Research Report

Analysis of the HIV-Sensitive Social Protection Schemes in Indonesia

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Research Team

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Executive Summary

Although nationally the HIV epidemic in Indonesia is still concentrated on vulnerable populations, the negative impacts of AIDS for infected people and their families have the potential to become catastrophic because the infected people are mostly economically productive and HIV and AIDS in Indonesia are disproportionally experienced by poor families. A variety of attempts to reduce mortality rates related to HIV and AIDS have been undertaken, however, the attempts to mitigate the impact of HIV and AIDS on families have not received sufficient attention from AIDS program in Indonesia. Lack of concern regarding social protection of the PLHIV and their families in turn will impede the government's attempts to reduce poverty and provide universal access to health care.

Social protection is basically all efforts that are directed to provide income or consumption to the poor group, to protect the vulnerable groups from various risks that affect their welfare, and to strengthen the social rights and status of the marginalized groups. The goal of social protection is to reduce social and economic vulnerability of the poor and marginalized groups. As a means of social protection endeavors, different kinds of social insurance and social assistance have been promoted in Indonesia. In particular, Public Health Insurance (Jamkesmas) has been developed as a national social insurance that aims to overcome economic impact of health care cost for poor communities in Indonesia. Additionally, a number of local governments at the provincial and district/municipality levels have developed local health insurance (Jamkesda/Jamkesos) as a form of local government's responsibility in health decentralization.

Social and health insurance for certain groups have been implemented by some state-owned companies such as PT Jamsostek for private workers, PT Askes for civil servants, PT Asabri for armed and police forces personnel and PT Taspen for old age (pension for former workers in their old age). For those who are more fortunate, there are more options for health insurance provided by an array of private insurance companies in Indonesia. Unfortunately, the largest proportion of workers in Indonesia i.e. those who work in informal sector have not yet benefited from any type of health insurance neither from state nor private companies.

Existing social and health insurance and social assistance in Indonesia have not particularly addressed HIV and AIDS issue, however, by content these schemes have considerable potential to reduce the catastrophic impact to individuals and families who are affected by HIV and AIDS, because most of them come from poor and marginalized groups in the community. A number of studies have shown that social

protection developed in other countries with high HIV prevalence have contributed to reduction of poverty caused by HIV and AIDS, improved families' capability to earn income and enhancing access to education and health.

Seeing the considerable potential that the social protection schemes, particularly in social health insurance and social assistance, in Indonesia has to reduce the impact of AIDS to individuals and households, it is critical to see how far the various social protection schemes in country have given benefits to PLHIV. This study aims to map the array of social protection schemes in Indonesia, to identify different types of services that have been used by PLHIV and to assess the possibility of having a social protection policy that integrates the needs of PLHIV in its services.

This research was carried out in four cities i.e. Jakarta, Yogyakarta, Semarang and Pontianak. Data collection was performed in two ways. First, by collecting secondary data related to policies, procedures and previous research about social protection in Indonesia. Second, by collecting primary data through in-depth interviews and focus group discussions in each city. A total of 70 informants participated in the study. Data analysis was done through triangulation, where the data collected from different sources for a certain category is compared with and reviewed to obtain an insight about a certain topic.

Social Protection Schemes used by PLHIV

The study identify that a number of social assistance or social health insurance which is available in Indonesia within a certain level has been utilized by PLHIV for their healthcare. However , there are also PLHIV who have to use their own money or aided by friends in its community to obtain treatment services because they are unable to access the existing social health insurance. Several services that have been used, among others are:

- Global Fund Projects for PLHIV Treatment and Assistance
  Some informants stated that they have utilized a variety of free services provided by NGOs, health center, referral hospital supported by a project funded by the Global Fund. Types of services that have been accessed are VCT, ARV therapy, CD4 and Viral Load examinations, and delivery (PMTCT).
- Jamkesmas, Jamkesos, Jamkesda Schemes
  Most PLHIV reported that they have utilized healthcare services which requires hospitalization associated with opportunistic infections when they suffer it with the support of health insurance schemes available in their respective region. Some PLHIV use Jamkesmas facility if they are listed as Jamkesmas participant in certain areas or use SKTM (Certificate of Disadvantage). Some

PLHIV utilized Jamkesos through NGOs whom are believed to be able to assist Jamkesos membership because they are not registered as resident in a particular area. There are few PLHIV that reported having access to such services through Jamkesda schemes because they are permanent residents of a city or county but not listed as a Jamkesmas participant.

- Assistance for Socio Economic and Educational Improvement
  A number of PLHIV or their families reported that they have obtained social assistance from the Social Service Office in their province or city to start a business or increase their income. Communities who receive social assistance, among others, are the community of sex workers, transgenders and PLHIV including children with HIV. This assistance is intended as initial capital to start businesses after they follow training on business development.

Coverage

In principle, Jamkesmas or Jamkesos/Jamkesda bears 100% of the cost of required medical including the need for diagnostics. However, in practice not all of the costs incurred by the patient are allowed by Jamkesos/Jamkesda because the implementing agency (Bapel Jamkesos/PT Askes) imposes limits for benefits to be borne. Therefore, a number of cases found in this study shows that there are still many PLHIVs who have to finance themselves (out-of-pocket) some components of the healthcare such as the purchase of drugs, shortage of inpatient costs, and transport for referrals to health services.

The coverage area of social health insurance scheme issue is quite problematic considering the existing schemes have not been able to touch all the poor families or individuals in a province/district. Jamkesmas as a social insurance scheme which is a national health scheme basically only covers some poor families/individuals in a region and the remaining is the responsibility of provincial and district/city. Varying financial capability of the provincial or district/city causes some district/city or province to be able to provide Jamkesda as a complement to Jamkesmas scheme and some are not able to.

The availability of three social health insurance schemes appear as a major obstacle in the implementation of portability principle of a social insurance in which Jamkesos/Jamkesda (provincial and district/city) only bear people who have an address in the area concerned. As a result, people who do not have ID cards in the province/area cannot access to the existing healthcare. Several PLHIV who have background as transgender or sex workers are most often dealing with legal issues like this because most of them are not locals. Fortunately, there are some efforts made by NGOs or Kelurahan (local government) that finally allows them to access health services under the scheme.

Information regarding available social health insurance

Most PLHIV who access Jamkesos/Jamkesda use information provided from assisting NGOs. Some others obtain information from local village authorities (RT/Kelurahan) because they were listed as Jamkesmas beneficiaries. Although there are Jamkesda/Jamkesmas administrators who have published information about these services in the form of brochures/leaflets, few PLHIVs have seen or obtained these brochures. Limited access to existing social health insurance information cause various obstacles in accessing services provided by the schemes, such as the perception that the procedure to obtain social security is complicated, that it takes a long time to wait before they can access services, and the need to go back and forth between institutions to complete the administrative requirements. This lack of information also causes people to be denied of health services due to the fact that they don't follow the procedures required at health services offices and or social security implementing bodies.

Role of NGOs and PLHIV Network

In general, from the three cities it appears that most of PLHIV who affiliates with NGOs or peer support groups have been able to access Jamkesmas/ Jamkesda/ Jamkesos services. The role of NGOs to encourage PLHIV to utilize services and reduce barriers to become social insurance participant is very significant. Efforts to coordinate and conduct advocacy to the social health insurance management, KPAP/D, Health Center and public hospital are very influential on the emergence of a positive attitude from them. Likewise, the role of NGOs or support groups as guardian or supporter also contributes substantially to the magnitude of PLHIV obtaining social health insurance. Therefore, observing further of the previous explanations, PLHIV who can access care health insurance are those who have affiliations with NGOs/Peer Support Groups. On the other side, these affiliated PLHIV must be willing to disclose their HIV status although they have never had healthcare treatment before to enable them to be listed by related NGOs/Peer Support Groups.

Stigma and Discrimination

Issues of stigma and discrimination have been one of the issues raised by the respondents. Some respondents reported incidents that indicated the presence of stigma and discrimination at some health service providers, as well as unclear information regarding types and coverage of services that can be accessed by PLHIV. Behavior history of PLHIV as IDUs, sex workers or transgenders also often becomes an obstacle to obtain social protection. There is an assumption that sex workers or transgenders are of

unknown background because they do not posses demographic identity (ID) and become a major constraint for government officials to help them get SKTM which is required for obtaining Jamkesmas/Jamkesda. In fact, often they must be willing to be considered as displaced persons (Mr/Mrs X) in order to obtain the required health services.

Health Care for Those Who Cannot Access Social Health Insurance

Many PLHIV do not have any type of health insurance, either provided by government or private companies. Several factors for PLHIV to not be able to utilize the existing social insurance:

- Administrative factors which include: not meeting the criteria as recipients of social assistance, not following the procedure of service management, not knowing the requirements information to obtain social assistance, and not having complete paperwork participation (KTP, KK, SKTM)
- Stigma and discrimination factors that PLHIV cannot obtain services from healthcare providers because of their HIV status known or labeled as HIV patients
- Organizational factors; in which PLHIV who can access social insurance are only those who are already registered as Jamkesmas/Jamkesda participants or members of NGO/Peer Support Group assisted groups
- Personal preference factors; in which a number of PLHIV choose not to utilize the service (although this is possible through the NGO/Peer Support Groups authorized for Jamkesos/Jamkesda) because they feel that they do not need nor afford to bear the costs of care when they have fallen ill or do not want their HIV status to be known by others.

Based on the interviews, it appears that affiliation with an NGO can be a way for a PLHIV to access the health service/assistance they need. NGOs have critical roles in advocacy, facilitation to go to service provider institution, and collecting mutual funds as much as they can to assist paying health cost.

Recommendation

The scope of Jamkesmas, Jamkesda, Jamkesos and other social assistance is very limited, in terms of the number of PLHIV that utilized the services; the benefits PLHIV obtained as social insurance participant; the area its cover; and the adequacy and the quality of service. Although social insurance is available and has been utilized, the impacts of AIDS on individual PLHIV or households PLHIV are still significant because the existing schemes have not anticipated the needs for the PLHIV who are in treatment to recover and have more productive lives. Efforts to develop an HIV-sensitive social protection need to consider various limited resources owned by the government and society on the one side, and on the other side should also consider various potential resources that could be optimized. Some

recommendations can be proposed for the development of social protection that is sensitive against HIV are as follows:

- Inclusion of social protection agenda as one of the priority efforts in HIV and AIDS eradication based on the framework of Law No. 40 Year 2004 on National Social Security System.
- Encourage civil society organizations to advocate the policy makers to integrate HIV sensitive social protection into existing HIV and AIDS Program in order to improve access and coverage of health services for PLHIV.
- Social protection interventions that are sensitive against gender needs to be developed considering the socio-economic impact of HIV and AIDS to women, including sex worker and female IDUs, and households which headed by women is more severe
- Focus of interventions should be addressed to the household because they are the primary source of social support of PLHIV
- Resilience of PLHIV families needs to be improved to deal with the socio-economic impact of AIDS to enable them providing the social support necessary by PLHIV.
- In the context of the stigma against HIV and AIDS and discrimination against people living with HIV is still high, then the public education about HIV and AIDS is a basic prerequisite for greater community involvement in supporting the sensitive social protection against HIV
- Communities of people affected by HIV and AIDS can develop short-term efforts for its members to avoid the economic impact of healthcare they are required to do. One way that simply could be done is to initiate a “health funds’ for their members. The funds could be collected from the members, NGOs, or families of PLHIV.
- Civil society continuously need to continue the role of education, care and support, and advocacy to policy makers, because the results of this study indicate that there is still reluctance on some of the government organizations to include HIV treatment as healthcare that can be covered by the existing social insurance schemes.
- Efforts to build synergies among civil society organizations should be intensified in order to provide greater pressure on the government to accommodate the establishment of social protection efforts which are sensitive against AIDS issues.
- The National AIDS Commission and Ministry of Health need to include sensitive social protection against HIV into policies related to social insurance which currently being

conducted at national and regional level. These efforts are considered as positive response to strengthen universal coverage of national insurance for all the people of Indonesia.

- Integration of financing health efforts in the provision of ARV drugs, prevention and promotion efforts from Global Fund into social health insurance scheme needs to be done as form of a greater government commitment over AIDS issues, where this epidemic is not only addressed as a condition of emergency but also as part of development efforts in the fields of social and health which have long-term dimension.
- International institutions working in Indonesia must integrate this social protection agenda into AIDS programs which currently under development, facilitate civil society in advocacy to integrating sensitive HIV social protection into under-developing social insurance regulations and policies and develop various analysis on social protection.
- There should be clear and definite guidelines for the Jamkesmas and Jamkesda regarding the mechanism and policies of coverage for HIV-positive patients. These guidelines can help the Jamkesmas and Jamkesda implementing bodies in providing services and protection for HIV positive patient, as well as provide a clear set of protocol for hospitals.
- National Social Security System needs to expand the coverage of its groups to allow PLHIV from non-poor group have access to social insurance which can fulfill their health needs.
- Participation process requires simplification to allow people without identification card to access much needed basic health and social services.
- Synchronization of various social insurances need to be done concurrently with the existing social health insurance, which covers the membership, benefits obtained, administrative procedure/arrangement and management. Synchronization also expected can solve the portability issues of a social security.

1. Introduction: Why focusing on HIV-sensitive Social Protection?

a. HIV Epidemic and Socio Economic Impact

HIV incidence in Indonesia continues to increase. According to the Ministry of Health's data, reported HIV and AIDS cases until December 2010 was 33,364 people, and 90% of them were in productive age[1]. It is estimated that approximately 70% of the infected people should receive ARV therapy. However, almost 30% of them did not get any available therapy. Until September 2010, around 59% were on treatment, while the rest of them dropped out from the therapy with various reasons such as ceasing therapy, untracked addresses, deceased, or relocated[2]. The availability of ARV therapy in Indonesia has an important contribution in reducing mortality rate of People Living with HIV (PLHIV) in the last five years. In 2001, the mortality rate related to HIV was 46%, but it fell to 18% in 2009.

Preventive actions have also been carried out to reduce new HIV infections through various interventions targeting higher risk populations such as injecting drug users, female and male sex workers, men having sex with men (MSM) and sex worker clients. Prevention of transmission from HIV-positive mothers to their babies has also been carried out. Actions to mitigate the negative effects of AIDS for children and families have also been developed, albeit in small scale.

A variety of approaches in HIV and AIDS prevention and treatment have been developed, from individual approaches that are focused on behavior change of the high risk groups, up to structural approaches that is directed to promote social change that allows positive conditions for reducing HIV incidence, including reducing the stigma of HIV and AIDS and discrimination against PLHIV) and the high-risk groups/population[3]. These various preventions have given different results. Prevention of transmission through contaminated needles has given positive results because new HIV transmission cases have declined. Nevertheless, the prevention through sexual transmission through seemed to be a big challenge in implementing the

[1] Ditjen PP & PL, Kemenkes, AIDS cases report, up to January 2011
[2] Subuh, M. 2011, National Policy of HIV/AIDS Control, presented during the Spiritia Foundation Annual Evaluation And Development Of 2011 Action Plan
[3] KPAN, National Strategy for AIDS Eradication 2010-2014

National AIDS programs.

Although nationally the HIV epidemic in Indonesia is still concentrated on vulnerable populations, the negative impacts of AIDS for infected people and their families have the potential to become catastrophic because the infected people are mostly economically productive and HIV and AIDS in Indonesia are disproportionally experienced by poor families. One of the main impacts of this situation is the decrease of productivity and inability to earn income that impoverishes the families further. Research on socio-economic impact of HIV in 7 provinces with 1,019 sample households who have HIV-positive family members and 1,019 households who do not have HIV-positive family members as a control group shows that the families of those who are infected experienced a higher expenditure for health, a higher possibility of losing household assets, and a lower opportunity for their children to go to school[4]. Furthermore, the research also indicates that females tend to experience worse socio-economic impacts than of their male counterparts. These impacts are worsened by poverty, considering that the poor are disproportionally affected by HIV. In addition, strong stigmatization toward HIV and people infected by HIV has caused PLHIV and their families must repeatedly deal with strong social pressure from different sources.

Although a variety of attempts to reduce mortality rates related to HIV and AIDS have been undertaken, the attempts to mitigate the impact of HIV and AIDS on families have not received sufficient attention from AIDS program in Indonesia[5]. Lack of concern regarding social protection of the PLHIV and their families in turn will impede the government's attempts to reduce poverty and provide universal access to health care, which are the targets of Millennium Development Goals (MDGs).

[4]JOTHI & BPS, Survey of Socio Economic Impact On Individuals and Households with HIV in seven provinces in Indonesia

[5] Efforts to overcome effects of AIDS to infected people and their families in National Strategy for AIDS Eradication is still limited to efforts to increase access to health care, education for children affected by HIV/AIDS efforts to give business capital for PLWHA.The strategy developed is not yet comprehensive and widened because it's still focused on social assistance strategy that was developed by Ministry of Social Affairs. See National Strategy for AIDS Eradication 2010-2014.

b. Social Protection and the Impact of AIDS

Social protection is basically all efforts that are directed to provide income or consumption to the poor group, to protect the vulnerable groups from various risks that affect their welfare, and to strengthen the social rights and status of the marginalized groups. The goal of social protection is to reduce social and economic vulnerability of the poor and marginalized groups[6]. In Indonesia, the attempts to put social protection into practice can be seen from the legislation of Law No 40/2004 on National Social Security System that aims to secure the fulfillment of adequate basic rights for the Indonesian population through health insurance, work accident insurance, old age insurance and pension and death insurance.

As a means of social security endeavors, different kinds of social assistance have been promoted in Indonesia. In particular, Public Health Insurance (Jamkesmas) has been developed as a social insurance that aims to overcome economical impact of health care cost for poor communities in Indonesia (see Appendix 2). Jamkesmas is part of Health Care Insurance (JPK) program from the Ministry of Health. This program gives free health care services for Indonesian citizens that aim to increase access and quality of health care service for the entire poor and unfortunate people to increase the optimum degree of health of the community effectively and efficiently.

Meanwhile, as mandated by Law No. 32/2004 on Regional Autonomy, a number of local governments at the provincial and district/municipality levels have developed local health insurance as a form of local government's responsibility in health decentralization. Local Health Insurance (Jamkesda) is basically a local social health protection that is funded by local government (province or district or joint efforts between the two) through local government's budget (APBD) to complement Jamkesmas in cities/districts. The management pattern of this local health insurance refers to Jamkesmas.

In 2011, the Ministry of Health launched a new social health insurance that complements Jamkesmas namely Maternity Benefit (Jampersal). Jampersal aims at increasing access to service during birth that is assisted by medical doctors or midwives in order to reduce the

[6] Devereux, S. and Sabates-Wheeler, R. 2004, Transformative Social Protection', IDS Working Paper 232, Brighton

Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) through provision of financial security for birth services.

