

# Priority setting in HIV/AIDS control in West Java Indonesia: an evaluation based on the accountability for reasonableness framework

Noor Tromp,<sup>1,2\*</sup> Rozar Prawiranegara,<sup>2</sup> Harris Subhan Riparev,<sup>3</sup> Adiatma Siregar,<sup>1,3</sup> Deni Sunjaya<sup>4</sup> and Rob Baltussen<sup>1</sup>

<sup>1</sup>Department of Primary and Community Care, Radboud University Medical Center, Geert Grooteplein Noord No. 21, 6525 EZ Nijmegen, The Netherlands, <sup>2</sup>Medical Research Unit, Faculty of Medicine, Padjadjaran University, Jalan Eijkman No. 28, 40161 Bandung, Indonesia,

<sup>3</sup>Department of Economics, Faculty of Economics, Padjadjaran University, Jalan Dipatiukur No. 35, 40132 Bandung, Indonesia and

<sup>4</sup>Department of Public Health, Faculty of Medicine, Padjadjaran University, Jalan Eyckman No. 38, 40161 Bandung, Indonesia

\*Corresponding author. Department of Primary and Community Care, internal post code 117, Radboud University Medical Center, Geert Grooteplein Noord No. 21, 6525 EZ Nijmegen, The Netherlands. E-mail: Noor.Tromp@radboudumc.nl

**Accepted** 1 March 2014

**Background** Indonesia has insufficient resources to adequately respond to the HIV/AIDS epidemic, and thus faces a great challenge in prioritizing interventions. In many countries, such priority setting processes are typically ad hoc and not transparent leading to unfair decisions. Here, we evaluated the priority setting process in HIV/AIDS control in West Java province against the four conditions of the accountability for reasonableness (A4R) framework: relevance, publicity, appeals and revision, and enforcement.

**Methods** We reviewed government documents and conducted semi-structured qualitative interviews based on the A4R framework with 22 participants of the 5-year HIV/AIDS strategy development for 2008–13 (West Java province) and 2007–11 (Bandung).

**Results** We found that criteria for priority setting were used implicitly and that the strategies included a wide range of programmes. Many stakeholders were involved in the process but their contribution could be improved and particularly the public and people living with HIV/AIDS could be better engaged. The use of appeal and publicity mechanisms could be more transparent and formally stated. Public regulations are not yet installed to ensure fair priority setting.

**Conclusions** To increase fairness in HIV/AIDS priority setting, West Java should make improvements on all four conditions of the A4R framework.

**Keywords** Accountability for reasonableness, priority setting, HIV/AIDS control, Indonesia

## KEY MESSAGES

- Improvements should be made in HIV/AIDS control in Indonesia on all four conditions of the A4R framework.
- Criteria for priority setting are used implicitly and the HIV strategic plans contain many activities.
- Many stakeholders are involved in the process but engagement of the public and people living with HIV/AIDS could be improved.
- Mechanisms to appeal decisions and to inform stakeholders on the priority setting process and its results need to be formally stated.

## Introduction

In Indonesia, the available budget for HIV/AIDS control is far below the resources needed to control the epidemic; thus, priority setting is required. In 2010, only US\$ 69 million was spent on HIV/AIDS control, whereas US\$ 152 million was needed to effectively control the epidemic (National AIDS Commission 2009; UNGASS 2012). In 2012, an estimated 610 000 people in Indonesia were living with HIV/AIDS (PLWHA) (0.4% of the population age 15+), with the epidemic mostly concentrated in high-risk groups, that is injecting drug users (IDUs), female sex workers (FSWs) and men having sex with men (MSM)—except in the Papua province where the epidemic is generalized (AIDSdatahub 2013). Recently, the epidemic has started shifting further towards the general population, indicating that it is not yet controlled, and challenging the government to carefully deliberate over choosing the right HIV/AIDS programmes (AIDSdatahub 2013).

