:

*"Provisions as referred to in Article 1 paragraph (1) does not reduce enactment of that living law within society."*

The concern behind the draft code is that there will be a wider understanding of living law by a group of patrons to launch political actions at the expense of other marginalized parties so that there is even the possibility of perpetuating an act of persecution. For example, in Indramayu, the local welfare bureau issued a circular letter on Socialization and Prevention of LGBT Behavior dated 27 February 2018<sup>55</sup>.

The circular Letter signed by the Regent of Indramayu<sup>56</sup>, is used the Penal Code as a reference to a regional regulation to impede the civil liberties of a certain group and could provoke violence towards the group. The Circular mentions groups with different gender identities and sexual orientations as "dangerous" and invites people directly to discriminate against them by making posters that express hatred.

Also, in 2018, the Mayor of Depok City issued an Instruction Letter Number 2 concerning the Implementation of Strengthening Family Resilience towards Sexual Abnormal Behavior<sup>57</sup>. The regulation went into effect in early 2019. The ratification of the draft regulation will only perpetuate violence that has often befallen LGBT groups.

Also, as part of revising the criminal code draft, article 414 of the draft states that:

*"Anyone who openly displays, offers, broadcasts writings, or shows contraceptives to children is liable to criminal fines."*

The draft code is still pending. The criminalization in the draft code will further fuel HIV if demonstrating contraceptives, including condoms, as part of sexual and reproductive education, is considered an illegal act.

Article 417 paragraph 1 reads:

*"Every person who has intercourse with another person who is not a husband or wife is convicted of adultery, with a maximum imprisonment of 1 year or a fine of category II."*

The article in this draft code does not protect underage sex workers who became the victim of human trafficking.

The major implications of the criminalization (and the potential criminalization) as well as the lack of protection from discrimination are: (1) an increasing number of people who are members of key populations will become hidden, and reaching them will be profoundly difficult; (2) even if it is possible to reach them and provide prevention (condoms and syringes), possession of these commodities can be used as evidence against them; (3) if they are incarcerated, there is an increased risk of being exposed to HIV and other co-infections<sup>58</sup>.

Moreover, Law on HIV/AIDS Prevention and Control (No. 64 year 2006/QH11) in Viet Nam stated that rights and obligations of PLHIV include applying measures to prevent HIV transmission to other people, and to inform their spouse or fiancé (fiancée) of their HIV status (Article 4). Having said that, purposefully transmitting or causing transmission of HIV to another person, and threatening to transmit HIV to another person are prohibited by the law (Article 8)<sup>59</sup>. Although the law obligated PLHIV to apply HIV prevention measure, and the act of intentionally transmitting HIV to another person is punishable by law, there were no reported cases of one being punished under this law.<sup>60</sup>

## Stigma and Discrimination of People Living with HIV

Rates of internalized stigma among PLHIV were high in both countries, with 42% and 51.5% of respondents from Indonesia and Viet Nam, respectively, blaming themselves for their HIV status. Furthermore, many respondents decided not to have sex (Indonesia 35%; Viet Nam, 30%), not to have (more) children (Indonesia 34%; Viet Nam 46%), not to see friends or family (Indonesia 32%; Viet Nam 9.5%) and not to attend social gatherings (Indonesia 31.5%; Viet Nam 6.5%).

Survey respondents reported being the subject of gossip (Indonesia 10%; Viet Nam 8.5%). Unfortunately, loss of employment or other income-generating activities due to discrimination or poor health are still common in

Indonesia, with 8.5% of respondents reporting this experience in the past year, versus only 1.5% in Viet Nam. In addition, being denied health services due to HIV status was more common in Indonesia (4.5%) than in Viet Nam (0.5%), as well as being excluded from family activities (cooking, eating together, sleeping in the same room) (Indonesia 6%; Viet Nam 0.5%). Although health services are not always withheld from PLHIV, many reported negative experiences, even in healthcare facilities delivering HIV services,



*Yes, I was having difficulty in accessing PMTCT services. The health service staffs requested me to bring 5 liters of bleach/ disinfectant to be used during my labor. Other patients in the hospital questioned me because I was walking in the healthcare facility ready for labor but I was coming to the hospital with a gallon of bleach. Knowledge does not always translate to having the right attitude. It applies to many healthcare services—TB, reproductive health, substance abuse rehab.”*

—Woman living with HIV, Indonesia

In Viet Nam, the rate of HIV disclosure to family members was very high (99%); in Indonesia, 84% of respondents disclosed their HIV status to their families. Unsurprisingly, respondents from Viet Nam (97%) were more open about their HIV status to anyone other than spouses, close family members, and doctors than survey respondents in Indonesia (47%).