Social and health insurance for certain groups have been implemented by some state-owned companies such as PT Jamsostek for private workers, PT Askes for civil servants, PT Asabri for armed and police forces personnel and PT Taspen for former workers in their old age (see Appendix 2). For those who are more fortunate, there are more options for health insurance provided by an array of private insurance companies in Indonesia. Unfortunately, the largest proportion of workers in Indonesia i.e. those who work in informal sector have not yet benefited from any type of health insurance neither from state nor private companies.

Number of social and commercial insurance participants in 2009 can be seen from the table below.

Table 1: Situation of Health Insurance in 2009

Health Program	Number of participants (in millions)
Community Health Insurance (Jamksesmas)	76.4
Local Health Insurance (Jamkesda)	10.8
Social and Health Insurance for Civil Servants (PT Askes)	14.9
Jamsostek for private workers	3.9
Health insurance for armed and police personnel	2.0
Private Commercial Insurance	8.8
Total	116.8

Source: Kompas February 13, 2010[7]

Although social and health insurance that are developed in Indonesia have not particularly addressed HIV and AIDS issue, by content, the Law has considerable potential to reduce the catastrophic impact to individuals and families who are affected by HIV and AIDS, because most of them come from poor and marginalized groups in the community. A social protection scheme is considered sensitive toward HIV when the benefit of such protection can be used by the persons who are at risk to be HIV infected and vulnerable against the negative impacts

[7]Quoted fromWidjaya Muliadi & R.A Simanjuntak, Social Protection in Indonesia: How Far Have We Reached?

incurred by HIV and AIDS[8]. Thus, an HIV sensitive social protection can be interpreted as efforts to ensure availability of access to basic social and health services for the disadvantaged groups so that it can reduce the poverty gap, vulnerability toward infection, and socio-economic impacts of HIV for PLHIV and their families, which also aims at increasing economic capacity and productivity of the families affected by HIV and AIDS[9].

Ideally, the type of social protection that should be developed is a comprehensive one that has national coverage and is based on understanding of various risks and vulnerabilities of different groups, especially the poor and marginalized groups. Understanding the risks and vulnerabilities from the HIV perspective means understanding about epidemic phases, factors that influenced the epidemic and factors that expose someone to the risk of HIV infection, access, care and support, taking into account that these are the things that must be considered in developing the form of social protection as mentioned before. A number of studies have shown that social protection developed in other countries with high HIV prevalence have contributed to reduction of poverty caused by HIV and AIDS, improved families' capability to earn income and enhancing access to education and health[1011].

Seeing the considerable potential that the social protection in Indonesia has to reduce the impact of AIDS to individuals and households, it is critical to see how far the various social protection schemes in country have given benefits to PLHIV. Considering that until now there have not been any comprehensive information regarding what type of protection that have been used by PLHIV in Indonesia, a study is therefore required to map the array of social protection schemes in Indonesia, to identify different types of services that have been used by PLHIV and to assess the possibility of having a social protection policy that integrates the needs of PLHIV in its services. Thus, the main problem that will be addressed in this study is whether the existing social protection schemes in Indonesia have already been sensitive toward the needs of people with HIV.

[8] Temin, Miriam, HIV-Sensitive Social Protection: What Does The Evidence Say? Presented at the IDS, UNICEF and UNAIDS Meeting on the Evidence for HIV-Sensitive Social Protection. June 14-15, 2010, Brighton, UK
[9]. Temin, Meriam, op.cit
[10]Slater, Rachel 2004, The Implications Of HIV/AIDS for Social Protection, DfID
[11] UNICEF, 2010, Social Protection: Accelerating the MDGs with Equity, in Social and Economy Policy Working Brief

2. Research Objectives

This research's objectives are: (1) To identify types and characteristics of social protection chemes in Indonesia that are used by PLHIV. (2) To provide recommendations for the implementation of social protection that integrates the needs of PLHIV and their families. Some aspects that will be observed in more depth for each of the social protection scheme are:

a. Structure, mechanism and process of each social protection scheme
b. Implementation of each scheme at the local level
c. The possibility of PLHIV to utilize each scheme
d. Challenges and opportunities for PLHIV to utilize the schemes

The end result of this research is a comprehensive analysis about the implementation of social protection schemes from the views of providers and beneficiaries. This result will also include recommendations regarding attempts to give more focus on social protection issue in AIDS prevention and care in Indonesia and to integrate an AIDS sensitive social protection into the national AIDS strategy. It will also recommend a range of roles that can be played by stakeholders that are related to HIV-sensitive social protection issue such as families, civil society organizations, government and international institutions.

3. Methodology

a. Scope of study

The scope of this study is review of various policies, structures and implementation of various social protection schemes in Indonesia that can influence PLHIV in Indonesia to utilize health services. Thus this study is divided into two main parts. The first part is the review of various documents related to policies and implementation of social protection system in Indonesia, including review of previous studies/researches about social protection/insurance. The second part is focused on getting a picture of the implementation of social protection schemes at the provincial and district/municipalities level. This latter part highlights the empirical experience of PLHIV in utilizing social protection scheme to address their needs of health care service in health facilities in their respective cities. The other highlight is on the experience of the management of social protection scheme and health care service provider in giving the

required health services to PLHIV.

b. Research Location

This research was carried out in four cities i.e. Jakarta, Yogyakarta, Semarang and Pontianak. Jakarta was chosen because the discussion and the main actors related to the national social protection scheme takes place in Jakarta, such as the Ministry of Health, Ministry of Social Affairs, commercial/private insurance companies and social protection experts. The other three cities were selected considering the variation of social and health insurance that are implemented in those areas that can be accessed by PLHIV. Source of information in each city are the management of social security schemes (Bapel Jamkesos, PT Askes, Health Office), AIDS Eradication Commission at provincial/district/city, Peer Support Groups, NGOs working with PLHIV, Regional Development Planning Body (BAPPEDA), Office of Social Affairs, Hospitals and Community Health Centers (Puskesmas).

c. Data Collection

In line with the scope of this study, the data collection was performed in two ways. First, by collecting secondary data related to policies, procedures and previous research about social protection in Indonesia. These data are collected by requesting copies of the documents from various sources, searching for the documents in libraries and the internet. Second, by collecting the primary data in the form of qualitative data from the informants in four cities. The qualitative data were collected in two methods, namely in-depth interview with informants in those four cities and focus group discussions with stakeholders of AIDS and social protection program. These focus group discussions were only conducted in three cities (Yogyakarta, Semarang and Pontianak). Focus group discussions were held twice in each city, in which one of the discussions was conducted with the government agencies, and the other one was with PLHIV.

In-depth interviews were conducted using semi-structured interview guide that was adjusted according to the background of informants (management of social insurance, PLHIV, social protection experts, NGO activists/KDS). As for focus group discussions, a different semi-

structured discussion guideline was used, depending on whom the participants are (PLHIV or stakeholders). The discussions were led by a team with two members, the first one as a discussion leader and the other one as a note-taker. In general, the instrument used in the primary data collection covered a variety of issues on implementation of each social protection schemes, experiences and possibilities for PLHIV to utilize each scheme and perceptions about challenges and opportunities for them to utilize the schemes.

Primary data collection took place in May and June 2011 by two research team members for each city. For the preparation of data collection, the research team was assisted by NGOs or network of PLHIV in each respective city. Those are: NGO Victory Plus Yogyakarta, NGO Graha Mitra Semarang, and JOTHI West Kalimantan. Each organization assisted the team during the discussions with stakeholders and PLHIV in each city. Seventy people participated in interviews and FGDs in four cities. Informants in primary data collection can be seen in the following table:

Tabel2: List of Informants and FGD Participants

Yogyakarta	Participants organizations/institutions	Females	Males	Transgender	Total
FGD Stakeholder	Provincial KPA, Provincial Dinkes, Provincial Dinsos, RSUD Sardjito, Puskesmas Gedong Tengen, NGO Kebaya, NGO Victory Plus, Provincial Jothi	0	7	1	8
FGD PLHIV		2	6	0	8
In depth interview	Subdit Pembiayaan Jamkesmas, Subdit Child Protection, Provincial Dinsos, Bapel Jamkesos, NGO Kebaya, NGO Victoria Plus, Puskesmas Gedong Tengen, Social Protection experts	2	4	1	7
Semarang					
FGD Stakeholder	KPAP, City Dinkes, City Dinsos, Kelurahan Kali Benteng Kidul, Kariadi hospital, City Bappeda	1	5	0	6
FGD PLHIV		1	4	2	7
In depth interview	Subdit funding, City Dinkes, NGO Graha Mitra , NGO Kalandra, NGO Griya Asa PKBI, City Bappeda, Key informants	3	3	1	7
Pontianak					
FGD Stakeholder	KPAP,Provincial Dinsos, Sudarso local hospital, Puskesmas Yos Sudarso, NGO Pontianak Plus, Kesra Bureau, Governor office, PT Askes Pontianak	3	4	0	7
FGD PLHIV		4	6	0	10
In depth interview	KPA Provinsi Kalbar, Provincial Dinsos Kalbar, Sudarso local hospital, NGOPontianak Plus, PT Askes Pontianak	1	4	0	5
Jakarta					
In depth interview	Centre of funding MoH, Forum Asuransi kesehatan PT Taspen, Ikatan Perempuan Positif Indonesia, Social security experts	3	2	0	5

d. Data Analysis

Each FGD and in-depth interview was recorded and transcribed word by word (verbatim) to be

input into the database and processed through qualitative data processor software, Nvivo. The data was processed based on categories that were determined in prior, and in accordance with scope of the instrument that was used. Data analysis was done through triangulation, where the data collected from different sources for a certain category is compared with and reviewed to obtain an insight about a certain topic[12]. Based on those categories, data from FGDs were compared with information gained from the interviews. Meanwhile, the data collected from document reviews were also compared with the data about their implementation that were gathered from discussions and FGDs.

The analysis is presented in three parts in this report. First part is presented descriptively, regarding the implementation of social protection schemes based on the experience of PLHIV after they were infected, types of social protection and their management, and accessibility and constraints in obtaining social and health insurance. In the second part, some insights from this study will be presented, focusing on analysis about how far social protection in Indonesia , particularly in the three areas are able to address the needs for HIV health care and its socio economic impacts to the individuals and the families. The third part will be the analysis of how broad is the coverage of the social protection scheme from the membership aspect, benefits received by participants, areas of coverage. and sufficiency and quality of services that are borne by social protection schemes in each region. In the last part, a number of recommendations to develop HIV sensitive social protection in Indonesia that is based on an understanding about HIV and AIDS program and social protection contexts and social protection policies in Indonesia, will be presented.

e. Research Limitation

This research will be the first research that specifically studies about the use of social protection by people infected by HIV and their families, therefore it is expected that this research will give meaningful contribution for the development of an HIV sensitive social protection model in Indonesia. The other added value of this research is that it provides a study based on the implementation of various policy documents on social protection, particularly social health

[12]UNAIDS, 2010, An Introduction to Triangulation

insurance that are available in Indonesia so that an insight about the gap between policies and practices of health insurance at the field level can be obtained. The result of this study can be used as a basis to improve the implementation of social and health insurance schemes in Indonesia. Although this research has the strengths and potentials to give contribution to the development of an HIV sensitive social protection model, this research has some limitations, for instance:

a. Selection of research locations and informants in this research was done purposively, based on assumptions that the three researched provinces have HIV-sensitive social protection, so that they can reflect the best possible situation in Indonesia in terms of sensitivity towards HIV. Although some data can portray the implementation of those social health insurances, precautions must be taken before applying these results in another context, because these are specific portraits of the three cities of research locations, and cannot describe the real situation of the implementation of health insurance in other provinces in Indonesia.

b. As a qualitative research, this research, by design, has limitation in describing broader aspects of the problems found in the field. Nevertheless, this limitation can be addressed by using triangulation techniques in analyzing the data so that it is possible to compare the data with other documents related to problems that are indicated by the data collected in this research.

c. Akin to primary data collection in other qualitative research, the using of interview method and FGDs has also limiting the possibility to find more comprehensive information. The information from FGDs or interviews often contained *recall bias*, considering that the participants were asked to tell about various past events that might have taken place long time ago. Information from FGDs sometimes could not be probed further because of time limitation, the different activity level of participants to give answers and the participants' factor during the discussion process. To address this issue, the interviews were done after FGDs were held. Aside of to anticipate the activity issue of participants, in depth interviews were also directed to explore problems arose during

FGDs. That is the reason why informants for in-depth interviews are the same with the participants of FGDs.

d. Use of the term 'social protection' can provide different interpretations because the definition of this concept is very broad so that it may give a vast array of interpretations about different policies and activities covered. To reduce the possibility of altered interpretation of social security concept, the readers will be continually reminded about definitions used in this research.

2. The Use of Social Protection

This research aims to identify the forms of social protection that have positive contribution to reduce negative impacts that are incurred by HIV infection on those who live with HIV and AIDS. Since there have not been any social and health insurance that are specifically developed to address the needs of PLHIV, the information explored more deeper on types of social health insurance that are familiar and used by people who live with HIV and AIDS in three cities (see Appendix 1).

Information in this chapter comes from literature review before field data collection was undertaken: interviews and FGDs in three research locations (cities), supporting interviews with a number of resource persons in Jakarta, and discussion of research team during the process and after field data collection was conducted. The following explanation will describe the needs and experience of PLHIV related to their needs for health service. After that, forms and types of social assistance identified from field data collection will be presented. In the next part, we will explain how implementation of the available social insurance service and the experience of PLHIV in accessing those various services.

A. The Need of Health Service after Recognizing the HIV+ Status

For someone who is at risk to be infected with HIV, it is recommended to undertake VCT test to ensure whether he/she is infected or not. Once he/she is found to be HIV-positive, a series of health tests must be done. Based on the National Guidelines for Antiretroviral Therapy 2007 that was issued by Ministry of Health, Republic of Indonesia, during the initial visit of people identified having HIV at the health facility, some things must be done such as: exploring the complete history of the disease, a complete physical examination, a routine laboratory examination, a calculation of total lymphocyte and if possible, testing the level of CD4. It is also necessary to conduct clinical assessment such as: assessing clinical stage of HIV infection, identifying other diseases related to HIV in the past, identifying diseases related to HIV in present time that needs to be treated, identifying other Antiretroviral (ARV) treatment and opportunistic infections, and identifying other treatments that can affect therapy selection. By

identifying somebody's clinical condition, a clinical stadium that is the basis to start an ARV treatment and opportunistic infection therapy can be determined. Once it is decided that the patient must start an ARV therapy, a routine checkup, -at least once a month, needs to be performed. A CD-4 checkup, at least once in three months, is also a practice that should also be done regularly to monitor the immunity of patient's body. Other check ups are also need to be done such as viral load, liver function check up, thorax photo/x-ray when necessary, and other check ups based on opportunistic infections that might follow. Beside the need to perform such aforementioned check ups, people infected by HIV also need other supporting services, such as psychological counseling and other medical assistance.

Seeing at the series of health check ups required by a PLHIV as mentioned above, whether during initial check up or regular check up, the health cost for a PLHIV is definitely increased. A survey that was undertaken by BPS and JOTHI in 2009 revealed that health cost in general is 50% higher than of the families who are not infected HIV. Although that study represents group infected with IDU background, the information reported there is useful as preliminary information to know the need of a PLHIV in general. From the findings in the field, for certain cases, health cost for person infected with HIV and AIDS is very high that the family needs to sell all their assets to pay various health costs incurred.

> *"The cost cannot almost be counted. Honestly we did not want to count it any more; we have spent almost everything because we didn't know at that time. We came in and out of hospital as we just knew that it's a disease, 'though we did not know what disease. Some said that it's sent by someone (magic), yes we did not know at that time because we had no idea about HIV. No matter how much the money required for buying medicines that people suggested, I still bought them. The last time I went for therapy to an elder in Surabaya, the old man said that he can cure (it) but he asked for Rp 10 million and I even gave the money to him… These things happened for almost two years. So from first treatment when she started to be sick until my wife passed away, I have sold my paddy field for Rp 65 million and I also used to have a Feroza that I sold for Rp 53 million. Hundreds of millions madam, that was what I spent to focus on my wife's medication."* (FZ: FGD PLHIV, Semarang)

It is obvious that health cost for a PLHIV can soar so high that it decreased the family economy drastically. While for PLHIV who are still in good condition, the routine health cost that must be spent is health check up to the doctor as well as to get ARV once a month. For this purpose,

PLHIV only need to pay registration fee between Rp 5,000 – Rp 20,000. In addition, they also need to pay for transport cost from their residence to check up locations, either in Puskesmas, local public hospital (RSUD), or provincial public hospital (RSUP). The cost they have to spend varies from Rp. 5.000 – Rp. 50.000 for a visit. For light illnesses such as coughing or a headache, most HIV and AIDS patients do not visit a hospital or doctor, but they only purchase the medicines in nearby kiosks/shops.

> *" They do not need to pay, miss, they come and only pay the ticket. After that, taking ARV medicine" (Doctor, K Hospital, Smg)*

> *" It is much better nowadays, the complaints are still there, but only some light complaints, well, I just need to buy the medicines in the kiosk and it's well again. If we don't have any complaints, it's just for hospital registration fee, that's all. But if we count in average, for instance the access to go to Semarang too, the cost is about Rp 50,000 because my wife is in Salatiga. If I go to Semarang, the cost is Rp 50,000, then paying for registration fees for two persons is Rp 35,000 each. It means in a month we have to spend Rp 200,000 to access ARV"* (FGD PLHIV, Smg).

From the findings in the field, it can be said that the money that must be spent by a person diagnosed of having HIV and AIDS is quite varied, depends on that person's level of health. In general, a PLHIV will need more health services and spend more for health costs compared to other people. Through the Ministry of Health ARV program that is funded from Anggaran Pendapatan dan Belanja Negara/National Budget (APBN) and Global Fund, the purchase of ARV for PLHIV who are members of such program is fully subsidized (commenced in 2005 and fully applied in 2006). In 2011, Ministry of Health allocates 70% of ARV purchasing with APBN and the rest is covered by the Global Fund. At that time, monthly cost for a PLHIV to access ARV was Rp 385,000. Even so, patients have to pay for registration fee and check up cost for doctor when he/she wants to take medication the following month; the consultation fee is between Rp 60.000- Rp 120.000. At the hospital, it is a must for the patient to consult a specialist (internist) to get ARV. In some places, there are clinics and health centers that provide counseling service with a lower price. Some NGOs give this service but still demand the ARV patient to make a first registration to one of the ARV referral hospitals.

Beside the aforementioned costs, there are other costs incurred as a consequence of accessing the required services. Supporting tests or diagnosis to get ARV services, treatment related to opportunistic infections that occurred during certain period, often become an additional burden for PLHIV. Other indirect costs are transport cost and additional time to access those health services once the patient required a more regular service.