Priority setting in HIV/AIDS control in Indonesia has not been previously investigated. Indonesia's HIV/AIDS responses focus on a wide range of activities [e.g. harm reduction programmes, voluntary counselling and testing, and antiretroviral treatment (ART) services] that are offered mainly for the most-at-risk populations, whereas mass media campaigns and out-of-school HIV education are introduced on a small scale for low-at-risk populations (National AIDS Commission 2009; UNGASS 2012). For most programmes, coverage remains low—that is 18% for ART in 2012 (AIDSdatahub 2013). Policy makers face difficult dilemmas and conflicting values in priority setting of all possible HIV/AIDS programmes. For example, they must decide whether to prioritize programmes that are highly effective at reducing the spread of HIV, such as distribution of clean needles and condoms for high-at-risk groups, knowing that these are less politically and culturally accepted. Alternatively, they can invest in prevention of mother-to-child transmission programmes, which will lead to a smaller reduction of the spread of HIV/AIDS but will be politically more accepted because they prevent HIV infection among children.

Priority setting is also made difficult—particularly in less developed countries—by wide gaps between available and needed resources, insufficient data to inform decisions and frequently weak decision bodies (Kapiriri *et al.* 2007). As a result, priority setting decisions are often history-based and ad hoc, and strongly influenced by policy makers' opinions, preferences of international funding agencies, lobbying and political pressure (Chalkidou *et al.* 2010). Generally, they are dominated by concerns of effectiveness and efficiency at maximizing population health. Other factors, such as equity and feasibility of implementation are also becoming more prominent (Baltussen and Niessen 2006; Guindo *et al.* 2012). Without consensus on which values should guide priority setting, the focus is placed on analysing the 'process' of priority setting, assuming that the right process will produce fair and legitimate outcomes.

The ethical framework 'accountability for reasonableness' (A4R) was introduced to define a fair priority setting process; it is theoretically grounded in justice theories that emphasize democratic deliberation (Daniels and Sabin 1997, 1998; Daniels 2002, 2008). According to A4R, a fair priority setting process should meet four conditions: relevance, publicity, appeals and

revision, and enforcement (definitions are presented in Table 1). Since its introduction, A4R has been successfully used to evaluate priority setting processes in several countries (Kapiriri *et al.* 2007; Greenberg *et al.* 2009; Maluka *et al.* 2010; Tuba *et al.* 2010; Mori and Kaale 2012). However, it is not yet applied in Asia and differences in countries' political system and cultures will likely affect priority setting processes and the outcomes of an A4R evaluation. The use of the framework seems appropriate for the Indonesian setting as the country has a democratic political system and thereby aims to fulfil the underlying principles of A4R. More specifically, formal government regulations state that decision-making processes should incorporate the views of different stakeholders and be informed by scientific evidence (Suzetta 2007; Overseas Development Institute 2011). As in the A4R framework the conditions are loosely defined (e.g. mechanisms for appeals and revision are not specifically outlined), it allows context-specific interpretations and makes it appropriate for use in various settings, also beyond Indonesia.

This study evaluates the HIV/AIDS priority setting process at the decentralized level in the West Java province of Indonesia with regard to the four conditions of the A4R framework. For other low-income settings beyond Indonesia, the results of this evaluation may give insights in whether their priority setting processes are fair and could provide lessons for improvement.

## Methods

### The study setting

Our study area was the West Java province, home about 43 million inhabitants, with an estimated 58 834 PLWHA in 2013 (West Java AIDS commission 2013a). Like elsewhere in Indonesia, the epidemic is concentrated in high-risk groups (estimated HIV prevalence in 2013: IDUs 23.2%; FSWs 6.4%; MSM 8.4%) but has started shifting towards the general population (estimated HIV prevalence in 2013: 0.18%) (West Java AIDS commission 2013a). West Java has established a range of HIV/AIDS activities, including harm reduction programmes for IDUs, voluntary counselling and testing and ART at hospital and community clinics, condom distribution and school-based education programmes in Bandung city. However, coverage of these programmes remains low according to the latest data available, at around 30% in 2009 (West Java AIDS commission 2013b). With about 3 million inhabitants, Bandung is West Java's capital and is the centre for HIV/AIDS control. It houses West Java's largest public referral and teaching hospital, Hasan Sadikin, and has HIV/AIDS in- and outpatient services.