This study assessed perceived confidentiality in two ways: first, whether healthcare professionals (e.g. doctor, nurse, counselor, laboratory technician) ever told other people about a respondent's HIV status without their consent, and second, on whether, and to what degree, respondents think that medical records relating to their HIV status in the clinic/hospital are kept confidential.

A few respondents reported that healthcare professionals disclosed their HIV status to other people without their consent (Indonesia, n=6 and Viet Nam, n=2). Quite a number of respondents from Indonesia were confident that their status was not disclosed to other people without their consent (87.5%). In contrast, 50% of survey respondents in Viet Nam were confident about the confidentiality of their HIV status, and nearly half of them (49%) did not know whether or not their status had been revealed to other people without their consent,

and 48% of respondents were not sure about the confidentiality of their medical records.

Only 45.5% of respondents from Viet Nam were sure that their records were kept completely confidential. In Indonesia, 88.9% participants answered that they were sure that their medical records were confidential. Sadly, some respondents from both countries reported that their medical records were clearly shared without their consent (Indonesia, n=4 and Viet Nam, n=13).



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# 6

# RECOMMENDATIONS

**The findings from Indonesia and Viet Nam show that despite strong progress towards reaching the 90-90-90 targets, both countries still encounter challenges with timely diagnosis, quality of care, stigma and discrimination (internalized as well as from healthcare providers and communities), and breaches of confidentiality. Criminalization (and potential criminalization from revisions of the criminal code) also pose challenges, especially for people who are members of key populations.**

To address these challenges, we must:

- Ensure that all people living with HIV have access to high quality, comprehensive care and treatment
- Educate community members on the importance of prompt HIV testing and treatment initiation
- Ensure that healthcare providers and health systems can provide simplified diagnosis and treatment
- Advocate to remove legal barriers through stigma reduction, training of health care providers on human rights, legal literacy, and monitoring and reforming laws and policies relating to HIV
- Ensure all PLHIV, their families, community members, healthcare providers and policy makers have consistently updated information about HIV prevention, care and treatment.
- Ensure data protection so that medical records are kept confidential and secure, including encryption, secure systems
- Implement legal frameworks to protect privacy of individuals.

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- 2 Azfar E.Alam Siddiqi et al., "Population-Based Estimates of Life Expectancy after HIV Diagnosis: United States 2008-2011," *Journal of Acquired Immune Deficiency Syndromes*, 2016, <https://doi.org/10.1097/QAI.0000000000000960>.
- 3 Patrice Severe et al., "Early versus Standard Antiretroviral Therapy for HIV-Infected Adults in Haiti," *New England Journal of Medicine*, 2010, <https://doi.org/10.1056/NEJMoa0910370>.
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- 5 By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.
- 6 Joint United Nations Programme on HIV/AIDS and 2017 UNAIDS, "Ending Aids: Progress Towards the 90-90-90 Targets," *Global Aids Update*, 2017, [https://www.unaids.org/en/resources/documents/2017/20170720\\_Global\\_AIDS\\_update\\_2017](https://www.unaids.org/en/resources/documents/2017/20170720_Global_AIDS_update_2017)
- 7 UNAIDS, "Epidemic Transition Metrics," 2019, <http://aidsinfo.unaids.org/>.
- 8 Laporan Perkembangan HIV AIDS dan Penyakit Infeksi Menular Seksual Triwulan I tahun 2020
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- 10 Amy L. Althoff et al., "Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-Site Study," *AIDS and Behavior*, 2013, <https://doi.org/10.1007/s10461-012-0372-1>; Morgan M. Philbin et al., "Factors Affecting Linkage to Care and Engagement in Care for Newly Diagnosed HIV-Positive Adolescents Within Fifteen Adolescent Medicine Clinics in the United States," *AIDS and Behavior*, 2014, <https://doi.org/10.1007/s10461-013-0650-6>.but half of PLWHA in the US are continuously engaged in care. Incarcerated individuals are an especially challenging population to retain, and empiric data specific to jail detainees is lacking. We prospectively evaluated correlates of retention in care for 867 HIV-infected jail detainees enrolled in a 10-site demonstration project. Sustained retention in care was defined as having a clinic visit during each quarter in the 6 month post-release period. The following were independently associated with retention: Being male (AOR = 2.10, p B 0.01
- 11 Philbin et al., "Factors Affecting Linkage to Care and Engagement in Care for Newly Diagnosed HIV-Positive Adolescents Within Fifteen Adolescent Medicine Clinics in the United States"; Kimberly B. Ulett et al., "The Therapeutic Implications of Timely Linkage and Early Retention in HIV Care," *AIDS Patient Care and STDs*, 2009, <https://doi.org/10.1089/apc.2008.0132>; Jialun Zhou et al., "Loss to Followup in HIV-Infected Patients from Asia-Pacific Region: Results from TAHOD," *AIDS Research and Treatment*, 2012, <https://doi.org/10.1155/2012/375217>.over 50 % of newly diagnosed persons do not receive HIV-related care within 6 months of diagnosis. We evaluated a linkage to care and engagement in care initiative for HIV-positive adolescents in 15 U.S.-based clinics. Structural and client-level factors (e.g. demographic and behavioral characteristics, clinic staff and location
- 12 Ulett et al., "The Therapeutic Implications of Timely Linkage and Early Retention in HIV Care"; Amanda Mcroft et al., "Risk Factors and Outcomes for Late Presentation for HIV-Positive Persons in Europe: Results from the Collaboration of Observational HIV Epidemiological Research Europe Study (COHERE)," *PLoS Medicine*, 2013, <https://doi.org/10.1371/journal.pmed.1001510>; Jae M. Sevelius et al., "Barriers and Facilitators to Engagement and Retention in Care among Transgender Women Living with Human Immunodeficiency Virus," *Annals of Behavioral Medicine*, 2014, <https://doi.org/10.1007/s12160-013-9565-8>.linkage to outpatient treatment, antiretroviral initiation, and longitudinal retention in care represent the foundation for successful treatment. While prior studies have evaluated these processes in isolation, a systematic evaluation of successive steps in the same cohort of patients has not yet been performed. To ensure optimal long-term outcomes, a better understanding of the interplay of these processes is needed. Therefore, a retrospective cohort study of patients initiating outpatient care at the University of Alabama at Birmingham 1917 HIV/AIDS Clinic between January 2000 and December 2005 was undertaken. Multivariable models determined factors associated with: late diagnosis/linkage to care (initial CD4 < 350 cells/mm3