Until early 2011, there are 182 points of treatments and care related to HIV and AIDS in 33 provinces. In addition, there are some additional Community Health Centers that were activated as HIV and AIDS service and Harm Reduction centers in some cities. This fact indicates that the service points for PLHIV are relatively distributed equally for the whole country.

B. Type of Social Protection

As mentioned in the previous section, one of the formal social protections that are available for the poor is Jamkesmas, while other services cannot yet be categorized as form of social protection. Although some HIV and AIDS infected people can already access the services, some of the services are still considered social assistance.

HIV intervention program that was started in the early 1990s to early 2000 has emphasized on preventive intervention. The effort to strengthen health services related to HIV started to grow after some government's commitments such as Sentani Commitment and commitment to scale up HIV and AIDS service in 2003. One of the early social assistance that was widely known by AIDS program implementers was Akeskin (health insurance for poor families) that was launched in 2004. In 2005, a number of NGOs that provided support services in form of case management service have been actively facilitating PLHIV, who mostly come from poor family background, to access services in health service centers. Since then, NGOs and/or networks of HIV and AIDS infected people have been familiar with the administrative requirements and realized the importance of having certain information letter (e.g. Surat Keterangan Tidak Mampu) to be able to access the available services.

Over the last 3 years there has been a significant increase in number and type of social assistance that can meet parts of PLHIV needs. Since Askeskin was launched in 2004, -it was

later continued with Jamkesmas in 2006, many of the poor people who are also living with HIV and AIDS are helped through health service related to AIDS. However, -as it is with the general population, -many of PLHIV have just started to participate in social insurance scheme when they fall sick. That is why the problems occurred during their attempts to access services through social insurance scheme tend to arise during the early period of sickness or when they started to show symptoms that require medical attention. Research by Atma Jaya Research Centre for HIV and AIDS regarding compliance to ARV medication (PPH, 2009) revealed that most of the interviewed respondents mentioned that they knew their HIV status after their condition dropped drastically, they are sick and needed intensive care such as in-patient care.

> "*Most of them are like that, when they are healthy they forget, after falling sick, then they remember to take care of this and that*." (FGD stakeholder, Pntk)

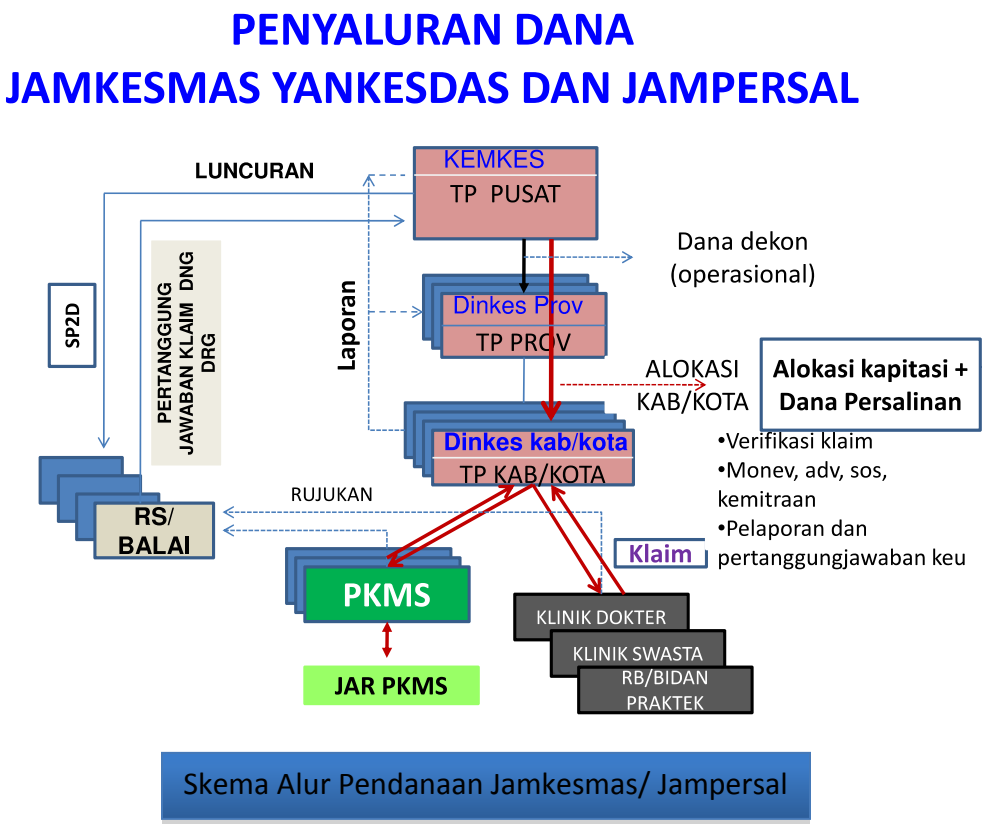
Jamkesmas is health security service that is most used by patients with AIDS, in particular the poor ones. In its procedure, Jamkesmas should be given to the registered people and verified by local administrator. Jamkesmas card is given to people who were identified earlier as poor people by BPS. This list is updated every five years.

The main policy used in the implementation of Jamkesmas program refers to Jamkesmas Implementation Guideline that was issued by Ministry of Health, Government of Indonesia. This guideline determines the membership management, type of services available, funding, organization and monitoring and evaluation. Jamkesmas memberships mainly targets the poor communities, endorsed by Surat Keputusan (SK) Bupati/Walikota year 2008 based on the quota of each district / municipality in accordance with BPS data as national database. If there are still poor people who are in a district/municipality who are not covered by national database, his/her health insurance should be the responsibility of the local government. The implementation of local health insurance should be in adherence with Jamkesmas[13].

Some of the PLHIV from middle and lower economical level are usually assisted by NGOs who have experience in arranging administrative requirements to access Jamkesmas. The process is, certainly, not as easy as expected. From some interviews and FGDs, it can be concluded that to

[13] Implementing Guide of Jaminan Kesehatan Masyarakat (Jamkesmas), 2010.

be able to access services, a poor patient who is not registered as a member of Jamkesmas have usually been facilitated by NGO to request RT, RW or *kelurahan*, to give recommendation to access the service. During this process, sometimes the patient has to coordinate many times with staff in the said puskesmas or hospital. As a result, most of the emergency cases experienced by PLHIV who have relations with NGO or facilitated by NGO are able to access Jamkesmas services.



Skema Alur Pendanaan Jamkesmas/ Jampersal

Jamkesda is a social protection scheme that has similar goal with Jamkesmas. The distinction between the two is only on the source of funding of each scheme. Jamkesmas is funded by central government while Jamkesda by local government, whether provincial or district government's budget (APBD). Basically, Jamkesda is for people who meet all the criteria to get Social Insurance (poor category), but not included in BPS' list or Jamkesmas management at local level. In its implementation, mechanism and regulation about how the funding can be utilized is varied between each region. Most of the Jamkesda funding comes from district/municipality government. For instance in Central Java province, it is mentioned that Jamkesda is applied using a combined funding from district and provincial APBD with the

proportion 60:40 for referred cases. Further, it must be noted that Jamkesda does not necessarily cover the whole area of such province, but depends on the commitment and financial capacity that is given by municipality/district government.

Based on the interview with an informant from Jamkesda management (as Bapel Jamkesda) in Pontianak city, it was mentioned that Jamkesda uses regulation from PT Askes, which means that based on the existing regulation, its services excludes PLHIV as recipients of health insurance through Jamkesda funding.

Beside Jamkesmas, one of the interesting health insurance is the Jamkesos system that is only available in DI Yogyakarta province. Jamkesos is funded by Office of Health and can only be used by DI Yogyakarta residents. An interesting issue related to the usage of Jamkesos by PLHIV is that according to Jamkesos regulation, participation or cost of health service for patients with B-20 code (code for HIV cases) is not allowed under the scheme. Based on interviews and FGDs, those who work with people infected by HIV (doctors, NGOs) attempt to respond to this regulation by registering the HIV infected patients who need health care to access Jamkesos according to the opportunistic infections that are suffered by the patients, and not listing B-20 code. Based on the experience of some discussion participants who come from NGOs, most doctors and medical workers whom they have known or have good relationships are quite sensitive about this issue. They are usually helpful in making such information that indicates client as an HIV infected individual does not appear in service claim forms.

Basically, the three aforementioned health insurances have similar goals, namely to secure health services for the poor and unfortunate people with the principles of social health insurance. The differences between them are about their membership coverage, service coverage and funding sources. The criteria of membership are different, for instance, Jamkesmas membership is divided into:

1. Members whose membership is based on BPS database, which is endorsed by SK (Decree of the) Bupati/Walikota. Members from this category have membership cards that are managed by PT. Askes. To access health service, members need to attach citizens' identity documents, ID card and Family Card. The quota for this category has

been determined for each district/municipality. The figures of Jamkesmas for Central Java, DI Jogyakarta and West Kalimantan respectively are: 11,715,881 people; 942,129 people and 1,584,451 people.

2. Members who comprise of homeless, beggars and abandoned children as well as poor people who do not have identity cards. Members from this category do not have membership card, so they need to show information letter (surat keterangan) or recommendation from local Social Affairs office.

3. Poor people who are endorsed by Health Minister Decree No 1185/Menkes/SK XII/2009 about the increase of membership for Jamkesmas participants from social nursing homes, prisoners and incarcerated people in state detention houses and disaster victims.

4. Infants and children who are born from couples who are Jamkesmas members. Birth certificate from medical workers should be shown when accessing Jamkesmas.

As for Jamkesda, the members are poor and near poor people who are not members of Jamkesmas. Specific to Yogyakarta's Jamkesos, aside of providing health insurance for the poor and near poor who are not members of Jamkesmas, the scheme also gives health services to poor and near poor people who are members of appointed institutions which are registered non-government organizations.

Beside differences in membership coverage, Jamkesmas, Jamkesda dan Jamkesos also have different funding sources. Jamkesmas is sourced from APBN that is proposed by the Ministry of Health, as well as from Anggaran Pendapatan dan Belanja Daerah/District Budget (APBD). Local government contribute and support the implementation of health care service for poor and near poor people within its jurisdiction, such as transport cost from origin hospital to the referred advanced health care service as well as the patient's return cost, transport cost for staff who aided the patient from origin hospital, support for operational cost management

coordination team and Jamkesmas management team at provincial/district/municipality[14]. Jamkesos/Jamkesda are funded by APBD.

From the aspect of benefits for participants or service coverage that are assured by health insurance, Jamkesmas gives a comprehensive health care service benefit scheme based on their medical needs and medical service standard. Meanwhile, there are some restrictions for Jamkesda and Jamkesos participants due to limited financial capacity of the local govenrments,. For example, in Central Java, Jamkesda will cover a maximum cost up to Rp 14 million, while based on FGDs with people living with HIV in West Kalimantan, they mentioned a maximum 10-15% of the total cost, while for DI Yogyakarta it was mentioned that the maximum cost is Rp 15 million for each health care service. Some informants explained that to cover the cost before the patient is fully recovered; the patients is sent home and then sent back in to the hospital, so that they do not need to pay for the additional health care cost.

In addition to health insurance such as Jamkesmas, Jamkesda dan Jamkesos, there are other social assistance programs. Respondents said that they have heard or received social assistances such as training for working skills, equipments for small business as well as cash for business start up capital. Special programs for special groups such as children are also mentioned, in the form of provision of educational costs and suplementary food. Eligible children for these schemes are children who affiliate with institutions which recommended or registered by the provincial/district social welfare office. The entire aforementioned assistances, especially those that are not related to health aspects, are only “one shot” in their nature, due to the lack of monitoring and action plan. As a result, -based on resource persons’ experience – those programs relatively failed without giving any significant impact in empowering poor people and those who live with HIV or to ease the socio-economic burden that they encountered.

The presence of the three aforementioned health insurances has opened the opportunity for PLHIV to meet their demand for free health care services. Unfortunately, from the FGDs or interviews that were conducted in three provinces, there is an indication that not so many of

[14] Implementing guide of Jaminan Kesehatan Masyarakat (Jamkesmas), 2010.

those people have accessed Jamkesmas or Jamkesda. It is unlike Jamkesos; since the memberships also come from guardian institutions where most of them work to aide HIV vulnerable groups, thus more PLHIV have used this insurance.

Albeit there is no formal written policy that excludes or distinguishes PLHIV whether in terms of membership, coverage or standard of service, the actual implementation depends much on contextual situations. In similar cases, actions and responses from health workers could differ due to limited understanding and experience of the workers. As a result, there are some personal attitudes that are less sensitive in providing service for PLHIV. Lack of information, either by service providers or people living with HIV as Jamkesmas members themselves, have often caused them to have difficulties in accessing health care services.

One of the reasons why social protection services do not cover HIV mentioned by the secretary of the health insurance association is due to the lack of information from other private insurance companies regarding the cost and coverage of such services. There is also a misconception from Jamkesda and Jamkesmas that HIV and AIDS health-related services are already covered by the Global Fund, therefore these two social assistance schemes do not provide coverage for HIV and AIDS.

> *"...Em, no, it's not covered. It's already covered by the Global Fund so the APBN (state budget) doesn't cover it." (Health insurance expert, Jkt)*
>
> *"But I don't know PLHIV, if (the patient) is PLHIV, I immediately give them to the Global Fund" (representative of Jamkesos Implementing Body, Yk)*

Another factor that might lead to HIV not being covered is the misconception from local government in charge of Jamkesda that the cost for HIV coverage will be too high for the local government to afford. There is also the issue of implementation body subjectivity, in which they refuse to provide services to cover HIV and AIDS based on the fact that the technical guidelines for Jamkesda do not specify whether or not HIV and AIDS related health issues can be covered.

Most of the resource persons both from service providers and the families of the HIV infected people, could not definitely mention whether there are any rules or part of the rules that distinguish someone's HIV status. Some PLHIV informants stated that some of the service

provider officials who served them gave an impression that someone's HIV status may cause him/her to fail to utilize health care service using those three health insurances.

> *"From Bapel, ifit is B20, it's not allowed, but for side disease is OK, but if it is B20 or HIV,it's not allowed …"* (PLHIV, YK)

> *"… Usually the HIV disease is not mentioned. So if his/her status is PLHIV, most probably the service will not be covered by Askes. So it is 'handled' by those who deal with it everyday, so you know lah….The tricks are from the staff themselves, from doctors themselves. Then the policy of each region is depends on the region itself…."* (TG, PLHIV, Smg)

> *"That's the trouble, PLHIV patients usually are not covered by Jamkesda,nor by any other insurances.We sometimes get confused, moreover if the reference is already made as HIV, the region cannot covered it either. We eventually return to region (daerah) with different diagnosis. It is OK with Kariadi Hospital, they can help. Maybe (by putting) the side diseases of PLHIV such as chronic diarrhea or febris or TB, Kariadi can accept them. But, well...if there is the word HIV, in quote, we cannot make any step because region cannot covered it..."(*FGD Stakeholder, SW, Kariadi Hospital, Smg)

Although not many of research respondents have experience in using Jamkesmas services, some of the experiences told by PLHIV in accessing Jamkesmas, whether it is their own or others' experiences, are quite helpful to identify health care services that are utilized by PLHIV.

The results of interviews and FGDs showed that most of the patients spent some amount of money during regular visit, whether it's for purchasing medication, or to pay for services that are not covered by Jamkesmas. Typically, PLHIV patients who are covered by Jamkesmas do not understand what kind of services that are covered and which ones are not. They tend to hesitate asking about the details of their expenses to the Puskesmas staff.

> " *I felt uncomfortable … We still need his/her help, however. Moreover when I was hospitalized the other day and I was paid for up to 5 to 7 million. Eventually, I just accepted… Ideally yes.. just let me know. So that we know in advance how much we*

should prepare and for what. … Another thing is that sometimes the doctor writing prescription without looking at our condition as patients. Sometimes he/she just prescribed the drugs that arenot on the list of drugs covered by Jamkesmas. The reason is because generic drugs are not available. Run out of stock. Instead, if he/she wants to help, he/she could find other type of similar drugs or anything close to it ,that are still under Jamkesmas coverage…" (PLHIV, 35 tahun, Jawa Barat)

PLHIV who can afford to pay from their own pocket tend to use private/personal medical doctor service for HIV and AIDS related service (Interview and FGD Pontianak, June 2011). It is commonly opted out because convenience or familiarity considerations of Jamkesmas referral service is far from client's expectation. For example is the issue of confidentiality. Due to experience of stigma and discrimination, some PLHIV decline to access the available services (including Jamkesmas) and prefer to access the services in other cities (or private hospitals/clinics).

C. Accessibility and Constraints in Accessing Service

Prevention and Treatment services was scaled up in 2005 and PLHIV who access those services (has increased. The improvement of service system has accelerated increased access to health care services for PLHIV. Until the end of 2005 approximately 10,000 PLHIV have accessed ARV therapy[15], while in the next six years, more than 23,000 PLHIV have become active participants of ARV therapy[16]. This significant improvement cannot be separated from the reality that during the same period, NGOs were getting more active in outreach and supporting programs. One of the important factors is the increasingly active peer support groups that were grown in various Indonesian cities. Yayasan Spiritia in its 2010 annual report stated that it has conducted support to 12,000 PLHIV nationwide[17]. In 2006, Jaringan Orang Terinfeksi HIV (JOTHI) was officiated at the national level, followed by Jothi's activities in advocacy and promotion of HIV and AIDS related services in various cities. It is estimated that efforts that have been done by the NGOs and PLHIV networks have great influence to improving access for ARV service.

[15] MoH, 2006
[16] MoH, 2010, Report on Therapy Service Use
[17] Spiritia, 2010

a. Role of NGOs and PLHIV Network

Intervention program that is supported by USAID and AUSAID as the main funding agencies through projects implemented by NGOs have significantly improved in reaching population groups that are vulnerable to HIV transmission. Through these projects, many of the PLHIV were facilitated to have access to the existing health care services, whether state-owned or non state-owned services.

In general, from the three cities it appears that most of PLHIV who affiliates with NGOs have been able to access Jamkesmas/ Jamkesda/ Jamkesos services (for those in provincial DIY). Victory, an NGO in Yogyakarta, reported that currently they have provided support to approximately 500 PLHIV who live in Yogyakarta. They also provide support for other groups such as transgendered people and street children.

With the growing number of NGOs/networks who work directly with the PLHIV, more PLHIV can access the available and accessible free health services. The existing personal relationship and institutional network have made PLHIV and their families who need support able to access government or local government facilities.

b. Stigma and Discrimination

As mentioned before, the issues of stigma and discrimination have been one of the issues raised by the respondents. Some respondents reported incidents that indicated the presence of stigma and discrimination at some health service providers, as well as unclear information regarding types and coverage of services that can be accessed by PLHIV. These issues were not just mentioned by PLHIV, but also from the stakeholders such as NGOs that facilitate PLHIV and the service providers.

