Primary Health Care (PHC) Readiness on Back-Referral Policy in Human Immunodeficiency Virus (HIV) Service Provision

Diah Evasari Husnul Khotimah[1], Iko Safika[1], Nurhalina Afriana[2], Lanny Luhukay[2], Yuli Farianty[3], Ackhmad Afflazir[3], Hasbullah Thabrany[1]
[1]ThinkWell LLC, Jakarta, Indonesia [2] HIV and STI Working Group, Ministry of Health of the Republic of Indonesia [3]Center for Health Financing and Decentralization Policy, Ministry of Health of the Republic of Indonesia

Introduction

The Indonesian National Health Insurance Scheme (Jaminan Kesehatan Nasional, JKN) operates under a gatekeeper system, which regulates costs and streamlines care. Patients with uncomplicated cases are treated by primary health care (PHC) providers, with those requiring specialist attention, referred to hospitals. However, 2018 data on JKN claims revealed that 80% of HIV-related treatments occurred in hospitals, with 75% being outpatient and 25% being inpatient. This suggests that the gatekeeping function of PHC facilities is not functioning effectively. To address this issue, there is an initiative to refer people living with HIV (PLHIV) in stable conditions and being treated at the hospital back to PHC. This study aims to evaluate PHC facilities' readiness to provide comprehensive HIV services to PLHIV in stable conditions.

Methodology

This study aimed to determine if the gatekeeping function is ineffective or if HIV-positive patients choose to use hospital services. Additionally, the readiness of PHCs to treat HIV patients without complications was examined. Using a mixed-method approach, we conducted a study on health providers in 16 municipalities from April to November 2022. An online survey was administered to 142 PHC providers, 659 PHC workers, and 561 PLHIV. We followed up with focus group discussions and in-depth interviews with 181 respondents, including municipal health officials, medical doctors in PHC, HIV program administrators, JKN administrators, PLHIV, and peer groups of PLHIV. The study employed descriptive and thematic analysis to identify factors associated with an improved referral system.

Results

Figure 1. The proportion of PHC Facilities that can provide HIV counseling, diagnostic, treatment, and viral load test