- 13 Philbin et al., "Factors Affecting Linkage to Care and Engagement in Care for Newly Diagnosed HIV-Positive Adolescents Within Fifteen Adolescent Medicine Clinics in the United States"; L. D. Bwirire et al., "Reasons for Loss to Follow-up among Mothers Registered in a Prevention-of-Mother-to-Child Transmission Program in Rural Malawi," *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 2008, <https://doi.org/10.1016/j.trstmh.2008.04.002>; Bach X. Tran et al., "Financial Burden of Health Care for HIV/AIDS Patients in Viet Nam," *Tropical Medicine and International Health*, 2013, <https://doi.org/10.1111/tmi.12032>.over 50 % of newly diagnosed persons do not receive HIV-related care within 6 months of diagnosis. We evaluated a linkage to care and engagement in care initiative for HIV-positive adolescents in 15 U.S.-based clinics. Structural and client-level factors (e.g. demographic and behavioral characteristics, clinic staff and location
- 14 Zhou et al., "Loss to Followup in HIV-Infected Patients from Asia-Pacific Region: Results from TAHOD."
- 15 Gabriel J. Culbert et al., "The Influence of Medication Attitudes on Utilization of Antiretroviral Therapy (ART) in Indonesian Prisons," *AIDS and Behavior*, 2016, <https://doi.org/10.1007/s10461-015-1198-4>.
- 16 Rose Zulliger et al., "High Drop-off along the HIV Care Continuum and ART Interruption among Female Sex Workers in the Dominican Republic," *Journal of Acquired Immune Deficiency Syndromes*, 2015, <https://doi.org/10.1097/QAI.0000000000000590>.but little evidence exists on the care experiences of key populations. Methods: A cross-sectional survey was conducted with 268 female sex workers (FSWs
- 17 Sevelius et al., "Barriers and Facilitators to Engagement and Retention in Care among Transgender Women Living with Human Immunodeficiency Virus"; Bwirire et al., "Reasons for Loss to Follow-up among Mothers Registered in a Prevention-of-Mother-to-Child Transmission Program in Rural Malawi"; Zulliger et al., "High Drop-off along the HIV Care Continuum and ART Interruption among Female Sex Workers in the Dominican Republic."yet they are disproportionately underserved by current treatment efforts. Purpose: This study aimed to examine culturally unique barriers and facilitators to engagement and retention in HIV care and strengthen efforts to mitigate health disparities, guided by the Models of Gender Affirmation and Health Care Empowerment. Methods: Through 20 interviews and five focus groups (n = 38
- 18 Bwirire et al., "Reasons for Loss to Follow-up among Mothers Registered in a Prevention-of-Mother-to-Child Transmission Program in Rural Malawi"; Zulliger et al., "High Drop-off along the HIV Care Continuum and ART Interruption among Female Sex Workers in the Dominican Republic"; Erica H. Layer et al., "Multi-Level Factors Affecting Entry into and Engagement in the HIV Continuum of Care in Iringa, Tanzania," *PLoS ONE*, 2014, <https://doi.org/10.1371/journal.pone.0104961>.range 22-55 years
- 19 Althoff et al., "Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-Site Study"; Ulett et al., "The Therapeutic Implications of Timely Linkage and Early Retention in HIV Care."
- 20 Zulliger et al., "High Drop-off along the HIV Care Continuum and ART Interruption among Female Sex Workers in the Dominican Republic."but little evidence exists on the care experiences of key populations. Methods: A cross-sectional survey was conducted with 268 female sex workers (FSWs
- 21 Elena Losina et al., "The 'ART' of Linkage: Pre-Treatment Loss to Care after HIV Diagnosis at Two PEPFAR Sites in Durban, South Africa," *PLoS ONE*, 2010, <https://doi.org/10.1371/journal.pone.0009538>.
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- 23 Layer et al., "Multi-Level Factors Affecting Entry into and Engagement in the HIV Continuum of Care in Iringa, Tanzania."
- 24 Layer et al.
- 25 Layer et al., "Multi-Level Factors Affecting Entry into and Engagement in the HIV Continuum of Care in Iringa, Tanzania."
- 26 Tran et al., "Financial Burden of Health Care for HIV/AIDS Patients in Viet Nam"; Roseanne C. Schuster, Devon E. McMahon, and Sera L. Young, "A Comprehensive Review of the Barriers and Promoters Health Workers Experience in Delivering Prevention of Vertical Transmission of HIV Services in Sub-Saharan Africa," *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 2016, <https://doi.org/10.1080/0/09540121.2016.1139041>.and identify associated factors in Vietnam. Methods: Cross-sectional multisite survey of 1016 HIV/AIDS patients attending 7 hospitals and health centres in Ha Noi, Hai Phong and Ho Chi Minh City in 2012. Results: HIV/AIDS patients used inpatient and outpatient care on average 5.1 times (95% CI = 4.7-5.4
- 27 International Labor Organization, "Position Paper on Mandatory HIV Testing in the Arab States," n.d., [https://www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/meetingdocument/wcms\\_330311.pdf](https://www.ilo.org/wcmsp5/groups/public/---arabstates/---ro-beirut/documents/meetingdocument/wcms_330311.pdf); World Health Organization, "Critical Enablers," in *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update*, 2016, <https://www.ncbi.nlm.nih.gov/books/NBK379680/>.