For instance, it is interesting to see the different attitudes of service providers in dealing with patient diagnosed as HIV positive.

> "*Yes, you know our PLHIV buddies, they feel comfortable touching us. In the regional (level), honestly it is still like in the K Hospital during the early period, so the staff are still afraid, still wearing astronaut outfit and so on" (Doctor, K Hospital, Smg)*

"Yeah, it is still happen sometimes. But it's not like in the past times. It is less likely to occur now. About the bed sheet problem, my client once has experienced it too. In midwife room, the nurses cleaned the room themselves, while in PLHIV room, it has to be cleaned by the cleaning service. The PLHIV patient protested to me. I said that's OK, just leave it. That's all."

Discrimination based on one's economic status has also taken place, although it seems like it might not have anything to do with the HIV-AIDS status of the person.

"Indeed for the service, I'm sorry but, plainly say, between those who do not pay and those who pay, it is easier for those who pay. It happens everywhere." (Health service staff, K Hospital, Smg)

Another form of discrimination reported include different treatment from service provider to certain social insurance schemes' participants (Jamkesmas, Jamkesda atau Jamkesos) and those who used Surat Keterangan Tidak Mampu (SKTM).

"SKTM. Yes, I did. I felt like being ignored when I arrived there."(FGD PLHIV, Pntk)

According to some respondents, it was because of staff rotation among those who provide HIV and AIDS service and the front liners of HIV and AIDS service such as doctors, nurses and other staff. This insensitivity of service providers can make patients feel uncomfortable and subsequently hesitate to access such service.

"There are some trainees. Sometimes there are new intern nurses in the room and they just don't understand. It's different with the senior nurses, they understand already."

"It is different in each district. There is district where the doctor cares, there is district where the doctor does not care because the doctor is not a specialist yet, never attended any HIV AIDS training, that is also the case for the counselor and the nurses, and there is no NGO either..." (FGD stakeholder, Ygy)

c. Information regarding health services that are covered

Other interesting aspects regarding the use of health services by PLHIV is about hospital's policy. Jamkesmas itself does not exclude any health care and services for PLHIV, but from interviews with some PLHIV, they stated that they tend to find it difficult to access hospital services. From the interview with Health Office from financing division, it was revealed that although Jamkesmas does not exclude any type of service from PLHIV, the hospital still holds the authority to decide which type of service (diagnosis, intervention, and treatments) that will be given to PLHIV.

> *" Yes, but we do not tell the hospital what they should do. It is up to the hospital whether they want to provide service or diagnosis or intervention or give any drugs with the package of money that's paid. If the diagnosis says severity level 1 it's this much, 2 this much and 3 this much."*

> *"Yes. Maybe the advocacy to hospital is that actually Jamkesmas has indeed given the allocation, but now it's about how the hospital managed to give the benefits for the members."*

One of the constraints that made it difficult for PLHIV to access services provided by Jamkesmas is their worry that about the disclosure of their HIV status and fear that they will receive discriminatory treatments due to their HIV positive status. In particular for Jamkesos scheme, it is known that people with HIV positive status (B20) cannot receive health services. As a result, doctors and NGOs who work and help PLHIV usually will register PLHIV to access health service by listing the opportunistic infection they suffered, to avoid HIV-positive status from being recorded. For the regions that have specific program for PLHIV this is a constraint, but for regions that targets poor people as a general category for inclusion in health security, HIV status should not be relevant because if an individual is categorized as poor, he/she should be able to access health services regardless of his/her HIV status.

> *".. But my research,- it's quite old, was done in 2006, showed that there were still many PLHIV who paid for the services, although it should be free (because some are not yet*

covered I think?) Maybe because first, they were not considered as poor, second, they did not admit to the insurers so they did not get the insurance. It means those who admitted, they're lucky because they got the insurance but those who did not admit must pay from their pockets. And my research showed that most of them still have to pay for some of the services." (interview, stakeholder, Yogyakarta)

Other issues that made PLHIV do not access health services through social insurance is the worry about how much they have to pay for the services. Based on interviews and FGDs, it was found that PLHIV often did not know the procedure to access service and services that are covered by the schemes. Lack of accurate and complete information have caused PLHIV to feel that the procedure that they have to go through to access certain schemes is difficult, thus they tend to be reluctant to settle the administrative requirement.

"(So it's because the procedure is not so clear?) It is not just less clear, it is indeed not clear at all." (FGD PLHIV, Smg)

"Yes I did. But when I want to fix it, they said it's not complete yet, it's difficult to settle it. To arrange all of it I have to travel to and fro from Semarang to Salatiga."(FGD PLHIV, Smg)

d. Adminsitrative Requirement for Health Insurance

There is another issue identified from FGDs and interviews, i.e. the difficulty to settle administrative requirement to access health insurance scheme that is related to ambiguous residential status. Some PLHIV do not have residential status because they are migrants from other regions and they did not record their relocation properly.

"That's what my friend experienced. Jamkesmas is not yet for the transgenders, it's difficult because most of the transgenders are not originally from Semarang but migrants. Migrants don't have identities. Most of them, well, most of them have escaped

from their family, that's why it is hard for us to have Jamkesmas in one certain place." (FGD PLHIV, Smg)

"As far as I know, our friends here can access Jamkesmas. Maybe it is difficult for the migrants. Maybe it's difficult because of the identity card, I think. Because in here, it is admitted that the funding is just for the original residents, so it's difficult for the migrants to access."(Interview Griya Asa, Smg)"

e. Access to HIV and AIDS services for Women with HIV

The results of Survey of Social-Economic Impact on HIV-affected Individuals and Households in Seven Provinces in Indonesia conducted by JOTHI and UNDP showed that more women act as the head of household in HIV-affected households (by 10%) and women are more likely to get HIV-related infection compared to men (21% of women compared to 17% of men). The same survey also revealed that twice as much women claim to find difficulties in accessing health services. Furthermore, lack of information and knowledge about HIV-positive expectant mothers has led to cases of mistreatment to these women, such was found by a survey conducted by the Association of HIV-Positive Women of Indonesia (IPPI).

"Regarding access to services, mostly it's about access to mother-and-child services. (Our) survey was to HIV-positive women who were or are pregnant between 2009 and now. How did they get access to services such as mother and child health, did HIV-positive women access services while they are pregnant, what happened when they accessed services when they were pregnant, after they delivered. And it was astonishing, 70-80 percent of them were advised to get an abortion. (IPPI staff, Jkt).

With the development of ARV treatments and PMTCT programs, HIV-positive expectant mothers can now manage their pregnancies in a way that would keep both mother and baby safe. However, based on previous research by Atma Jaya AIDS Research Center (2010), the number of pregnant HIV-positive women who access PMTCT services are still very low, due to lack of support for local PMTCT programs. This issue should also be a concern in establishing a gender-sensitive social protection program, especially for HIV-positive women, considering their specific needs for programs to manage their pregnancies.

f. Health Care for Those Who Cannot Access Health Insurance

Based on the interviews, many PLHIV do not have any type of health insurance, either provided by government or private companies, for various reasons e.g. administrative requirement is not complete, do not meet the 'poor' criteria for government's social protection, or other reasons. There is also a problem for PLHIV to access health service based on private companies, mainly because private insurance does not cover HIV cases (except some cases with certain specification such as HIV infection because of accident at work or blood transfusion).

Without having any type of insurance, PLHIV will find it difficult to face health problems. Based on the interviews, it appears that affiliation with an NGO can be a way for a PLHIV to access the health service/assistance they need. NGOs have critical roles in advocacy, facilitation to go to service provider institution, and collecting mutual funds as much as they can to assist paying health cost.

> *"We usually try to help so they can access, but if they can't, they often just wait. Yeah, we understand that they don't have money if our organization doesn't help them. But most of them, our friends, if they fall sick, they feel hopeless."*(Interview, IPPI, Jkt)

> *"We try but it's not much, it gives a feeling of togetherness, helping friends or IPPI members who fall sick, we try to build our other friends' concern too, so that if there is anyone fall sick we can give them support. It's not always in form of money, we can also visit them for instance. If they have money, they can contribute as much as they willing to."*(Interview, IPPI, Jkt)

Other responses from PLHIV supporting organization to access health service is by cooperating with service provider agency. It is carried out in Yogyakarta under Jamkesos program. Some support organizations cooperate with Jamkesos management, in which their members can access health services under Jamkesos scheme with guarantee or notification from the organizations, as long as they are registered in Jamkesos Implementing Body (Bapel). However,

this mechanism is not always effective because every organization still have a quota of how many of their members can access health services from Jamkesos scheme.

In the locations outside Jamkesos scheme coverage, some PLHIV who are not registered in the list of Jamkesmas and Jamkesda beneficiaries try to access health service by using others' identity card (whose names are on the list). Some PLHIV support organization except Yogyakarta stated that they used this way as one of their strategies to assist their members to access health service.

One of the attempts of PLHIV who are not registered in Jamkesmas to access health service is by arranging Surat Keterangan Tidak Mampu/Certificate of Disadvantage (SKTM) from the local government (RT/RW) where he/she lives. By using SKTM, a person (in this case, PLHIV) is approved as near poor by the local government (RT/RW) and will be entitled to receive support in accessing health services. Even so, those who use SKTM as reference still did not get fully insured health service such as in Jamkesmas scheme.

> *"SKTM is only for health care, only for discounted care. As for drugs, you need to pay them yourselves. After returning, it was totaled, then it was discounted, around 10 – 15%. But for drugs, you still have to pay."* (N, FGD PLHIV, Pntk)

> *"To reduce health care cost only, that SKTM. For hospitals."*(FGD PLHIV, Pntk)

f. Perspective of service provider toward beneficiaries

Interesting findings from the perspective of service provider is the tendency to perceive service for PLHIV and poor people as humanitarian assistance, rather than an obligation to provide health services as the rights of people, including those who live with HIV and AIDS. This was not revealed in all cases, but from the result of interview with some service providers, some of the respondents demonstrated this tendency in their answers. The interviewed service providers, both program managements and service providers often stated that they try to help poor communities and PLHIV to be able to access service as a humanitarian service. This perspective placed poor communities and PLHIV as the ones who need "mercy" and not as the ones who "have rights" to receive the service. This view may lead to a relatively low service quality.

"For PLHIV, we do not give privilege, as long as he/she is a member of certain social insurance, because actually the three programs are social, namely Askes for civil servants, Jamkesda and Jamkesmas, so based on the regulation from us, for PLHIV, the treatment cannot be charged, but since it is Jamkesmas now, it does not mean that we made our own additional regulation but there is also a human side. .." (FGD stakeholders, Pntk)

"… maybe I can explain that things that are not covered (by social insurance)for example HIV, trying to have a child, beautificationefforts –plastic surgery, suicidal efforts, why they are not covered? Because, say that these are the diseases that, they are assumed as not diseases, but diseases that people are looked for themselves. Indeed the regulations are made that way, and have not been changed. But we still assist from human side, by not violating regulations that we have made, we are not that rigid, so we still can help...." (FGD stakeholders, Pntk)

Other interesting finding is about the role of doctor as health service provider in helping PLHIV to access the service that the patients' need. This applies both for PLHIV who don't have social security and those who want to access services but are restricted by their HIV status. These service providers tend to have the ability to assist PLHIV in accessing health service that the patients need, especially in the regions where the available social security system has not been too flexible toward the needs of PLHIV.

"I don't have anything, a friend of mine (who has) Jamkesos, was relocated, I was the one who took care of the stuff. As for me, I have never had it. I took care of my friends, Jamkesmas, Jamkesos. If I am sick and don't have money, where to go, just call the doctor, I want to be healed, help me. I don't care if they want to contribute, KPA, Dinkes just call the doctor – doctor I'm sick, they pitch in. 10 doctors 500-500.5 million." (FGD PLHIV, Pontianak)

"It's good over there. It's very bad here. The doctor is bad. Try Doctor Sudarso's story. Discrepancy visit cost in Antonius is just Rp 3,000. Indeed Singkawang city..in the beginning when we came, nurse said HIV positive.. it's not that I praised the doctor too

much – but – but he has multi-meeting with CST doctor to give right information, you were rejected to have surgey, that was. There are stories there. You have eyes disease from where. Mawar Clinic? No, done with tooth detachment. The service is also OK, no rejection because of this doctor. If you don't believe let's go there. Or I call the doctor Budiono and let him tell you the story. It's not a made up story". (FGD PLHIV, Pontianak).

Meanwhile, from all the description of PLHIV regarding access to services, it can be said that all types of health services provided by social security schemes (Jamkesmas, Jamkesda dan Jamkesos) are mostly curative and protective in their nature, without preventive/promotional, moreover transformative services. Health services are only provided to the members after they have health complaints.

"If it is Jamkesda, we have to fall sick in advance, miss. Should be like that. Sick, report to RT first, , RW, Kecamatan, Bapel then make letter of notification about the poor status then after that the decision is made." (Interview, Griya Asa, Semarang)

Social security scheme that is protective like this targets more on the efforts to finance health care cost that protects its members from economic backdrop due to the high spending. Nevertheless, this type of social security scheme does not help PLHIV in managing their health for preventive purposes, whether preventing HIV from becoming AIDS nor preventing HIV transmission risk. There is no promotional services in these social security schemes, that will promote PLHIV to maintain their health. In short, the existing social insurance has not covered PLHIV efforts to maintain their quality of life. Further, there have not been any transformative efforts in these existing schemes.

... Actually preventive actions should also be covered by insurance. The principle of insurance as far as I know, is to minimize the chance of people to be hospitalized. So from Jamkesmas, Jamkesda, Jamkeskot, there should be funds to educate people about prevention of HIV transmission. So that people would not come to hospital in bad condition because they don't know the preliminary symptoms. Second, please just reduce risky sexual activities. So we should suggest Jamkeskot, Jamkesda to have fund to promote HIV prevention. Second, to have fund to identify HIV cases as early as possible.

Because early HIV cases will reduce transmission and the cost of hospitalization. Recently we started to find patients in VCT clinic whose CD4 are still high, still 400-350, the limit for taking ARV. They started to appear with high CD4, after received some education. Her husband passed away yesterday, the doctor said they did not know what the cause was, but seemed like the symptoms were like Doctor M's explanation. He came to VCT clinic, positive HIV test, his immunity was still good. Things like that should be facilitated by Jamkeskot Jamkesda too, I suppose". (Doctor, RS K, Smg)

The result of this study, both from literature or based on field findings, show that the available social security schemes have not yet covered advocacy efforts to counter stigma and discrimination against marginalized groups such as PLHIV – with various backgrounds – whom, because of a range of social, legal and cultural factors, have been restricted to access their rights to health service which is equal and in line with their needs. It appears that the current social security schemes have not attempted to divert these constraints to become support for marginalized groups such as PLHIV in enabling them to access their rights to a comprehensive health service and in accordance to their needs.

D. Micro Insurance

The idea of micro-insurance for HIV-positive people is somewhat far-fetched, in the sense that no one has a clear idea of what needs to be done to create this scheme. So far, some people from the PLHIV communities are enthusiastic about the idea and are willing to form small groups to form micro health insurance schemes. However, some parties remain skeptical of the plan. An expert of social health insurance from Yogyakarta mentioned that he didn't think a micro-insurance scheme for HIV-positive people can work effectively, considering that the PLHIV community is relatively small, and the people from this community tend to be financially challenged, which would make it difficult for them to pay for the premium.

"I don't think so, because it's been tried before, if they tried to make their own (micro insurance), it fails, not that they can't but they don't pay it routinely, after the money is used to pay for the sick, the healthy ones don't pay." (doctor, Yk)

Another concern is that the people in the PLHIV communities find it difficult to find a reliable and trustworthy party to handle the finances of a micro insurance scheme.

> *"It depends on the spirit and needs of our friends. However, it's typical for them to not trust whoever holds (the money), it might be worrisome." (NGO staff, Smg)*

> *"It will be difficult, who's in charge of the money and what he will do with it. Maybe they have this concern. Let alone free money, even potluck (arisan)money would immediately disappear, the mobility in Semarang is high, so the situation is like that. But it should be tried, if our friends can build trust among their friends in their support group it can be better." (NGO staff, Smg)*

3. HIV Sensitive Social protection

The HIV epidemic is a complex issue and requires a comprehensive response, from HIV-infection risk reduction, clinical care, nutrition improvement, psychological support, social support, involvement of PLHIV and their families in AIDS response actions, meeting basic human rights and legal protection, as well as efforts to minimize the impact of the HIV epidemic[18]. These various responses are usually connected to the prevalence and continuum of care for HIV.

In Indonesia, with the exception of Papua and West Papua, the level of prevalence is still concentrated on several vulnerable/at-risk populations, such as IDUs, sex workers, and Men who have Sex with Men (MSM), so that efforts to deal with HIV is still prioritized to lower the risk of infection and to care for those who have been infected. Meanwhile, efforts to mitigate the impacts of the HIV epidemic is still limited to forms of social assistance such as education opportunities, health services, nutritional services and access to economic assistance, but lacks attention to efforts to assist individuals or households to recover from the impacts of HIV[19]. The lack of attention towards efforts to provide social protection for PLHIV has created a situation that has not been beneficial for PLHIV and their families, as was found in the research conducted by BPS and JOTHI[20]. The results of focus group discussions with PLHIV groups in various cities regarding the social-economic impact of HIV further confirms the previous research.

Priority is always the issue at hand, on whether the efforts of risks reduction are more important compared to efforts to mitigate the effects, or the efforts towards various risks are more important than recovery efforts on the effects caused by HIV and AIDS at individual, household and community level. Illustration of the socio-economic impact of AIDS to individuals

[18] UNAIDS, 2010, UNAIDS Terminology Guidelines 2010

[19] KPAN, Stranas Penanggulangan HIV/AIDS 2010-2011

[20] BPS-JOTHI,

and households essentially reflects that the impact of HIV and AIDS problems is not necessarily associated with prevalence rates of HIV and AIDS in the region or country[21]. This argument implies that a low HIV prevalence does not always provide a negligible impact, especially at the level of individual or family. Therefore, the lesson learned is that interventions aimed at reducing socio-economic impacts should be developed based on the real impact and not solely on the prevalence rates. Various indicators such as the percentage of children who have no parents (one or both), the proportion of income used for healthcare, families or individuals who have access to healthcare, or gender of the household head should be used as a basis for the development efforts of social protection against PLHIV (People living with HIV and AIDS) and their families.