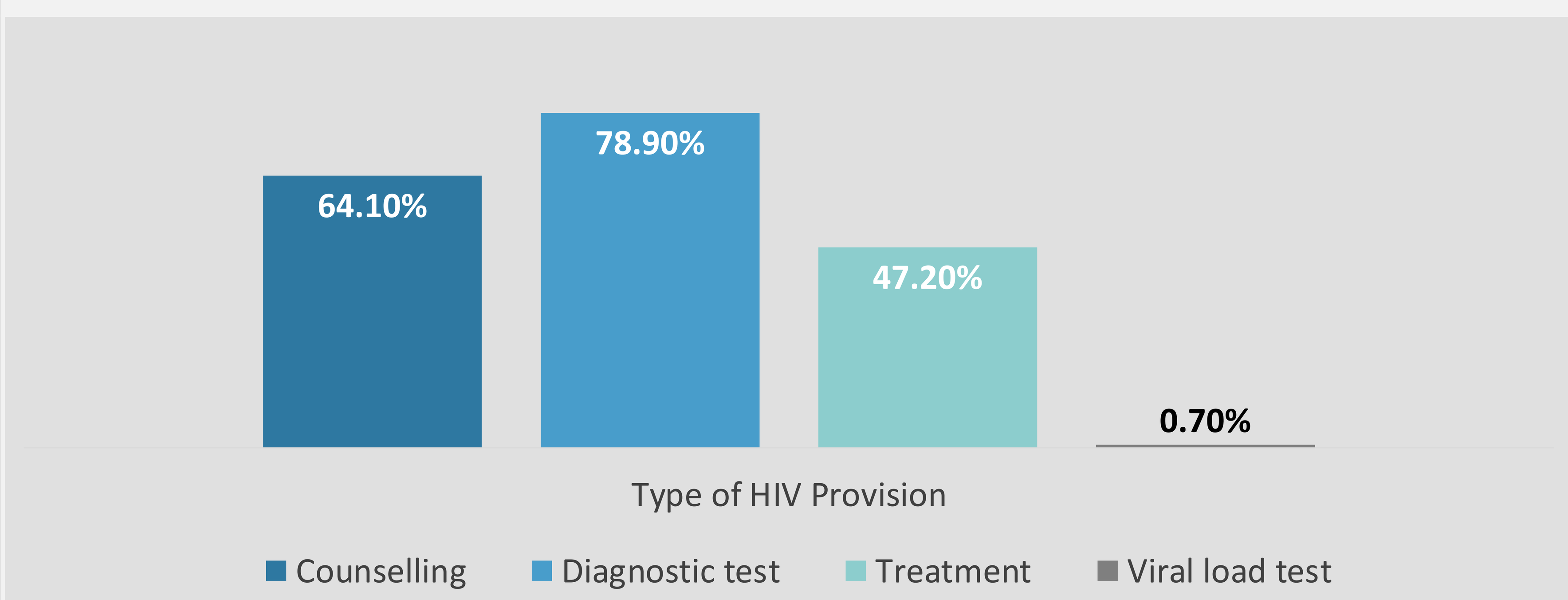
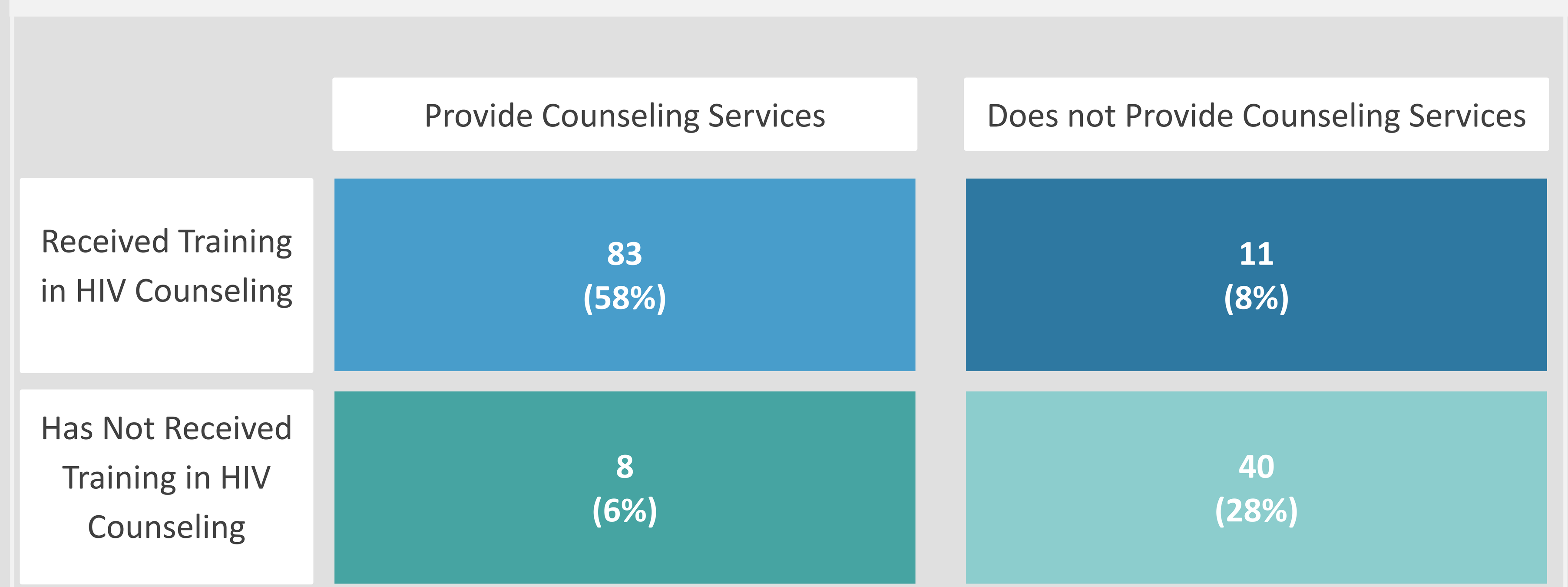


Figure 2. The discrepancy between PHC facilities that have received training on HIV counseling and those that provide HIV Counseling



	Provide Counseling Services	Does not Provide Counseling Services
Received Training in HIV Counseling	83 (58%)	11 (8%)
Has Not Received Training in HIV Counseling	8 (6%)	40 (28%)

Figure 3. The discrepancy between doctors and nurses who have received training on HIV treatment and those who provide HIV treatment