### The study design and data collection

We reviewed national and local AIDS strategies, guidance documents for strategic planning, UNGASS reports, and local monitoring and evaluation data (Bandung AIDS Commission 2007; National AIDS Commission 2009; National AIDS Commission 2011; West Java AIDS Commission 2009; UNGASS 2012). We further conducted semi-structured qualitative interviews with 22 stakeholders involved in the 5-year HIV/AIDS strategic planning at the West Java province level (2009–13) and the Bandung city level (2007–11). The

**Table 1** The four conditions of the A4R framework (Daniels 2008)

Relevance	The rationales for priority setting decisions must be based on reasons that stakeholders agree are relevant in the context
Publicity	Priority setting decisions and their rationales must be publicly accessible, and leaders must take action to 'push' the message out to all segments of the public
Appeals and revision	There must be a mechanism for challenge, including the opportunity for revising decisions in light of considerations that stakeholders may raise
Enforcement	There is voluntary or public regulation to ensure that the first three conditions are met

respondents were selected from a list of participants by purposive sampling. For the province and city level we interviewed, respectively, three and two representatives from the AIDS commission secretariat, three and four from the government health office, one and two from the local planning board, and five and two from non-governmental organizations (NGOs) and HIV clinics.

Interview questions were based on the four conditions of the A4R framework, and previous A4R studies were used for input (Kapiriri *et al.* 2007; Maluka *et al.* 2010). For the 'relevance' condition, we asked questions about the involvement and dominance of stakeholders, about which criteria and data were used for decisions. For the 'publicity' and 'appeals and revision' conditions, we asked how consensus was reached among stakeholders, and which mechanisms were installed to ensure publicity of decisions and the ability to appeal decisions. For the 'enforcement' condition, we asked about quality of leadership and whether decisions were implemented. Daniels defines enforcement as 'there is voluntary or public regulation to ensure that the first three conditions are met', and we further operationalize this condition by additionally asking questions about 'leadership' and 'implementation of decisions'. Leadership is essential in facilitating explicit priority setting (Mitton and Donaldson 2004) and could be important to ensure that a priority setting process meets the first three conditions. Implementation of decisions is important as it indicates whether stakeholders indeed follow up on the outcomes of decision-making processes. Both items were also put forward as elements of fairness in other settings and it is recommended to use the A4R framework with flexibility (Kapiriri *et al.* 2009). All interviews lasted 1–2 h and were carried out in April and May of 2011. We interviewed respondents until saturation was reached, meaning that the respondents in successive interviews gave no new insights on for example criteria used for priority setting.

### Data analysis

Interviews were recorded and transcribed. One researcher (R.P.) coded the transcriptions on the basis of the interview questions, using Nvivo version 8.0. During the coding a wider list of codes was established to find more specific information, for example for type of appeals and revision mechanisms three codes were used: 'formal mechanisms', 'informal mechanism' and 'after decision taken mechanisms'. A second researcher (N.T.) went through all the coded transcriptions to check the coding and any disagreement between the two researchers was resolved through discussion until reaching consensus. Next, the two researchers summarized together the answers per respondent in

a matrix. All findings were summarized in this article. We then consulted the AIDS commissions to give feedback on our results, and minor adaptations were made based on their comments.

### Ethical clearance

This research was approved by the Bandung citizens ethical committee and the Padjadajaran University Medical Faculty ethical committee. Respondents were sent an invitation letter, and all participants gave their consent. Respondents were told that our study aims to evaluate the decision-making process in HIV/AIDS control in West Java and they could stop the interview at any time. The interviews were recorded with informal consent of the respondents, and a souvenir was given as a reward. Anonymity of the respondents was maintained during data coding, and respondent categories (e.g. NGOs) were used during data analysis. In data storage, anonymity was not maintained.