Following on the above understanding, this section is focused on the analysis of the various efforts that can be done to encourage the development of social protection interventions for PLHIV and their families, relying on the existing social protection system in Indonesia. Sensitive social protection against HIV issues are both formal and informal initiatives which are directed to provide social assistance to PLHIV and their families who are poor, social services for PLHIV and their families as individuals/groups who are stigmatized in society and often have difficulty in obtaining basic services; social insurance for people to be protected from the risk of transmission of HIV and its impact on their lives, and social equity, especially to avoid discrimination or unfavorable treatment[22]. Thus, basically social protection efforts related to HIV and AIDS cover various protection, prevention, promotion and transformation measures. Therefore, this analysis is developed based on the understanding that the inability of PLHIV and their families to access health services which are readily available are more due to various social, legal and cultural barriers rather than their physical or mental inability.

[21]Topouzis, D. (2003) 'Mitigating the impact of HIV/AIDS: a review of response and concepts', Workshop on Mitigating of HIV/AIDS: Impacts through Agriculture and Rural Development, Human Sciences Research Council, Pretoria, 27–29 May, Available online:
http://www.sarpn.org.za/mitigation_of_HIV_AIDS/m0023/Daphne_Topouzis.ppt

a. Is Social Insurance in Indonesia sensitive to HIV issues?

Studies in the previous section show that a number of social assistance or social health insurance which is available in Indonesia within a certain level has been utilized by PLHIV for their healthcare. Several services that have been used, among others are:

- Global Fund Projects for PLHIV Treatment and Assistance

  Some informants stated that they have utilized a variety of free services provided by NGOs, health center, referral hospital supported by a project funded by the Global Fund. Types of services that have been accessed are VCT, ARV therapy, CD4 and Viral Load examinations, and delivery (PMTCT). Nevertheless, it should be noted that not all of these services is a service that is fully supported by said related project. Partially it is a part of a program supported by the Ministry of Health through the state budget funding, such as antiretroviral therapy and tuberculosis treatment.

- Jamkesmas, Jamkesos, Jamkesda Schemes

  Most PLHIV reported that they have utilized healthcare services which requires hospitalization associated with opportunistic infections when they suffer it with the support of health insurance schemes available in their respective region. Some PLHIV use Jamkesmas facility if they are listed as Jamkesmas participant in certain areas or use SKTM (Certificate of Disadvantage). Some PLHIV utilized Jamkesos through NGOs whom are believed to be able to assist Jamkesos membership because they are not registered as resident in a particular area. There are few PLHIV that reported having access to such services through Jamkesda schemes because they are permanent residents of a city or county but not listed as a Jamkesmas participant. Meanwhile, there are also PLHIV who have to use their own money or aided by friends in its community to obtain treatment services because they are unable to utilize the existing healthcare insurance.

- Assistance for Socio Economic and Educational Improvement

A number of PLHIV or their families reported that they have obtained social assistance from the Social Service in their province or city to start a business or increase their income. However, the social assistance is not specifically intended for PLHIV or their families but is obtained because they are members of a community which is considered as requiring social assistance and the community has enrolled in the Social Office. Communities who receive social assistance, among others, are the community of sex workers, transgenders and PLHIV including children with HIV. The types of assistance they receive are in cash, ranging between 8-10 million dollars. This assistance is intended as initial capital to start businesses after they follow training on business development.

Meanwhile, to aid children with HIV, as part of the Child Welfare Program (PKSA), they receive aid in the form of cash transfers earmarked for their education. Management of education funds is done by the child's legal guardian. This funding comes from the state budget, amounted to Rp1.2 million per year. Children with HIV also can access the service provision of supplementary food (PMT) which is provided by the Public Health Service, as long as they have problems of malnutrition.

It cannot be inferred from the findings related to the implementation of various social health insurance or assistance that the existing social protection is sensitive against HIV issues. The main issues in implementing the social protection are the strong stigma against AIDS and the behavior history of PLHIV. For example, although AIDS treatment based on the guidelines of categorization of cases (Ina-CBGs/Ina-DRGs) is a case which can be handled by Jamkesmas with three levels of severity; however, there is a tendency for regional hospitals to not provide the services and refer these AIDS cases to higher AIDS referral hospital.

Similarly, the issues in Jamkesos/Jamkesda clearly does not categorize AIDS as a disease that cannot be covered[22]. The main reason mentioned why AIDS is not covered is because of the understanding that the fee for treatment of HIV and AIDS have been borne by the Global Fund and thus no longer need to be borne by Jamkesos or Jamkesda. Nevertheless, this scheme was

[22]Dinkes Provinsi DI Yogyakarta, Informasi Jamkesmas dan Jamkesos dan Informan dalam Diskusi Terarah bagi Stakeholder di Jawa Tengah

widely used by PLHIV for treatment of opportunistic infections provided they access the service by eliminating the category of disease (B-20). Transfer of HIV into opportunistic infection treatment category is possible because the continuous approach from PLHIV support NGOs with the Jamkesos Management Board and health personnel (doctors/nurses) in health centers and referral hospital. Furthermore, one of the ironies in this situation is that one of the PLHIV support agencies is believed to be able to assist PLHIV members who want to access Jamkesos, but when they are utilized, the healthcare related to AIDS the HIV status should be eliminated so that the examination or the purchase of the medicine can be borne by Jamkesos.

Behavior history of PLHIV as IDUs, sex workers or transgenders often becomes an obstacle to obtain social protection. There is an assumption that sex workers or transgenders are of unknown background because they do not posses demographic identity (ID) and become a major constraint for government officials to help them get SKTM which is required for obtaining Jamkesmas/Jamkesda. In fact, often they must be willing to be considered as displaced persons (Mr/Mrs X) in order to obtain the required health services.

Economic cost of healthcare for poor PLHIV can be reduced by the available social health insurance schemes, though they experiencing various obstacles to obtain it. However, for PLHIV who are not classified as poor, the healthcare cost provides a significant burden which even makes them poor. Encounter of a successful businessman who eventually falls into poverty because of long-term healthcare costs for his wife and himself could perhaps illustrate the catastrophic impact of AIDS on the household without social protection for its economy. The aforementioned explanation illustrates the vulnerability of PLHIV who have a higher economic status without health insurance. Unfortunately, until now there is no single form of social protection from the health insurance scheme offered by private and by state-owned enterprises[23] that can be accessed by PLHIV.

The above discussion suggests that the existing social protection schemes (Jamkesmas, Jamkesos, Jamkesda, social assistance, social insurance, either private or government) are not directly addressed to anticipate the impacts cause by of HIV and AIDS but more focused on

[23]Interview with Ibu Ade, Indonesia Health Insurance Forum, 18 July 2011.

their poverty status[24]. Various example cases being presented also show that the existing social protection schemes are more protection in the form of healthcare. There are no preventive or promotional, let alone transformative, social protection. Rights of PLHIV in Indonesia to obtain social protection from the catastrophic impact of AIDS are yet to be met by the state through social insurance schemes. This is further complicated by the fact that although the principle of social protection scheme does not preclude treatment of HIV and AIDS as the type of treatment that can be covered, the negative stigma of AIDS and PLHIV are visible in its implementation.

b. Coverage of Existing Social Insurance

Every form of social protection always indicates the coverage[25]. Although various forms of existing social protection do not specifically address the impact of HIV and AIDS, this study aims to analyze the coverage of these services based on information derived from various focus groups discussions and interviews for both PLHIV and stakeholders. In this analysis, scope definition is referred to several aspects as follows:

a. Accessibility

Most PLHIV who become informants in this study reported that they have utilized the services covered by some existing social insurance schemes, particularly Jamkesmas and Jamkesos/Jamkesda. A small number of PLHIV who are unable or have been denied access to health services state that these incidents are incurred because of various administrative barriers including not having ID cards, not included in the list prepared by the authorized NGO or not qualified as poor. If the Global Fund-funded projects are to be considered as one form of social health assistance, then almost all PLHIV have utilized the offered services such as VCT, ARV therapy and CD4 examination or Viral Load. Meanwhile, only a small number of PLHIV have reported that they have utilized social assistance from Social Services. One of the PLHIV escort agency in DIY reported that eight out of approximately 500 members ever get assistance for business

[24]This conclusion is similar to review conducted by Miriam Temin in her analysis on HIV-Sensitive Social Protection: What Does the Evidence Say**.** UNAIDS, Juni 2010.

[25]ILO, Social Health Protection: An ILO strategy towards universal access to healthcare, 2001

development/venture capital provision from social services. Furthermore, in West Kalimantan, twenty-eight PLHIV from two cities are reported to obtain social assistance for Productive Economic Enterprises (UEP) given by the Provincial Social Services.

The role of NGOs/KDS to encourage PLHIV to utilize services and reduce barriers to become social insurance participant is very significant. Efforts to coordinate and conduct advocacy to the social health insurance management, KPAP/D, Health Center and public hospital are very influential on the emergence of a positive attitude from them. Likewise, the role of NGOs or support groups as guardian or supporter also contributes substantially to the magnitude of PLHIV obtaining social health insurance. Therefore, observing further of the previous explanations, PLHIV who can access care health insurance are those who have affiliations with NGOs/Peer Support Groups. On the other side, these affiliated PLHIV must be willing to disclose their HIV status although they have never had healthcare treatment before to enable them to be listed by related NGOs/Peer Support Groups[26].

Other than providing an overview of how a PLHIV can obtain social insurance, findings in the previous section also identifies several factors for PLHIV to not be able to utilize the existing social insurance. Some factors include:

- Administrative factors which include: not meeting the criteria as recipients of social assistance, not following the procedure of service management, not knowing the requirements information to obtain social assistance, and not having complete paperwork participation (KTP, KK, SKTM)

- Stigma and discrimination factors that PLHIV cannot obtain services from healthcare providers because of their HIV status known or labeled as HIV patients

[26]There is tendency for NGOs/KDS who have authority to process social health insurance to include all the people they have escorted to ease the process whenever the PLWHA needs healthcare treatment or falling sick.

- Organizational factors; in which PLHIV who can access social insurance are only those who are already registered as Jamkesmas/Jamkesda participants or members of NGO/Peer Support Group assisted groups

- Personal preference factors; in which a number of PLHIV choose not to utilize the service (although this is possible through the NGO/Peer Support Groups authorized for Jamkesos/Jamkesda) because they feel that they do not need nor afford to bear the costs of care when they have fallen ill or do not want their HIV status to be known by others.

b. Benefits for PLHIV

In principle, Jamkesmas or Jamkesos/Jamkesda bears 100% of the cost of required medical including the need for diagnostics[27][28]. For AIDS-related cases, Jamkesmas explicitly categorize it into three levels of severity, the maximum cost covered for level I cases is Rp3 million, level II cases can be covered up to Rp4 million and level III cases can be covered up to Rp8.8 million[29]. However, in practice not all of the costs incurred by the patient are allowed by Jamkesos/Jamkesda because the implementing agency (Bapel Jamkesos/PT Askes) imposes limits for benefits to be borne. For example, Jamkesos in DIY can only bear Rp15 million for each treatment; the patient or their families bears the shortage[30]. Furthermore, as reported by the majority of PLHIV in the focus group discussion in DIY that Jamkesos does not bear the purchase of drugs for opportunistic infections because they are prescribed and not generic drugs as set out in the Jamkesos guidelines. It stated also that the type of prescribed drugs is not generic.

Apart from the issues of social health insurance implementation, the social health insurance scheme is quite comprehensive because it refers to the medical needs for

[27]Interview with Head of Funding of Social Office Jogjakarta Province

[28]Interview with Bapel Jamkesos Staff Jogjakarta Province

[29]Interview with Head of Funding of Social Office Jogjakarta Province

[30]This statement is made by PLWHA Focus Group participant and supported by Bapel Jamkesos Staff Jogjakarta Province

treatment of a case as prescribed in the Ina-CBGs. Furthermore, majority of PLHIV perceived the participation in social health insurance scheme as protection for them from a worse situation caused by HIV and AIDS in particular by reducing their economic burden.

c. Coverage area of social insurance scheme

The coverage area of social health insurance scheme issue is quite problematic considering the existing schemes have not been able to touch all the poor families or individuals in a province/district. Jamkesmas as a social insurance scheme which is a national health scheme basically only covers some poor families/individuals in a region and the remaining is the responsibility of provincial and district/city.

Varying financial capability of the provincial or district/city causes some district/city or province to be able to provide Jamkesda as a complement to Jamkesmas scheme and some are not able to. For example, only four cities and nine districts in collaboration with the Central Java Provincial Health Office are able to develop Jamkesda. This cooperation is to share the financing cost for treatment in Province referral hospital where 40% of the cost is borne by the provincial government while the remaining is borne by the city/county. However, there is also city-organized health insurance, which is fully funded by the level II local budget, namely Jamkesmaskot in the city of Semarang. This scheme is developed to cover households not borne/covered by Jamkesmas.

Besides Jamkesmas, some cities/counties in West Kalimantan province has developed a regional social health insurance (Jamkesda) managed by PT Askes in that region. However, until now there is no social health insurance scheme at the provincial level. Unlike the two other provinces, in DIY province the three social health insurance schemes (Jamkesmas-state budget, Jamkesos - provincial budget, Jamkesda – district budget) is readily available in all districts/cities despite Jamkesda have different variations in terms of benefits it covers and the amount of funds it provides.

The availability of three social health insurance schemes appear as a major obstacle in the implementation of portability principle of a social insurance in which Jamkesos/Jamkesda (provincial and district/city) only bear people who have an address in the area concerned. As a result, people who do not have ID cards in the province/area can not have access to the existing healthcare. A lot of PLHIV experience difficulty in accessing health services due to legal issues such as this. Several PLHIV who have background as transgender or sex workers are most often dealing with legal issues like this because most of them are not locals. Fortunately, there are some efforts made by guardian NGOs or Kelurahan (local government) that finally allows them to access health services under the scheme[31].

d. Adequacy and quality of services covered

Adequacy is defined as how much a social health insurance able to maintain, recover and improve the health status until the patient is able to return to work and satisfy his/her need for healthcare. As described earlier, the existing social health insurance in Indonesia in general is still focused on the protection of the financial aspects from the risk caused by the costs of healthcare. However, a number of cases found in this study shows that there are still many PLHIVs who have to finance themselves (out-of-pocket) some components of the healthcare such as the purchase of drugs, shortage of inpatient costs, and transport for referrals to health services. This situation suggests that from the aspect of financial protection, social health insurance have not provided adequate protection for those who are covered. Since most of the PLHIV who access the scheme include the poor category, any out-of-pocket amount will provide an enormous economic impact.

Therefore, the existing social health insurance schemes in Indonesia are still focused on the aspects of protection only, and as a consequence the aspects of health preservation

[31]These efforts usually by issuing SKTM (Certificate of Disadvantages) to the sex workers or tranvestites live in the area. Howeer, these kind of efforts are vulnerable to violation which a number of SKTM issued by the local village government based on the recommendation from RT/RW for those who actually not poor (local village staff in focus group for stakeholder in Semarang)

and recovery are not addressed yet. For example, preventive health measures such as check-ups cannot be borne by all the social health insurance schemes. Similarly, efforts to provide insurance during illness or recovery from illness are not available.

Adequacy services aspect is closely associated to the pattern of the financing of social insurance schemes. Jamkesda that is usually funded by the district government, is often underfunded in the midst of the budget year because budget allocations have not reflected the medical needs covered by the scheme. This happened due to Jamkesda was used as a means of political campaign of the elected Head of Districts. Unsurprisingly, some Jamkesda managers (in this case the District Health Office) are in debt to third parties, either hospitals or SKPD in other areas in the district[32].

Another effort is by lowering the maximum limit of healthcare costs borne, or by conversion of the participants who are known to have great healthcare needs to Jamkesmas scheme[33]. Even though providing social health insurance has been mandated by Law No. 32/2004 on regional autonomy to local government, but the implementation of the social insurance has sometimes seemed more a populist political regional decisions than a decision based on financial ability and health infrastructure availability in the area.

It was not possible for this study to directly see the quality of services from social security schemes based on the aspect of adherence to the standard of care published by the Ministry of Health or other health authorities. However, this study tries to view the quality of services provided from the point of view of PLHIV when they access available services. These points of views include experiences of accessing health security, as well as the attitudes of service providers when PLHIV use provided services. As was explained in the previous section, most PLHIV who access Jamkesos/Jamkesda use information provided from assisting NGOs. Some others obtain information from local village authorities (RT/Kelurahan) because they were listed as Jamkesmas beneficiaries.

[32]Kedaulatan Rakyat, Jaminan Kesehatan Temanggung berhutang kepada pihak ketiga, 5 July 2011

[33]This conversion is done considering that Jamkesmas bears all medical needs. Interview with Bapel Jamkesos staff, DIY

Although there are Jamkesda/Jamkesmas administrators who have published information about these services in the form of brochures/leaflets, few PLHIVs have seen or obtained these brochures.

A situation in which access to information is limited such as this can cause various obstacles in accessing services provided by social security schemes, such as the perception that the procedure to obtain social security is complicated, that it takes a long time to wait before they can access services, and the need to go back and forth between institutions to complete the administrative requirements. This lack of information also causes people to be denied of health services due to the fact that they don't follow the procedures required at health services offices and or social security implementing bodies. This situation is often misperceived as health service officers being "demeaning" towards people who access free health services. Likewise, several PLHIV confessed not utilizing the service for fear of discrimination if they disclose their HIV status. Conversely, there are also PLHIV who were satisfied with the attitude of the staff of service providers because when they are experiencing problems they get assistance in processing of documents or services[34]. Although often earn less sympathetic treatment from the staff of service providers, some PLHIV who have experienced such situation continues to utilize the services at the institution because there is no other alternative.

Discussion on social insurance coverage above suggested that the scope of Jamkesmas, Jamkesda, Jamkesos and social assistance from the Ministry of Social Affairs is very limited, in terms of the number of PLHIV that utilized the services, benefits as a social insurance participant, the area its cover, and the adequacy and the quality service. Although the available social insurance has been utilized, the impact of AIDS on individual PLHIV or households PLHIV is still significant because the existing social health insurance has not addressed services that

[34]This attitude can be found in health insurance management who have been exposed to information on HIV/AIDS. The attitude comes in form of assistance by eliminate or converse HIV treatment into opportunistic infections and so the treatment and drugs pruchase borne by Jamkesmas/Jamkesos. The positive attitude can be found in several health personnel (doctors or nurses in public hospital/local health service) trained with HIV/AIDS or members from VCT in KPA Province/Regional.

can be used for recovery and treatment to meet the needs of healthcare and more productive life.