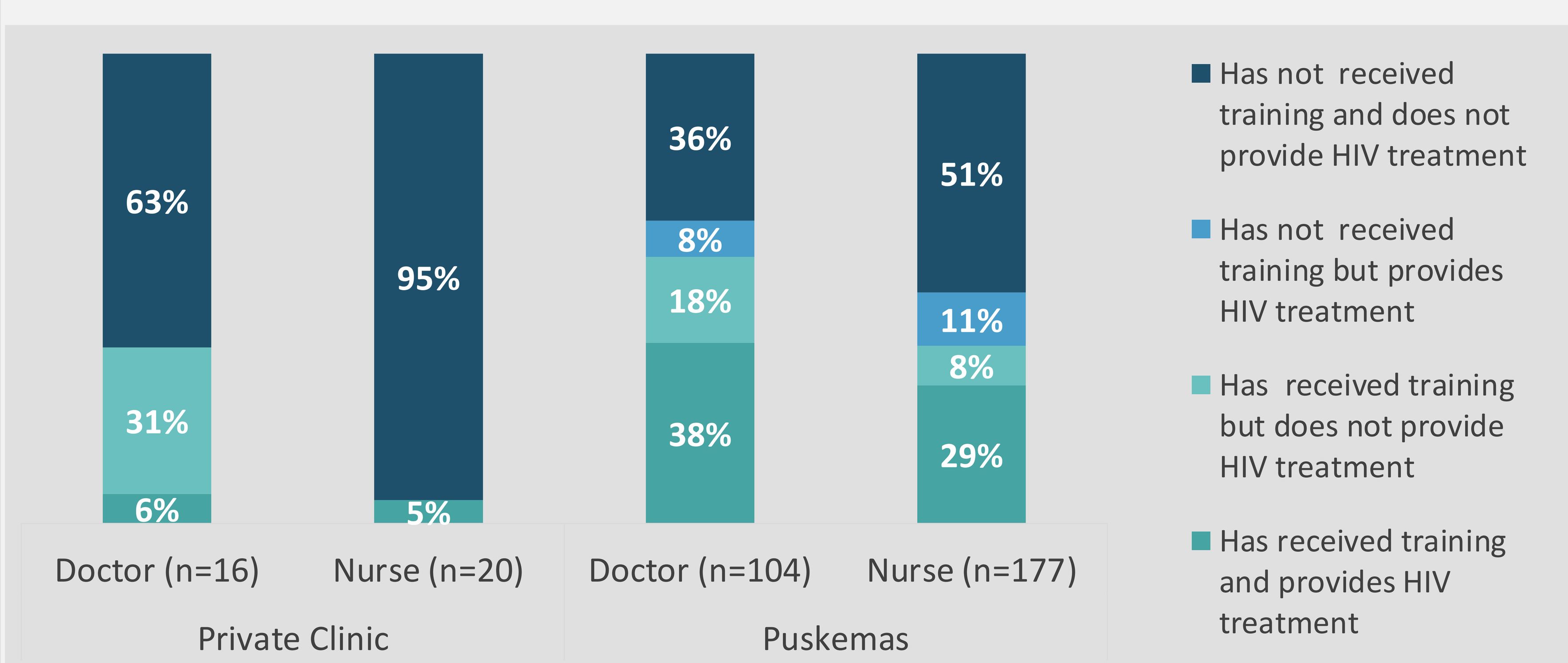
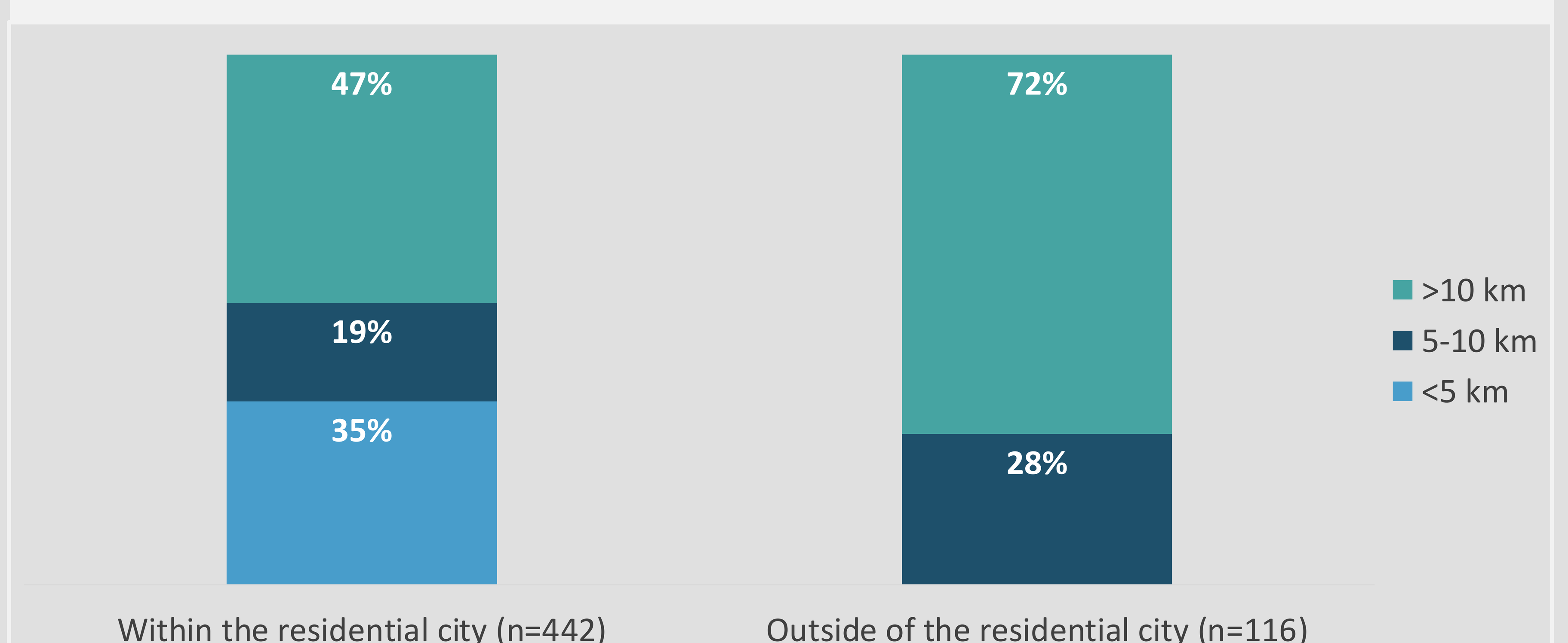