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- 30 East Africa, Eastern Europe and Central Asia, Latin America and the Caribbean, Middle East, South Asia, Southern Africa, and West Africa.
- 31 Indonesia included six sites because of the low number of PLHIV followed in the selected health facilities.
- 32 UNAIDS, "Epidemic Transition Metrics."
- 33 UNAIDS, "UNAIDS Data 2017," 2017, [https://www.unaids.org/sites/default/files/media\\_asset/20170720\\_Data\\_book\\_2017\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf).
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- 36 World Health Organization, "Progress Report on HIV in the WHO South-East Asia Region 2016," 2016, <https://apps.who.int/iris/handle/10665/251727>
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- 39 Keputusan Menteri Kesehatan RI No HK.01.07/MENKES/90/2019 tentang Pedoman Nasional Pelayanan Kedokteran Tatalaksana HIV
- 40 Keputusan Menteri Kesehatan RI No HK.01.07/MENKES/90/2019 tentang Pedoman Nasional Pelayanan Kedokteran Tatalaksana HIV
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- 44 Keputusan Menteri Kesehatan RI No HK.01.07/MENKES/90/2019 tentang Pedoman Nasional Pelayanan Kedokteran Tatalaksana HIV
- 45 Keputusan Menteri Kesehatan RI No HK.01.07/MENKES/90/2019 tentang Pedoman Nasional Pelayanan Kedokteran Tatalaksana HIV
- 46 Keputusan Menteri Kesehatan RI No HK.01.07/MENKES/90/2019 tentang Pedoman Nasional Pelayanan Kedokteran Tatalaksana HIV
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- 56 Surat Edaran No.443.1/24.a/Kesra Tentang Sosialisasi dan Pencegahan Perilaku LGBT, 27 Februari 2018
- 57 Surat Instruksi Wali Kota Depok Nomor 2 Tahun 2018 tentang Pelaksanaan Penguatan Ketahanan Keluarga terhadap Perilaku Menyimpang Seksual
- 58 <http://www.euro.who.int/en/health-topics/communicable-diseases/hiv/aids/policy/policy-guidance-for-key-populations-most-at-risk2/hiv-in-prisons>
- 59 Law on HIV/AIDS Prevention and Control (No. 64 year 2006/QH11) in Viet Nam
- 60 <https://www.hivjustice.net/country/vn/>

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