Nationwide social assistance is provided by the Ministry of Social Affairs. The scope of educational assistance for children affected by AIDS as a part of Social Welfare Program for Children (PKSA) is also still very limited both in terms of adequacy, utilization and quality. In 2011 only 777 children are covered by the scheme in 17 provinces[35]. Similarly, economic development program for PLHIV also has little coverage in terms of utilization, low quality services due to the absence of ongoing guidance, and many did not continue their business. With such a limited coverage of existing social insurance, obviously that efforts to reduce social and economic burden of individuals and households affected by HIV and AIDS must be integrated into a broader intervention efforts of HIV and AIDS considering the existing social insurance has not been directed specifically to address the various impacts of HIV and AIDS epidemic.

c. Developing a more HIV- sensitive social protection

Efforts to develop social protection which is sensitive to HIV in Indonesia is challenging considering the implementation of social protection to them currently still very limited only focused on the protection against the risk of worsen economy caused by the treatment of HIV and AIDS. Even these are still limited to poor PLHIV, while those who are near poor and not poor yet to have access to social protection provided by government or private. The vulnerability of economic impacts of the last two groups will eventually lead them to a poorer situation. Meanwhile, from the coverage aspect, the existing social protection is still limited in terms of number of PLHIV who can use the protection, received benefits, portability principle that is not met because of the social protection schemes segmentated by regions, inability to fulfil the needs of healthcare personally, and limited quality of service.

Social protection covers all the efforts carried out by government and non-governmental organization directed to provide assistance or social insurance to the entire community to

[35] **Data Base Program Kesejateraan Sosial Anak Direktorat Kesejahteraan Sosial Anak PKS-AMPK Tahun 2011, http://www.pksa-kemensos.com/wp-content/uploads/2010/11/PKSA_Anak_Memerlukan_Perlindungan_Khusus_2011.pdf**

reduce the risk of impacts caused by health problems, education, occupation, old age and disability. In the context of such social protection, the efforts to provide social protection for PLHIV and their families need to be fully pursued considering the catastrophic impact of the disease to their lives as demonstrated by previous studies and this study. However, efforts to develop such social protection programs that are sensitive to HIV issues also in general need to consider an array of limited resources encountered by the government and society on the one side, and an array of potential resources that can be optimized on the other side. Departing from such perspective, then some recommendations can be proposed for the development of social protection that is sensitive against HIV is as follows:

a. Integration of social protection initiatives into existing AIDS program

   In accordance with the progression of AIDS epidemic, the development of the HIV and AIDS program should consider specific goals and objectives that correspond to these progressions. HIV and AIDS interventions should focus on efforts to:

   - Prevent people being infected with HIV
   - Prevent HIV infected person from developing AIDS
   - Provide care and support to people with AIDS
   - Reduce the impacts caused by AIDS on individuals and families

Although each intervention purpose should be differentiated to sharpen the strategies and achievements determination, but it does not necessarily sacrificing the integration and balance of prevention, treatment and recovery efforts in line with the existing epidemic context in Indonesia. The development of HIV interventions needs to be distinguished with the development of social protection, while the first needs to pay attention on the level of the epidemic, the latter is more based on real impact of the treatments.

In the National Strategy for AIDS Prevention 2010-2014, efforts to reduce worse risk of HIV and AIDS treatment as a form of social protection has not been explicitly described. Efforts to address the impact of HIV are geared towards opening up access to education, health and

nutrition services for children and poor families affected by HIV. To address the economic impact, interventions are directed to improve the economic capability of poor PLHIV through vocational education and venture capital provision. Considering the complexity of the social protection issues, undoubtly the aforementioned efforts set out the National AIDS Strategy yet to answer the key aspects in the social protection, prevention, promotion and transformation. To do so, several things need to be done:

a. Include social protection into the agenda as one of the priorities of AIDS response. These efforts can be done by conducting various studies and researches on the feasibility of implementing social protection which is sensitive to HIV and AIDS based on the framework of Law No. 40/2004 on National Social Security System.

b. Encourage civil society organizations to advocate policy makers at national and regional levels, including donor agencies, to integrate social protection that is sensitive to HIV through HIV and AIDS programs which are being or will be developed.

c. Development of social protection interventions that is gender sensitive given the socio-economic impact of HIV and AIDS is more severe experienced by women and girls.

d. Interventions should not focus solely on individuals infected with HIV but needs to be directed at the family because the family is the primary source of social support of PLHIV.

b. Encouraging the organizational role of HIV and AIDS response stakeholders

Integration of social protection issues into AIDS program is basically implies different responses from the parties involved in the HIV and AIDS issues. Some responses that need to be pursued within the framework of social protection that is sensitive to HIV are as follows:

- Family and Community Response

Efforts to improve the lives of families is important to be developed systematically since the initial response when one family member needs healthcare treatment is the adjustment of the families basic needs starting from the food supply, tightening family disposals, until sacrificing the educational needs of the children in the family. Therefore, by giving intervention attention to the family will improve the resilience of family in facing the socio-economic impact of AIDS and in turn provides the social support needed by PLHIV in the family.

Extended family and community are basically an essential social support to reduce the socio-economic impacts caused by AIDS. However, as stigma and discrimination in Indonesia are still high, endeavours to involve family and community to engage in efforts to provide social protection to PLHIV is quite difficult. Moreover, the strong stigma saying that most people infected by HIV and AIDS are people who have inappropriate behaviour according the community values, causes social support difficult to obtain. Context as such should be considered when community is to be mobilized. Judgments over how far the community understands AIDS allow assessing the support potential of this social protection. Community education appears to be the most important thing to do in order the efforts could gain their attention and support.

Another source of social support is from the community where the PLHIV is a member. This community has a major role in the realization of social protection considering the community and NGOs are actively fighting for opening access to social health insurance for PLHIV in many regions or cities in Indonesia. In the context of social health insurance scheme coverage which is currently still limited, community can develop short-term efforts for its members to avoid the economic impact of healthcare treatment they should take. Most likely is by set-up a health fund for their members. Each member can raise some money and then the Money can be used by PLHIV who in need of treatment to buy medicine not covered by existing social health insurance schemes, helping transport fare if require higher referral healthcare services or even support the PLHIV who can not obtain a social health insurance.

Certainly, the efforts to raise fund is a short-term effort that can be done by the community, considering the efforts to achieve universal coverage for PLHIV is still difficult to realize in the near future. Meanwhile, to realize the micro-insurance for community members is unlikely possible in terms of economic and management considering the small number of community members and it is difficult to be managed by a third party because economically not possible.

Another recommendation to be made is to raise the awareness of PLHIV in Indonesia of their rights to access medical services and how to access these services. PLHIV need to know about the B-20 code in which they are coded under the InaCBG if they are known to be HIV positive and the implications of the B-20 code. On the other hand, there could also be a recommendation to eliminate the policy of coding HIV positive patients as B-20 which can deny them of their rights to medical services. This "local policy" to refuse treatment for B-20 or HIV positive patients stem from the lack of guidelines for the implementing bodies regarding the mechanism of services provided or HIV-positive patients. There should be clear and definite guidelines for the Jamkesmas and Jamkesda regarding the mechanism and policies of coverage for HIV-positive patients. These guidelines can help the Jamkesmas and Jamkesda implementing bodies in providing services and protection for HIV positive patient, as well as provide a clear set of protocol for hospitals.

- Civil Society Organization Response

The role of civil society organizations to integrate social protection into AIDS program is proven very important. Until now the NGOs working for and peer support groups are actors that have the greatest role in advocating the government to provide social health insurance for PLHIV. Having flexible and responsive organization characteristics, the role of CSOs in the education, care and support, and advocacy for policy makers remains to be done because the results of this study indicate reluctance from several government

organizations to put HIV and AIDS care as one of health services borne by the existing health insurance schemes.

The results of this study also indicate that the advocacy efforts over the utilization of social health insurance is mostly done by PLHIV support NGOs and focus support groups compared to the civil society organizations engaged in prevention of HIV transmission. Efforts to build synergies with other civil society organizations are expected to provide greater pressure to the government to accommodate the establishment of social protection efforts that are sensitive against AIDS because these efforts are not only limited to healthcare but also have to touch the areas of prevention, maintenance, promotion and social change, culture and laws that allow PLHIV or populations that are vulnerable to HIV transmission to get access the health services available in the community.

- Government Response

In conjunction with strengthening demand for universal coverage of national insurance for all people of Indonesia in recent years, it is the right time for the National AIDS Commission and Ministry of Health to immediately enlist the issue of social protection in the policies related to social insurance which are being developed at national and regional level. Ministry of Health who has been managing Jamkesmas which is a social health protection schemes is a key player to make this happen.

Although principally Jamkesmas bears cost of HIV treatment; however, benefits it provides are still focusing on the protective aspect of the social protecction. Jamkesmas is expected to also allow the integration of preventive and promotive efforts which currently is part of Global Fund-funded project so these efforts continuity can be more assured. Integration of health efforts financing in the provision of ARV drugs, prevention and promotion of the Global Fund-financed project into Jamkesmas scheme basically also showed a greater government commitment over AIDS issues, where the epidemic is not only addressed as a condition of emergency but as part of development efforts in the fields of social and health which have long-term dimension. (ensure that people with

hiv have equal access to all available health programs, that coverage levels are sufficient and that all barriers to utilization are eliminations (need to list barriers here)

One of the main issues that the respondents mentioned was the fact that even though Jamkesda or Jamkesmas provide assistance for HIV-positive patients, the hospitals reserve the right to choose which treatments to provide to their patients. Thus, hospitals can refuse certain types of treatments for HIV-positive patients if they consider the treatment to be too expensive. With a clear set of technical guidelines, hospitals can no longer create their own policies regarding the type and coverage of services provided for HIV-positive patients.

- International/Donor Agencies Response

  It has become a common understanding that the role of international agencies in initiating HIV and AIDS programs in Indonesia is enormous. It is evident in the funding proportion of AIDS eradication programs in Indonesia which currently nearly half of the programs supported by multilateral and bilateral cooperation[36]. To instigate the agenda of social protection that is sensitive against AIDS issues, the international agencies working in Indonesia could integrate this agenda into the AIDS eradication programs which currently being developed. (seems the role should be to increase the skills and capacity of social protection agencies to assess, plan, budget and implement social insurance schemes – eg it seems funding is often insufficient because no actuarial assessments have been carried out based on real utilization data)

  Another role the international agencies could take part in is to facilitate civil society to be able to advocate to policy makers at national and regional levels to integrate the social protection that is sensitive against HIV into the social insurance regulations and policies which are being developed. Not least important is their role to develop various assessments on social protection that potentially to be developed

[36] KPAN, Stranas Penanggulangan AIDS 2010-2014

in Indonesia, including the simulation of the social insurance model which can accommodate the HIV treatment. The results of this study are expected can be used to design policies that are based on more scientific evidence than on political considerations as happened to the implementation of Jamkesda in various regions in Indonesia who often tangled with management and the availability of funds issues.

c. Reinforce the inclusion of HIV and AIDS issues in the improvement of national social insurance system

In the context of limited financial resources, the development of social insurance systems that are sensitive against HIV and are separate from the existing social insurance systems is economically difficult or impossible to do. From the ethical side, the development of a separate social insurance scheme will also cause various issues related to justice and social equity. Meanwhile, from the administrative side, this effort makes the social insurance more complex and difficult to administer. On the other side, the existing social health insurance schemes have proven to be quite accommodating the needs of HIV treatment, although the coverage aspect is relatively low. Therefore, the efforts to reduce vulnerability and encourage self-sufficiency of PLHIV against AIDS impacts is to integrate the notion of social protection that is sensitive against HIV and the existing social insurance schemes or to adjust the implementation of national social insurance system as stipulated in Law No. 40/2004. Following are some efforts for the integration to take place:

- Taking into account the catastrophic impact of AIDS in the long run; thus, the social protection efforts which could accommodate the needs of medical, economic and social development of PLHIV, the existing social insurance needs to consider to expand the scope of the groups it bears. The PLHIV who are not classified as poor must have access to social insurance which meets their personal health needs. The Government needs to require social and private insurance companies to provide health insurance to this group.

- One of the main issues in the accessibility of the existing social insurance is the limited membership to those who listed as recipients of social insurance based on

identity of population and territory. Surely, this would exclude groups that have high mobility such as transvestites, female/male sex workers and their customers. It requires simplification of the membership procedure to allow those who have no identity documents easily access the health and social services they are needed. Efforts to ease and simplify the procedure of membership should be accompanied by a more rigorous monitoring effort to prevent membership abuse. For example the implemention in Jamkesos DIY where the executing agency appointed PLHIV support NGOs or Peter support groups as guardian or guarantor for its members in using health services.

- Having the existing social health insurance schemes, not only implies to the complexity in determining the membership but also create variation in benefits it provided. It will be beneficial if PLHIV become Jamkesmas participant because their medical needs 100% covered in accordance with CBGs. However, this may become less beneficial for PLHIV who are covered by Jamkesos or Jamkesda because its management body determines the maximum limit of the costs to be covered so often there is out of pocket to cover the shortfall. Therefore, it needs to be considered to synchronize the various social health insurance. This synchronization includes the membership, benefits provided, maintenance procedures, and management. This synchronization is also expected to address the issue of portability of a social insurance.

4. Conclusions and Recommendations

The existing social protection schemes are not directly addressed to anticipate the impacts of HIV and AIDS caused, rather more focused on their poverty status. Existing social protection is a more protection in the form of healthcare. There are no preventive or promotional, let alone transformative social protections. The state is yet to fulfil the complete rights of PLHIV in Indonesia to obtain social protection from the impact of AIDS. Stigma against AIDS and PLHIV is still quite dominant in its implementation.

The scope of Jamkesmas, Jamkesda, Jamkesos and social assistance from the Ministry of Social Affairs is very limited, in terms of the number of PLHIV that utilized the services; the benefits PLHIV obtained as social insurance participant; the area its cover; and the adequacy and the quality of service. Although social insurance is available and has been utilized, the impacts of AIDS on individual PLHIV or households PLHIV are still significant because the existing schemes have not anticipated the needs for the PLHIV who are in treatment to recover and have more productive lives.

Efforts to provide social protection for PLHIV and their families require great commitment from all parties related to HIV and AIDS response and social protection. Efforts to develop a social protection programs that are sensitive against HIV issues need to consider various limited resources owned by the government and society on the one side, and on the other side should also consider various potential resources that could be optimized. Some recommendations can be proposed for the development of social protection that is sensitive against HIV are as follows:

b. Integrate social protection development efforts into existing AIDS programs, through the following ways:

    - Inclusion of social protection agenda as one of the priority efforts in HIV and AIDS eradication based on the framework of Law No. 40 year 2004 on National Social Security System.

- Encourage civil society organizations to advocate the policy makers to integrate HIV sensitive social protection into existing HIV and AIDS Program in order to improve access and coverage of health services for PLHIV.

- Social protection interventions that are sensitive against gender needs to be developed considering the socio-economic impact of HIV and AIDS to women, including sex worker and female IDUs, and households which headed by women is more severe.

- Focus of interventions should be addressed to the household because they are the primary source of social support of PLHIV

c. Integration of social protection issues into AIDS prevention program is basically implies a different response from the parties involved in the issue of HIV and AIDS. Some responses that need to be pursued for social protection that are sensitive against HIV are as follows:

    - Resilience of PLHIV families needs to be improved to deal with the socio-economic impact of AIDS to enable them providing the social support necessary by PLHIV.

    - In the context of the stigma against HIV and AIDS and discrimination against people living with HIV is still high, then the public education about HIV and AIDS is a basic prerequisite for greater community involvement in supporting the sensitive social protection against HIV

    - Communities of people affected by HIV and AIDS can develop short-term efforts for its members to avoid the economic impact of healthcare they are required to do. One way that simply could be done is to initiate a “health funds’ for their members. The funds could be collected from the members, NGOs, or families of PLHIV.

    - Civil society continuously need to continue the role of education, care and support, and advocacy to policy makers, because the results of this study indicate that there is still reluctance on some of the government organizations to include HIV treatment as healthcare that can be covered by the existing social insurance schemes.

- Efforts to build synergies among civil society organizations should be intensified in order to provide greater pressure on the government to accommodate the establishment of social protection efforts which are sensitive against AIDS issues.

- The National AIDS Commision and Ministry of Health need to include sensitive social protection against HIV into policies related to social insurance which currently being conducted at national and regional level. These efforts are considered as positive response to strengthen universal coverage of national insurance for all the people of Indonesia.

- Integration of financing health efforts in the provision of ARV drugs, prevention and promotion efforts from Global Fund into social health insurance scheme needs to be done as form of a greater government commitment over AIDS issues, where this epidemic is not only addressed as a condition of emergency but also as part of development efforts in the fields of social and health which have long-term dimension.

- International institutions working in Indonesia must integrate this social protection agenda into AIDS programs which currently under development, facilitate civil society in advocacy to integrating sensitive HIV social protection into under-developing social insurance regulations and policies and develop various analysis on social protection.

- There should be clear and definite guidelines for the Jamkesmas and Jamkesda regarding the mechanism and policies of coverage for HIV-positive patients. These guidelines can help the Jamkesmas and Jamkesda implementing bodies in providing services and protection for HIV positive patient, as well as provide a clear set of protocol for hospitals

d. Emphasizing the inclusion of HIV and AIDS issues in the improvement of the National Social Security System, as follow:

- National Social Security System needs to expand the coverage of its groups to allow PLHIV from non-poor group have access to social insurance which can fulfill their health needs.

- Participation process requires simplification to allow people without identification card to access much needed basic health and social services.

- Synchronization of various social insurances need to be done concurrently with the existing social health insurance, which covers the membership, benefits obtained, administrative procedure/arrangement and management. Synchronization also expected can solve the portability issues of a social security.