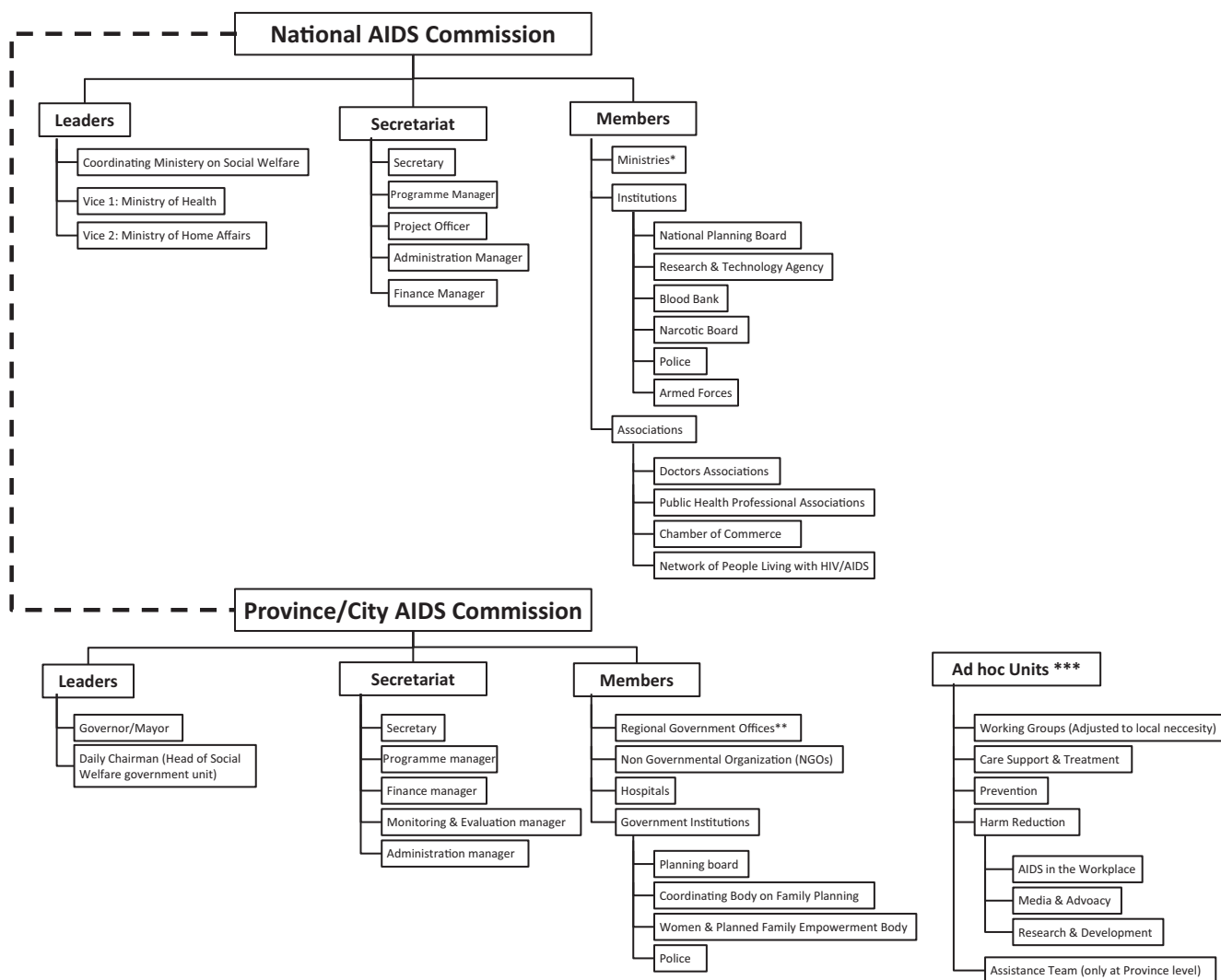
## Results

Here, we first describe HIV/AIDS priority setting in the West Java province. Secondly, we evaluate this process against the four conditions of the A4R framework. All findings were similar for Bandung city and the West Java province unless otherwise stated.