Figure 4. The proportion of People Living with HIV (PLIHV) by the location of health care facilities where they take anti-retroviral therapy (ART)



Key Findings

1. Limitations in the readiness of PHC to provide comprehensive HIV-related services, namely counseling, diagnostics, medication, and VL tests.
2. There is a need for more healthcare staff and increased capacity-building assistance for healthcare workers who provide HIV-related services.
3. Private clinics need more capacity-building assistance than Puskesmas, which are publicly funded PHCs.
4. The number of PHCs who can provide VL tests (including those who can prepare blood samples only) needs to be increased. While availability of ARV is sufficient, there is no plan to finance them through JKN in anticipation of a reduction in international donor support to MOH for logistics and supply of HIV reagents and drugs.
5. There is a need for regulation and improved incentives for HIV-related services to be referred back to PHCs.
6. Patients are more likely to support the back referral policy if they can access comprehensive and non-discriminatory HIV services nearby.
7. Access to medical care is often hindered by the high cost of transportation.

Conclusion and Recommendations

1. There is a need to increase the number of PHC facilities that are capable to provide comprehensive HIV services, especially for treatment and viral load tests.
2. There is a need for a stronger commitment from the PHC facilities leadership to provide HIV services once appropriate training has been received. In addition, leadership should strive to keep sufficiently trained healthcare workers for at least 5 years.
3. There should be a clear contingency plan in a stockout event within a designated area.
4. The number of facilities that can provide multi-month dispensing (MMD) of ART should be increased. This should be accompanied by a sufficient supply of anti-retroviral drugs. An innovative approach that could also be considered is to make ARV distribution for PLHIV with no complication automatic through an online application.
5. Not all PHC providers are ready to provide comprehensive HIV services and therefore, they need to be strengthened before back-referral policy is implemented nationally by the Government of Indonesia.
6. Local government can support PLHIV in covering their transportation cost to access HIV services, at least for collecting ART once a month.

Acknowledgments

This poster is made possible by the generous support of the American people through the United States Agency for International Development (USAID). It was produced by the USAID Health Financing Activity (HFA) under Contract No. 72049719C00002, which is implemented by ThinkWell. The authors' views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

Presented at IAS 2023, the 12th IAS Conference on HIV Science

USAID FROM THE AMERICAN PEOPLE

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

IAS 2023 23–26 July