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Appendix 1: Types of Social Health Protection in Three Cities

1. Jamkesmas

Type of insurance	Goal	Benefit	Coverage	Strategy to improve/maximize service	Criticism over program	Problems found	Recommendation
JAMKESMAS (type of social assistance which provides health services for the poor and other people whose premium is paid for by the Government)	To improve access and quality of health services, in order to attain optimal health, effectively and efficiently for all Jamkesmas participants. To improve access and quality of health services, in order to attain optimal health, effectively and efficiently for all Jamkesmas participants. To improve	2. First stage inpatient care (Rawat Inap Tingkat Pertama (RITP) All health services are covered (in accordance with INA CBG) Services provided in Puskesmas 1. Further stage outpatient care (Rawat Jalan Tingkat Lanjut (RJTL) Further stage inpatient care (Rawat Inap Tingkat Lanjutan (RITL) Health services in the form of: Services in the Puskesmas 1. First stage outpatient care (Rawat Jalan Tingkat Pertama (RJPT) 2. First stage inpatient care (Rawat Inap Tingkat Pertama (RITP) Services in the hospital 1. Further stage outpatient	<u>Participants/Members</u> 1. Members with a Jamkesmas membership card: participants according to the Mayor's decree, people living in social institutions, victims of disasters-post emergency response. 2. Members without a membership card: homeless people, beggars, abandoned children can access health services with a recommendation from local Office of Social Services, convicts or people who have been arrested can access health services with a recommendation from the Head of the Penitentiary, members of	Improve data of people eligible for assistance and making sure that information is distributed to all levels of the society. The Jamkesmas program needs to be socialized to all levels of the community, to make it possible for the poor who are not yet covered by it to access the program. . Recommendation for membership/participation for Jamkesmas can be done by submitting a request to the Mayor.	Total fund for this scheme is not enough to cover all poor people with all types of services. Mechanism for fund distribution needs to be reviewed. Mechanism for data collection regarding the poor are based on the BPS (Central Statistic Body) data; used as reference to decide eligibility for Jamkesmas. Still denies HIV-positive participants from accessing services (although HIV isn't an	Hospitals often complain that the reimbursement for services rendered are often late, causing hospitals to pay for these services. People who receive assistance are often those who are not poor and those who are eligible do not receive assistance (due to nepotism) People fail to follow procedure (for example, not wanting to to access services at the Puskesmas first, instead of immediately accessing services at	Available funds should be optimized to help/assist more people who need it. If the fund is not enough to cover all forms of assistance, choices should be made regarding which services should be covered and which shouldn't (focus on the amount of people covered insted of the types of services provided). - The Ministry of Health should provide correct

	access and quality of health services, in order to attain optimal health, effectively and efficiently for all Jamkesmas participants.	care (Rawat Jalan Tingkat Lanjut (RJTL) 2. Further stage inpatient care (Rawat Inap Tingkat Lanjutan (RITL) Health services at the Puskesmas and its network (First stage inpatient and outpatient care, normal deliveries, emergency medical services). . Services at Further Health Care Centers (further inpatient and outpatient care), emergency services, thalassemia.	the Hope for Family Program (Program Keluarga Harapan (PKH)) can access services using a PKH card, babies and children born from couples who are registered with Jamkesmas after the decree for membership/participants have been released can access services by showing the Birth Certificate/Family Card and the parents' Jamkesmas card. Jamkesmas membership is based on data regarding poor population from the BPS (Central Statistic Body). The people in the list is then recommended by the local government to be then decided by a decree from the National Ministry of Health. The Jamkesmas quota for Semarang is 306.700 people Jamkesmas and Jamkesmaskot provides	Jamkesda will try to cover health expenses of poor people who are not covered by Jamkesmas..	exception in the Operational Guidelines). Update for membership data is only done every 5 years. The target group sometimes does not receive assistance. Not all members of Jamkesmas are from the poor, some are even covered by more than one social assistance scheme, such as Jamkesda or even ASKES.	the hospital), which makes them fail to be covered by the scheme. Problems with data collection (regarding citizens eligible for the scheme) ; nepotism in recruitment of members . Several NGOs in Semarang (from the transgender and sex workers communities) find it very difficult to become members of these social security schemes due to the fact that they are not from Semarang. People fail to follow procedure (for example, not wanting to to access services at the Puskesmas first, instead of immediately accessing services at	information to the benficiaries about membership in social security schemes, how to access services and the types of services available, as well as information for the people who run the Jamkesmas program, to make sure that all the parties involved have the same understanding on requirements for membership, ways of accessing services, and exceptions in the program. An independent verifier is needed in ptocess of collecting data for membership eligibility to avoid recruiting participants who are not eligible for the scheme,

			the same services, the only difference between the two is in terms of payment/claims (Jamkesmas uses the INA-Case Based Group method, while Jamkesmaskot claims manually). The 2010 Jamkesmas budget for Semarang was Rp. 151 billion at 13 hospitals 1,586,409 poor people from 14 cities and districts in West Kalimantan (BPS & Capil, 2009 & 2010)			the hospital), There are still poor people who are not covered by Jamkesmas. Claims from hospitals or other primary health centers are often not immediately reimbursed by Jamkesmas, thus making the primary health centers pay for services provided for Jamkesmas members.	Services at first stage should be improved in terms of quality and quantity so participants won't immediately go to the hospital for health services, but go through the stages of referral. Improvement on the data collection system to ensure that Jamkesmas actually covers health car for the poor. Update for membership data should be done every year instead of every 5 years.

2. *Jamkesos*

Type of insurance	Goal	Benefit	Coverage	Strategy to improve/maximize service	Criticism over program	Problems found	Recommendation

JAMKESOS (Health insurance for the people of DIY, implemented and **managed by an Implementing Body (Balai Penyelenggara (BaPel))**	To ensure coverage of comprehensive health services, in cooperation with all Puskesmas and its network, as well as family doctors in DIY, hospitals, and cross city/district services.	Health services listed in the Jamkesos scheme (not all health services and medicines are covered) Services in the Puskesmas 1. First stage outpatient care (Rawat Jalan Tingkat Pertama (RJPT) 2. First stage inpatient care (Rawat Inap Tingkat Pertama (RITP) Services in the hospital 1. Further stage outpatient care (Rawat Jalan Tingkat Lanjut (RJTL) 2. Further stage inpatient care (Rawat Inap Tingkat Lanjutan (RITL) All participants/patients who access health care through Jamkesos must go through stages in procedure, beginning at the Primary Health Care centerI (Puskesmas/Family doctor/BP4/BPS), with the exception of medical emergency cases. If these procedures or requirements are not met, the person will not be covered by Jamkesos.	<u>Participants</u> People from DIY with the following criteria: 1. Poor people who are not covered by Jamkesmas or Jamkesda, and is recommended by the DIY Mayor to the Governor. 2. People with "social problems": people living in social institutions, street children, people living in halfway homes and abandoned people/children. . 3. Target group: children under five with poor nutrition, victims of gender-based violence against women and children 4. Posyandu cadres as a form of appreciation from the DIY Government.	Maximize the role and function of NGOs in terms of outreach, to find more members who are eligible for assistance.	Does not cover peopla with B20 status (no clear source of information regarding this statement). Not all health services and medicines are covered, and no information about which services/medicines are covered/not. Lack of socialization of program Membership of scheme is only based on the "charity" of NGOs; NGOs associated with the Jamkesos program will provide a list of names regarding who can be covered by Jamkesos (no formal regulations); on the one hand, this situation can be beneficial.	People fail to follow procedure (for example, not wanting to to access services at the Puskesmas first, instead of immediately accessing services at the hospital), which makes them fail to be covered by the scheme.	People with B20 status should be covered. The role and function of NGOs in terms of outreach should be improved, to find more members who are eligible for assistance.

3. *Jamkesda*

Type of insurance	Goal	Benefit	Coverage	Strategy to improve/maximize service	Criticism over program	Problems found	Recommendation
Jamkesda	Same as Jamkesmas Improve access and quality of service for Semarang's poor population. Similar to Jamkesmas, but covers poor people in the local city/district area, as well as the poor who are not coverd for by Jamkesmas.	Same as Jamkesmas Health services in the form of: Puskesmas (medical consultations, physical exams, medical procedures, laboratory services, dental exams and procedures, medical check-ups for pregnant and breastfeeding women, babies and children, medicine provision) and Hospital/BKIM/BKPM services (third class inpatient care, medical exams and procedures, diagnostic support, small-medium surgeries, emergency care, medical drugs provision). First and further stage inpatient care, first and further stage outpatient care (RJTP, RJTL, RTP, RITL), deliveries, medical drug provision	Poor population who are not covered for by Jamkesmas. Membership for this scheme is based on the recommendation from the DIY government. Based on the validation for poverty done by the Semarang township government in 2009, there are 398.009 people who are considered to be poor; Jamkesmas cover 306.700 of them, while the remaining 91.309 are covered by Jamkesmaskot. Jamkesda has 2 cost limitations, high cost and live-saving procedures. The 2010 Jamkesmaskot budget for Semarang is Rp 17 billion (of which Rp. 16.714.771.520 was used). The budget for 2011 is Rp13 billion Type of services: Puskesmas (medical consultations, physical	Local, low-level government (RT/RW) should be more sensitive in recommending who is eligible for the Jamkesda scheme. Most Jamkesda programs in Central Java still denies HIV positive patients (only one district in Central Java (Jepara) has made it a priority for PLWHA to access services and becoming jamkesda members). Update of membership every year makes it easier to manage compared to Jamkesmas, whose data membership is only updated every 5 years.	same Jamkesmas There are only 3 districts in West Kalimantan whose Jamkesda program is "universally covered". The other 11 districts/cities has local Jamkesda program.	Idem Jamkesmas Idem Jamkesmas The APBD (yeraly district budget) is not enough to cover all the poor people in the area.	Maximize budgets available in the area to provide effective assistance for people eligible for help. Cooperation between KPAP/D NGOs, and other networks to advocate local government in providing assistanec/coverage of health expenses for ODHA using the Jamkesda program. . If possible, universal coverage should apply to all 14 cities/district n West Kalimantan.

			exams, medical procedures, laboratory services, dental exams and procedures, medical check-ups for pregnant and breastfeeding women, for babies and children, medical drugs provision) and Hospital/BKIM/BKPM services (third class inpatient care, medical exams and procedures, diagnostic support, small-medium surgeries, emergency care, medicine provision). 783,404 poor people from 14 cities and districts in West Kalimantan (BPS & Capil, 2009 & 2010)				

Appendix 2: Summary of Social Securities and Social Assistance in Indonesia

PT Jaminan Sosial Tenaga Kerja (JAMSOSTEK)

PT JAMSOSTEK is a government-owned enterprise under the Ministry of Manpower and Transmigration that implements Law No. 3/1992, regarding Social Security for workers. The Workers Social Security program provides protection to workers in the form of cash compensation to replace to a certain extent the loss of or reduction in income and to assist workers in the event of work-related accidents, illnesses, pregnancies, old age and death. The definition of "worker" here is any person who is capable of working either within or outside an employment relation, generating services or materials to meet society's needs. Workers who work outside an employment relation can register themselves to become participants of JAMSOSTEK, but it is compulsory for every Company to register all their employees to become JAMSOSTEK participants. "Company" here refers to any business that employs 10 (ten) or more employees, or pays at least Rp.1.000.000,- (one million rupiahs) per employee.
JAMSOSTEK offers 4 (four) types of securities for workers, namely:

1. **A Health Care Security (HCS) program, which offers the following benefits:**
   a. Outpatient Level One services, which covers health care by General Practitioners or dentists at PUSKESMAS (Community Health Centers), Clinics, or private practitioners.
   b. Outpatient Level Two (extended), which covers check-up and treatment by Specialists by referral from Level One doctors based on medical indications;
   c. Inpatient treatment at hospitals (hospitalization)
   d. Delivery (giving birth) up to the third child;
   e. Special services, namely rehabilitation services, or benefits to obtain treatment to return physical functions/movements.
   f. Emergency services.

   The Company pays the premium for health services, calculated as follows:
   - Three percent (3%) of workers salary (Rp. 1 million max.) for single workers
   - Six percent (6%) of workers salary (Rp. 1 million max.) for married workers.
   - The premium calculation is based on wages up to a maximum of Rp.1.000.000,- (one million)

2. **A Work-related Accident Security program, which offers the following benefits:**
   a. Transportation costs
   b. Costs for examination by a physician, medication and/or treatment/hospitalization
   c. Rehabilitation costs
   d. Cash benefits, covering:

- Temporary inability to work
- Permanent partial disability
- Permanent total disability, both physical and mental
- Death

The Premiums for Work-related Accidents benefits are paid by the Company, totaling between 0.24% - 1.74% of workers income (depending on the category/type of business).

3. **A Death Benefits program, which offers:**
   a. Funeral expenses
   b. A cash payment

   The premiums for Death Benefits are paid by the Company, i.e. 0.3% of workers salary.

4. **An Old Age Security program**
   Old-age benefits will be paid in accordance with the premiums paid plus their investment returns, in the event the worker:
   - Reaches the age of 55, dies or has a permanent total disability;
   - Is terminated from his job after at least 5 years of service, with a one month waiting period;
   - Moves abroad permanently or becomes a civil servant, joins the Police Force or the Army.

   Old-age Benefit premiums are paid by the worker and the Company, based on the following calculation:
   - The Company pays a premium of 3.7% of the employee's salary
   - The worker pays a premium of 2% of his/her salary

As part of administrative procedure, participants of the Health Care Security (HCS) program must submit a list of family members who are also covered by the program, after which they will receive a Health Care Card (HCC). Showing this HCC to Health Care providers is one of the requirements for JAMSOSTEK participants to receive the services provided under JAMSOSTEK. All workers are entitled to the health care benefits provided by the HCS program; therefore Companies who do not enlist their employees in the program are facing a prison sentence of at least 6 (six) months or a fine of at least Rp.50,000,000,- (fifty million rupiahs), in accordance with Law No. 3/1992 article 29.

PT Asuransi Kesehatan (PT ASKES)

PT ASKES is a government owned enterprise under the Ministry of Health. PT ASKES has been appointed by the government to provide Health Care security to Indonesian citizens. The Health Insurance products provided by pt ASKES provide coverage for civil servants,

government officials, civil servant retirees, retirees from the Armed Forces and the Police, retired government officials, veterans and Independence Pioneers, and also "non-Payroll" civil servants (doctors, dentists and midwives) including their families, namely spouse and children (a maximum of 2 children based on order of birth and a maximum of one adopted child) under the age of 21, unmarried, not earning an income and still a dependent of the ASKES participant, or up to the age of 25 for children who are still enrolled in formal education.
The health services /benefits provided by PT ASKES consist of:

1. First Level Health care at a PUSKESMAS or family doctor, which covers:
   First Level outpatient care and First Level Inpatient care (hospitalization),

2. Secondary Level hospital care, which covers:
   - Secondary Level outpatient care
   - Secondary level inpatient care
   - Special hospitalization (ICU, ICCU)
   - Emergency treatment
   - Giving birth/delivery
   - Blood transfusion
   - Medication in line with PT ASKES's list of "ceiling prices for medications"
   - Surgical and nonsurgical medical procedures
   - Blood Dialysis
   - Kidney transplantation and non-surgical kidney stone removal
   - Diagnostic supporting tools such as : Laboratory, Radio-diagnostics, Electro-medics including USGs, CT Scans and MRIs

3. Medical equipment, covering:
   - IOL, pens, screws and other implants
   - Glasses, false teeth, hearing aids, arms/legs prosthesis (only for ASKES participants, not for their family members).

To receive the facilities provided by PT ASKES, participants must pay a premium/contribution (2% of their basic monthly salary). With such a system, the amount of premium/contribution paid by each participant is not the same. So there is a cross-subsidy between participants who pay large and those who pay small premiums/contributions. These premiums only part of the health care contributions managed by PT Astek, because a portion of the contributions is paid by the government (Central and Provincial).

Pendapatan Iuran Wajib Askes Sosial
Realisasi Tahun 2007, 2008, RKAP dan Realisasi Tahun 2009
Revenue from Askes Sosial's Required Fees
Realization of 2007,2008, RKAP and Realization of 2009

(Dalam Jutaan Rupiah | In Million Rp)

No.	Uraian / Description	Real 2007	Real 2008	RKAP 2009	Real 2009	%		
1	Premi Peserta Members' Premium							
	a. Iuran Wajib PNS Required fees from Civil Servants	1,432,996	1,850,096	2,026,953	2,204,163	129.11	119.14	108.74
	b. Iuran Penerima Pensiun Fees from Pension Beneficiaries Government's Fees	495,222	580,372	751,655	771,047	117.19	132.85	102.58
	Sub Total 1	1,928,219	2,430,468	2,778,608	2,975,210	126.05	122.41	107.08
2	Premi Pemerintah State Premium							
	a. Iuran Pemerintah Pusat Fees from Central Government	657,348	993,353	1,170,915	1,282,620	151.12	129.12	109.54
	b. Iuran Pemerintah Daerah Fees from Regional Government	1,071,389	1,367,645	1,607,693	1,617,129	127.65	118.24	100.59
	Sub Total 2	1,728,737	2,360,998	2,778,608	2,899,749	136.57	122.82	104.36
3	Iuran Veteran Non Tuvet Fees from Non-Tuvet Veterans	53,494	131,075	131,081	131,075	245.03	100.00	100.00
4	Iuran Katastropik Fees from Catastrophic Cases	-	-	130,000	130,713	-	-	100.55
5	Iuran Jamkesmen Fees from Jamkesmen	-	-	-	22,601	-	-	-
	Jumlah / Total	3,710,450	4,922,541	5,818,298	6,159,348	132.67	125.13	105.86

PT Asuransi Sosial Angkatan Bersenjata Republik Indonesia (ASABRI)

PT ASABRI is a government-owned enterprise that manages insurance on a national level and improves welfare, specifically for members of the Armed Forces (the Armed Forces Headquarters, the Army, Navy and Airforce), members of the Police Force and civil servants working for the Department of Defense/the Police Force, by providing insurance against loss of or reduction in income of its participants.
ASABRI has two programs for its participants, namely:

1. A Pension Plan

This is a social security program/a form of appreciation from the government, given to government employees for services rendered to their country, in the form of a monthly pension.
The Pension Program consists of:

a. A First Pension
b. A Widow/Widowers Pension
c. An Orphan's Pension
d. A Death Allowance

Based on Presidential Decree No. 8/1997, participants must pay a contribution of 4.75% of their income (basic salary plus wife and child allowances) every month.
According to the Pension Plan, the pension benefits will be paid to the participant as long as the participant is still alive. After the participant dies, the pension benefits will be paid to his/her legal beneficiaries. The Plan also incorporates a pension benefit for participants' children between the ages of 21 – 25, if they are still in school/studying.

2. Benefits/compensation

a. Insurance benefits
b. Insurance Cash Value benefits
c. Death Risk benefits/compensation
d. Funeral Costs benefits/compensation*
e. Special Death Risk benefits/compensation*
f. Duty-related disability benefits/compensation*
g. Non duty-related disability benefits*
h. Spouse's funeral costs benefits*
i. Child's funeral costs benefits*

*) Recipients of these benefits are determined by SURAT KEPUTUSAN from the Head of the Armed Forces or the Head of the Police Force and the amount is fixed, not based on rank, salary or years of service (but there are regulations regarding minimum years of service).
Participants must pay a contribution of 3.25% of their income (base salary plus wife and child allowances) every month.
In accordance with Ministerial Decree No. 257/PMK.02/2010, the government supports PT ASABRI in implementing its program by allocating APB N funds, taking into consideration the amount of funds proposed by PT ASABRI. The amount of funds managed by PT ASABRI covers Pension Spending funds and the printing costs of the Pension Payment List.
PT ASABRI does not have a health care program because all ASABRI participants are government employees and therefore also participants of ASKES. Therefore, health care benefits for ASABRI participants are handled by PT ASKES.

PT Dana Tabungan dan Asuransi Pegawai Negeri (TASPEN)

PT TASPEN is a government-owned enterprise mandated by Law No. 40/2004 to implement the National Social Security System. PT TASPEN provides social benefits specifically for civil servants and members of the Armed Forces not covered by PT ASABRI.
In general, PT TASPEN has 2 (two) social security programs, namely a Pension Plan and an Old-Age Saving Plan.