### Priority setting process in the West Java province

#### AIDS commissions

Indonesia has established AIDS commissions on a national level, in all 33 provinces, and in 172 out of 477 cities and districts. We found that these commissions had a multi-sectorial design, and the daily board comprised representatives of various government offices (e.g. health, education, social, tourism, law and religious affairs), NGOs and health care facilities (Figure 1) (National AIDS Commission 2011). They primarily aimed to co-ordinate activities and provide technical support for all involved parties, but some also ran their own programmes, that is condom distribution and health promotion. In Indonesia's decentralized system, the provincial health government offices were responsible for the infrastructure of HIV/AIDS clinics, and aimed to provide the district government offices with technical assistance and financial support for HIV/AIDS services. The district level health government offices ran all HIV/AIDS services, apart from ART distribution, which was implemented by the provincial Ministry of Health.



**Figure 1** Organizational structure of national and local AIDS commissions

\* List of involved ministries: Ministry of Law & Human Rights, Ministry of Cultural & Tourism, Ministry of Education, Ministry of Youth & Sport, Ministry of Research & Technology, Ministry of Social Affairs, Ministry of Religion, Ministry of Communication & Informatics, Ministry of Manpower & Transmigration, Ministry of Transportation, Ministry of women Empowerment, Ministry of National Planning & Development.

\*\* List of involved government offices: Health Office, Social Office, Manpower & Transmigration Office, Education Office, Law & Human Rights Office, Tourism Office, Communication & Informatics Office, Youth & Sport Office, Religion Office.

\*\*\* Consists of AIDS Commission members and other HIV/AIDS experts from government institutions, universities, NGOs and most at risk populations.

### Strategic planning

The latest National AIDS Commission strategy (2010–14) aimed to guide strategic planning of the local AIDS commissions and divided actions into four programmes: prevention; care, support and treatment; impact mitigation; and policy and programme management and development. The West Java and Bandung strategic plans contained a wide range of activities (including the AIDS commission's co-ordination and technical assistance activities) without specific coverage targets. The West Java strategy presented in addition a task division of activities among implementing institutions. Afterwards, yearly plans were developed for HIV/AIDS control activities in West Java and Bandung, as well as for the AIDS commission's technical assistance activities, both based on meetings with AIDS commission members from government offices, NGOs and HIV clinics.

The West Java provincial and district AIDS commissions received technical assistance for strategic planning from higher level that consisted of training in the Asian Epidemic Model and Resource Needs Model tools. The development of the 5-year strategy was led by the staff of the AIDS commissions and the total process took 2 years in the West Java province and 8 months in Bandung city.

### Budget flows for HIV/AIDS control

In 2010, donors funded 59.8% of the HIV/AIDS programmes in Indonesia (UNGASS 2012). The National AIDS Commission received funding from the national budget (Anggaran Pendapatan Belanja Nasional) and from international donors (e.g. Global Fund and AusAid) for their co-ordination activities and to fund provincial AIDS commissions. The provincial and district AIDS commissions received funding for



co-ordination activities and programmes from the local budget (Anggaran Pendapatan dan Belanja Daerah), the National AIDS Commission and from international donors; they also channelled funds to local governments and NGOs on the basis of received proposals. National and international donors funded NGOs and health care facilities. To receive funding directly from the local government budget for the activities in the yearly strategic plan, all government institutions had to write proposals each year in January for the year after. The funding, available one and a half year later, was influenced by the local planning board (BAPPEDA), the mayor/governor and the Musrenbang. The latter is an annual event where citizens meet government offices and the planning board to discuss issues faced by their communities. Together, they decided on the general priorities for improvement within government sectors and not on specific funding for certain HIV/AIDS programmes (Ministry of National Development Planning 2012). Figure 2 presents an overview of the different flows of funding for HIV/AIDS programmes in West Java.