The Pension Plan

Those who can participate in this Pension Plan are:

1. Civil servants, both working for the central government and autonomous provinces.
2. Government Officials
3. Members of the Armed Forces who were on active duty and retired prior to April 1, 1989,
4. Veterans and members of PKRI (Pioneers in the Independence of the Republic of Indonesia) / members of KNIP (The Central Indonesian National Committee)
5. Employees of KAI (the Indonesian Railroad Company).

The social benefits provided by this Pension Plan to participants and their families are among others:

1. An Initial pension payment and monthly pension payments
2. Continued pension
3. Death Allowance
4. Widow/Widower/Child pension
5. Payments to compensate for insufficient pension
6. Extended pension

Based on Presidential Decree No.8/1997, to become a TASPEN participant and receive its Pension Plan facilities, participants must pay a contribution of 4.75% of their monthly income (base salary plus family allowance).

Old-Age Saving Plan

Those who can participate in this Plan are:

1. Civil servants (civil servants working for the Department of Defense are not included),
2. Government officials,
3. Employees of government-owned companies / registered Province-owned companies.

The Old-age Saving Plan has 2 (two) insurance programs, namely:

1. The Dwiguna Insurance Plan, which is an insurance plan that provides financial security to participants when they reach retirement age or to their beneficiaries in the event the participant dies before reaching retirement age.

   This Plan invests the premium paid by participants and works to obtain maximum profits through these investment activities; these profits are then used for the welfare of the participants.

2. A Life Insurance Plan, which provides financial security to participants in the event their spouse or child (a maximum of 3 children) dies, or to the beneficiaries in the event the participant dies.

Participants of this Old-age Saving Plan are also required to pay a monthly contribution of 3.25% of their monthly income (base salary plus family allowance).

Children covered by both the Pension Plan and the Old-age Saving Plan are children up to the age of 25 who are still going to school/college, do not have a job yet and are not married.

Similar to PT ASABRI, PT TASPEN does not have a health care security program either; therefore the health care security for TASPEN members and their families is handled by PT ASKES.

The Ministry of Health

A. Jaminan Kesehatan Masyarakat (JAMKESMAS)

(Society Health Security). JAMKESMAS is a Health Care Security program from the Ministry of Health. The program provides free health care to Indonesian citizens with the objective to improve access to and the quality of health care for the underprivileged, to achieve an optimal level of public health in an effective and efficient way. The underprivileged must be listed in the list of poor households and not be listed as having any other form of insurance, either private or as a worker. PT ASKES (Company) has been appointed to provide support in the implementation/execution of participation in the health care program, by issuing Participant Eligibility Letters (PEL) and keeping a record of JAMKESMAS recipients' visits.

To benefit from JAMKESMAS facilities, the underprivileged must have a "JAMKESMAS card" issued by PT ASKES (Company). The homeless, beggars, neglected children and people who do not have identity cards can access health care facilities/services through JAMKESMAS with a recommendation letter from the local Social Office/Agency. People who are incarcerated only need a recommendation letter from the prison's warden (for further details refer to the Health Care implementation Guidelines).

The JAMKESMAS program guarantees that people have access to health care services free of charge or without paying any premium (in accordance with JAMKESMAS Implementation Manual and INA-CBG)*. The sources of funding for JAMKESMAS are the state budget (APBN) and provincial budget (APBD). Provincial governments, through their APBD, contribute in supporting the funding of health care for the underprivileged in their respective provinces.
(* INA-CBG stands for Indonesia Case-Based Groups)

In 2010, the program targeted 76.4 million participants (from the Central Bureau of Statistics macro data of 2006). New participants targeted by JAMKESMAS are:

- Underprivileged people who are incarcerated,
- Underprivileged people living in homes for the poor,
- People impoverished by natural disasters, and
- Children and babies born to poor families.

Other than that, the program also seeks to include participants of the Program Keluarga Harapan /PKH (Hopeful Family Program), and underprivileged people not yet listed in the database, such as neglected children and adults, beggars and the homeless (by attaching a letter from the Welfare Office).
JAMKESMAS services include health treatment expenses and death-related expenses. The health care provided is comprehensive:

a. Health treatment at PUSKESMAS (Health Care Centers) and related networks
    - First Level Outpatient Treatment
    - First Level Inpatient Treatment (hospitalization)

- Normal deliveries/childbirths are handled at PUSKESMAS without inpatient facilities/ by midwives in villages/at POLINDES(Village Delivery Post)/at patients' homes/at private midwife practices.
- Emergency treatments, given in accordance with JAMKESMAS emergency criteria.

b. Health treatment at Secondary Health Care Providers (Large Healthcare Centers/BALKESMAS, state hospitals including specialized hospitals, Armed Forces/Police hospitals and private hospitals as per referrals).
   - Secondary Level Outpatient Treatment
   - Secondary Level Inpatient Treatment
   - Emergency treatment – in accordance with JAMKESMAS emergency criteria.
   - All patients suffering from Thalassemia are covered, including those who are not participants of JAMKESMAS.

c. Limited service/treatment:
   - Spectacles
   - Hearing aids
   - Motion aids (crutches, wheelchairs, corsets)

d. Exclusions:
   - Treatments not in accordance with existing rules and regulations/procedures
   - Materials, tools and treatments for cosmetic purposes.
   - General check-ups.
   - Teeth prosthesis.
   - Alternative treatment/healing (acupuncture, traditional medications) and other treatments not scientifically tested/proven.
   - Sequence of examinations, medication and medical interventions for the purpose of attempting to produce offspring, including in-vitro fertilization and treatment for impotence.
   - Health care during emergency situations caused by natural disaster, unless the patient is a JAMKESMAS participant.
   - Health care services provided during charity activities/projects

   JAMKESMAS participants are entitled to hospitalization in Third Class rooms/wards; if Third Class is full they can be upgraded to Second Class, but claim payment for Third Class. Coverage of death-related expenses includes preparation of the body (bathing the body) and use of hearse for transportation of the body.

In order to better support the JAMKESMAS implementation process, it is necessary to increase familiarization with the Implementation Manual and the INA-CBG (Indonesia Case-Based Groups). INA-CBG is a form of prospective payment pattern, used in an effort to control the costs of operating JAMKESMAS.

B. Jaminan Persalinan (JAMPERSAL)

JAMPERSAL (birth/delivery security) is a health security program launched by the Ministry of Health in 2011. The goal of the program is to increase access to doctor- or midwife-assisted births, to reduce mortality rates for both mothers and infants through the provision of security to pay for delivery services. This is in line with the national health development goals and the Millennium Development Goals (MDGs).

JAMPERSAL targets pregnant mothers, mothers giving birth, post-delivery mothers (up to 42 days post-delivery), and newborns (up to 28 days after birth). In 2011 the JAMPERSAL program target is to reach all pregnant women in Indonesia, totaling 4,520,789 women. Anyone who doesn't have birth insurance yet can become a participant of JAMPERSAL. JAMPERSAL's services during the first year of the program cover all deliveries in Indonesia, but for the next program years services will be limited to the first two deliveries (up to the second child). This is to integrate JAMPERSAL with the Planned Parenthood program.

The execution of birth/delivery services is executed in a structure way and in stages based on referrals. The scope of delivery services covers:

1. **JAMPERSAL services Level One, which cover:**
    a. Pregnancy check-ups (four times)
    b. Assistance during normal deliveries
    c. Post-delivery services; includes newborn check-ups and provision of prophylactics after delivery (three times)
    d. Problem-deliveries and or pre-referral treatment of newborns with health complications,
    e. Post miscarriage treatment, vaginal deliveries requiring basic emergency measures.

    These Level One JAMPERSAL services are provided at a PUSKESMAS (Health Care Center), a PUSKESMAS PONED (which is a PUSKESMAS that has facilities and personnel to handle obstetric cases and basic neonatal emergency cases) and their networks including POLINDES (Village Birth/Delivery Post) and POSKESDES (Village Health Post) and private health facilities that have agreements in place with the Region's/City's management team.

2. JAMPERSAL Secondary Level Services

Provides medical services by Specialists and consists of midwife and neonatal care provided to pregnant mothers, mothers giving birth, post-partum mothers and "high risk" babies with complications that cannot be handled by Level One facilities. These services are provided at state and private hospitals and are provided based on referrals, except in emergency situations. The participants are entitled to treatment in Third Class rooms/wards of the state and private hospitals that have an agreement with the Region's/City's management team.

JAMPERSAL's funding comes from the Ministry of Health's budget and is integrated with the funding for JAMKESMAS. Management of JAMPERSAL's funds is part of the management of JAMKESMAS funds, and is done by the Health Office in its capacity as JAMKESMAS management team at Region/City level. Like JAMKESMAS, JAMPERSAL participants do not have to pay any contribution for the health services they receive. All implemention of JAMPERSAL services refer to the standards for Health Services to Mother-and-Child, the Technical Guidelines for Birth/delivery Security and INA-CBSs (Indonesia Case-Based Groups).

The Ministry for Welfare

A. Jaminan Sosial Lanjut Usia (JSLU)

JLSU (Old-age Social Security) is one of the forms of social assistance under the Ministry for Welfare, specifically the Directorate General for Social Services and Rehabilitation. Through JLSU, the government strives to provide social assistance in the form of cash to neglected elderly people who meet the 18 criteria set up by the Ministry of Welfare, the main criteria being that the person should be over 60 years of age and part of an underprivileged household. These 18 criteria were set up to avoid the assistance going to the wrong people (missing the intended targets).

Testing of the program started in the 2005-2006 budget year by distributing assistance to 2,500 elderly people. In 2010 the Ministry of Welfare channeled JLSU funds to 10,000 neglected elderly people, and in 2011 the number of recipients increased to 13,000 elderly people.

The assistance provided through the JSLU program is in the form of Rp.300,000,- (three hundred thousand rupiahs) in cash, handed monthly to each person. The assistance will continue to be given to the recipients for the rest of their lives.

B. Jaminan Sosial Penyandang Cacat (JSPC)

JSPC (Social Security for the Disabled) is a social assistance program to help people with disabilities. Disabled people entitled to receive JSPC are those who are severely disabled, based on the following criteria:

1. The degree of disability is such that rehabilitation if not feasible, both medically and socially;
2. The person is highly dependent on other people to perform daily activities such as getting up, taking a bath, eat, drink etc.;
3. The person is unable to earn his/her own living;
4. Persons from underprivileged families are given priority; and
5. The person is registered as a local resident.

The JSPC program was developed starting 2006 with the goal to meet the basic needs of people who are severely disabled, to allow them to have a reasonable standard of living. Up to 2009 the program had reached 31 provinces with recipients totaling 17,000 persons. JSPC provides assistance in the form of cash to disabled people in the amount of Rp.300.000,- (three hundred thousand rupiahs) every month during the program year. JSPC recipients are evaluated every year and assistance to a recipient can be stopped if the person is considered already able to earn his/her own living or when he/she passes away.

C. Program Kesejahteraan Sosial Anak (PKSA)

PKSA (Children Social Welfare Program) is a program from the Ministry of Welfare which covers various groups of children who come from underprivileged families. The goal of the PSKA program is to ensure that children's basic rights are met and to protect children from neglect, exploitation and discrimination, to enable them to develop, survive and participate.

The program reaches a broad range of children in need of assistance, and is categorized into 6 (six) sub-programs, as follows:

1. A program for neglected toddlers and toddlers who need special protection (ages 5 years and younger, including unborn infants).

2. A program for neglected children/children without parental care (ages 6 – 18), covering:
   - Children who are abused or neglected by their parents/family, or
   - Children whose parents/family have lost custody over them.

3. A program for children who are forced to work on the streets/Street Children (ages 6 – 18), covering:
   - Children who are at risk of working on the streets;
   - Children already working on the streets;
   - Children who work and live on the streets.

4. A program for children in trouble with the law (ages 6 – 18), covering:
   - Children suspected of breaking the law
   - Children who are in a court process;
   - Children who are diverted from the criminal justice system (returned to the supervision of their parents and local government);
   - Children who have been incarcerated;
   - Children who are victim of criminal acts
   - Delinquent children.

5. A program for disabled children (ages 0 – 18), covering:
   - Children with physical disabilities;
   - Children who are mentally disabled;
   - Children with multiple disabilities.

   In case of children with mental or multiple disabilities, their mental age is also taken into consideration.
6. A program for children who need other special protection/Special Protection Children (ages 6 – 18), covering:
   - Children in emergency situations;
   - Children who are victims of human-trade/child trade;
   - Children who are victims of physical and/or mental violence/abuse;
   - Children who are victims of exploitations (exploited children);
   - Children from isolated minority groups, and from remote traditional communities;
   - Children who are victims of addictive substance abuse (narcotics, alcohol, psychotropic substances and other addictive substances);
   - Children with HIV/AIDS.

PKSA provides social assistance for children in the form of cash for one program year. The amount varies among sub-programs, ranging from Rp.1.4 million to Rp.1.6 million per child. The money is managed by Lembaga Kesejahteraan Sosial Anak/LKSA (Children's Social Welfare Society), which has been appointed by the Ministry of Welfare, and is used as appropriate for each child's needs. Apart from receiving cash assistance, the children are also entitled to receive assistance to meet their basic needs, have access to basic social services, and strengthen the parents/family and society. To maximize the service to the children, the Ministry of Welfare has placed social workers at each LKSA. The social workers are provided with knowledge and training about the Children Social Welfare Program (PKSA), and this group of social workers is called "Satuan Bakti Pekerja Sosial" (Social Workers Service Unit).
The PKSA program was tested in 2009 on a group of neglected street children. In 2010, the recipients of PKSA assistance totaled 147,321 children spread over 33 provinces; Rp.251 billion

was managed centrally and Rp.20 billion locally ("deconcentration" of fund management). PKSA's target for 2011, as per President"s Instruction No. 3/2010, is as follows:

- Neglected toddlers : 6,925 children
- Neglected children : 142,530 children
- Street children : 4,200 children
- Children in trouble with the law: 930 children
- Disabled children : 1,750 children
- Special Protection children : 2,000 children

Total recipients will be 158,335 children with a budget of Rp.211,818,335,000,-.

Example of Private Health Insurance Companies

PT Prudential Life Assurance (Prudential Indonesia)

Prudential Indonesia was established in 1995 and is a part of Prudential plc, a prominent international group providing financial services, first established in the UK.
Prudential Indonesia offers a complete range of life insurance and investment products to meet customers' needs. Prudential's life insurance product can also be linked with investment, in what is called a unit link. With this system, customers can get double benefits, i.e. insurance protection and investment of their money.
The general criteria to become a customer of Prudential Indonesia are:

1. The person should be able to pay the established premium.
2. Clients with a pre-existing medical condition/problem (prior to purchasing the insurance product) are not eligible to receive benefits related to said condition/problem.

Regarding HIV/AIDS, individuals with HIV/AIDS are not eligible to become customers of Prudential Indonesia.
Products related to health and life insurance cover:

1. Daily hospitalization expenses/costs: room, accommodations, medications, doctor visits (General Practitioners and Specialists), various treatment costs), ICU, surgery;
2. Local ambulance costs;
3. Outpatient costs (such as: accident-related emergency, cancer treatment, blood dialysis);
4. Pre- and post-hospitalization costs (preliminary examination, laboratory, etc.);
5. Nurse's costs in case of treatment at home after hospitalization;
6. Benefits paid in the event the beneficiary becomes disabled, permanently disabled due to an accident, dies or becomes critically ill*.

*) diseases covered are those that the customer did not have prior to purchasing the insurance product and not a disease/condition that is excluded by the product.
To receive those facilities, customers must pay a certain amount of premium. The premium must be paid on a regular basis and the amount varies depending on the product/the insurance benefit package, age of the customer when purchasing the insurance and some other things.

PT Asuransi Allianz Life Indonesia

Allianz is one of the largest companies in the world with offices in many locations; they provide insurance, banking and asset management services. Allianz was established in 1890 in Germany. In Indonesia, Allianz has been present since 1981 with a representative office in Jakarta. In 1989, PT Asuransi Allianz Utama Indonesia officially started operations in Indonesia, providing general insurance services. In 1996 Allianz broadened their insurance services by establishing PT Asuransi Life Indonesia which moved in the field of life insurance, health insurance and Pension Plans. In 2006, both companies started a "Syariah" insurance (insurance based on Islamic law).
The general criteria to become a customer of Allianz Life are:

1. The person should be able to pay the established premium.
2. Clients with a pre-existing medical condition/problem (prior to purchasing the insurance product) are not eligible to receive benefits related to said condition/problem.

Regarding HIV/AIDS, individuals with HIV/AIDS are not eligible to become customers of Allianz Life.
Allianz Life offers a range of insurance products, both individual and for groups/companies.
Allianz Life's health and life insurance products guarantee the following:
Basic products:

1. Payment for hospital accommodations including ICU,
2. Payment for medication during treatment including diagnostic checks, administrative costs,
3. Payment for pre- and post-hospitalization care, costs of treatment/care at home, ambulance, and unexpected costs due to accidents for outpatient care and dental care,
4. Payment for Surgery,
5. HIV/AIDS is included in a life insurance product that that covers critical illness. HIV/AIDS patients covered are those who were infected due to a work-related accident and blood transfusion.

Additional products:
Outpatient treatment, births/deliveries, dental care and daily benefits.
Allianz also has a product for companies in the form of a Pension Plan, which provides the following benefits:

- Normal Retirement benefits
- Early Retirement benefits
- Deferred Retirement
- Retirement due to Disability
- Retirement due to Death

Allianz Life insurance participants are charged a premium that they must pay on a regular basis. The amount of the premium depends on the type of insurance benefit package/product, age (for individual products), and is adjusted based on the number of participants. The premium of products for groups/companies is also affected by how big the participants' benefits are.

AXA Mandiri Financial Services

AXA Mandiri Financial Services was established in December 2003 and is a joint venture between two large companies, namely PT Bank Mandiri (Company), the largest bank in Indonesia and the AXA Group, the largest insurance enterprise in the world. AXA Mandiri business is banc assurance and AX has more than 400,000 customers throughout Indonesia.
AXA Mandiri combines several benefits in their insurance package, such as: investment, health, life, education, and retirement. The choice of benefits can be adjusted with available product packages and customers' needs.
AXA Mandiri's health and life insurance products provide benefits to pay for the following:

- Hospitalization due to either illness or accident< including ICU costs and death allowance.
- Treatment if customer is diagnosed with one of 34 listed critical illnesses.
- Death allowance for death due to illness or accident.
- No information yet on coverage for HIV/AIDS.

As with other private insurances, AXA customers have to pay a regular premium, the amount of which depends on the type of the insurance benefits package chosen, the age of the customer and several other factors.