### Evaluation against the A4R framework

#### Relevance condition

A wide range of stakeholders was involved in strategic meetings; however, all respondents raised concerns about their HIV/AIDS expertise and contributions, due to frequent staff rotations, replacements, or low attendance of meetings.

Respondents recommended more involvement of religious leaders, the House of Representatives, and the governor. At the province level, respondents from NGOs expressed concern over not being invited to all meetings. The public was not explicitly involved in the priority setting process, but a respondent from the health government office at Bandung city level said that they were represented by the NGOs as they stand close to the community. A few PLWHA were involved directly as they represented NGOs that advocate for key affected populations such as IDUs or transgender.

*“The AIDS commission actually consists of all government offices, but not all come for the planning. In particular, the tourism government office rarely comes, is not really experienced, and doesn’t know what the role their office plays in HIV/AIDS control, and this creates confusion. However, tourism should be involved, because it regulates the places where the indirect female sex workers work, i.e. massage, karaoke, billiards, and sauna places.”—Bandung AIDS commission secretariat member*

Most respondents were confident that their party (i.e. NGOs, governments and health facilities) had the most influence in discussions during meetings. The government respondents said that they were most dominant in discussions because they run the health care system and co-ordinate HIV/AIDS surveillance, whereas respondents from NGOs and health care providers said

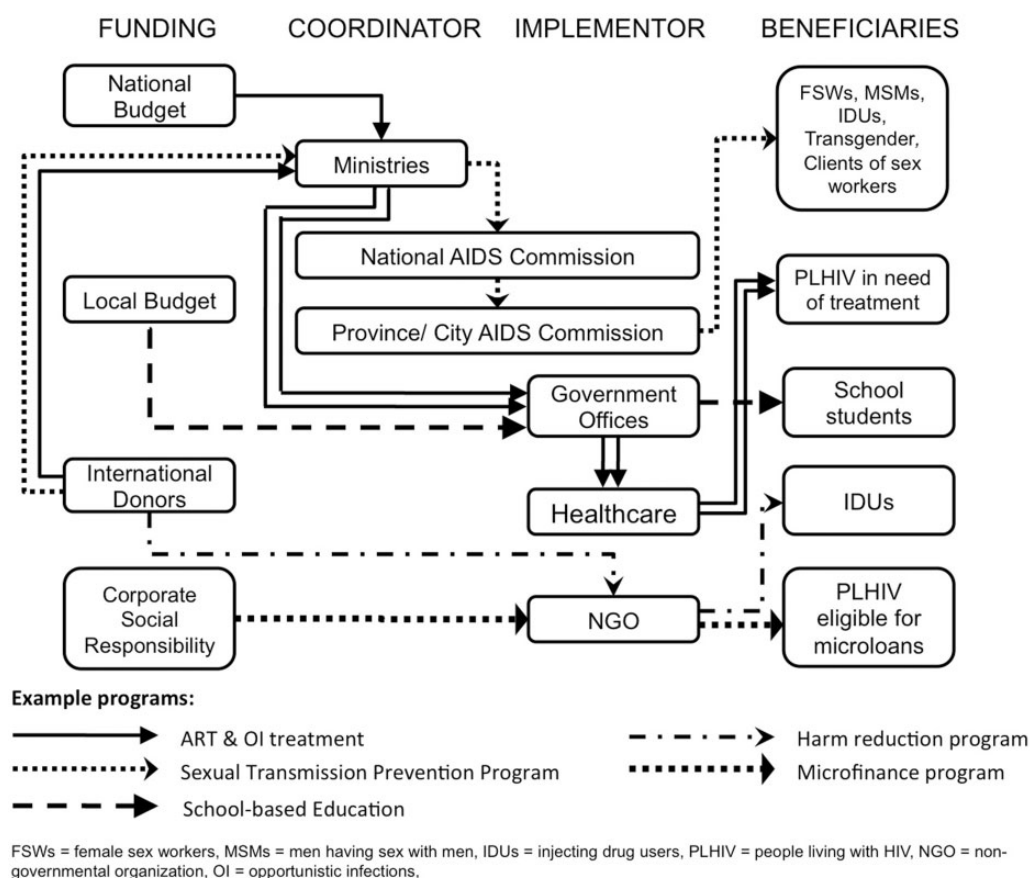


Figure 2 Funding flows for different HIV/AIDS programmes in the West Java province

that they had more power due to their field experience with high-risk groups and HIV/AIDS patients.

The most frequently mentioned reasons for including a programme in the strategic plan were (1) it being in line with the national strategy, (2) its impact on reducing the spread of the HIV epidemic, (3) its past effectiveness and (4) cultural, political and religious factors (Table 2).

*“In the past, we encouraged establishment of condom ATMs that provide free condoms in public places, but this did not go well because religious groups interpreted this differently. Therefore, we need to think of other ways to provide free condoms. The same also applies to clean needles for IDUs. Maybe a condom ATM is possible in a different culture, but not here.”*—Health Office staff member

Participants advocated for their own programmes because they believed that these programmes would work or would ensure receipt of funding from the local budget or international donors. At the city level, some programmes were prioritized for specific government offices (e.g. tourism and religion office) to improve their capacity to contribute to HIV/AIDS control.

Reasons for setting priorities were implicitly used during discussions and were not stated in the strategic plan. Data used included the number of HIV/AIDS cases per risk group as reported by the Ministry of Health, and the prevalence trends in these groups based on the Asian Epidemic Model projections. The budget impact of programmes was used to estimate the resources needed for HIV/AIDS control and not to prioritize programmes. In the discussions, participants were instructed to not be limited by budget limitations, but to propose all programmes that should be in the strategic plan.

*“We explain that the focus of programs is also shifting to the general population, by presenting data on the stabilizing HIV prevalence in IDUs”*—Provincial AIDS commissions secretariat member

#### Publicity condition

In Bandung, the 5-year strategic document was well distributed among stakeholders. Although the document was not directly published to the public, socialization meetings were held which were mainly attended by AIDS commission members but also a few sub-district leaders and health care providers. In these

**Table 2** Implicit criteria used for priority setting

Criteria	Example programme/situation
Bandung and West Java province level	
1 Current HIV/AIDS epidemic	HIV prevalence is stabilizing in IDUs and rising in FSW and MSM
2 Guidelines from provincial and national AIDS commissions	Predetermined programmes focus on four areas of intervention: prevention; care, support and treatment; impact mitigation; and policy and programme management development
3 Previous experiences of programme effectiveness	Proposal for new funding to upscale microcredit loans for PLWHA
4 Mix of local political, cultural and religious values	Sensitivity of condom distribution programmes
West Java province	
1 Feasibility related to current health care infrastructure	ART at community health centres is only partly established
2 Feasibility of reaching target groups	Clients of FSW are more difficult to reach than FSW/IDUs; programmes are started in families already familiar with HIV/AIDS
3 Likelihood of receiving local government budget funding	Preference for distribution of materials and products (e.g. condoms and ARVs)
4 Current programme coverage	Children living with HIV/AIDS have low coverage
5 Programmes enacted in the past	Socialization among policemen has been done and is no longer relevant
6 Focus on high-risk groups	Establishing IDU-friendly health services at public community health clinics (Puskesmas)
7 Programmes applicable in all cities in province	HIV–AIDS transmission through sexual transmission prevention programme (PMTS) funded by the Global Fund through National AIDS commissions
8 Draft already made by AIDS commission	Predetermined programme focuses on four areas of intervention: prevention; care, support and treatment; mitigation; and advocacy
9 Advocacy for own programmes	The prison staff advocates for programmes in prison; NGOs for premarital counselling
Bandung level	
1 Likelihood of donor funding	ARV distribution is funded by Global Fund
2 Non-existent programmes	Programmes to socialize the general population
3 Programmes for government offices with the least capacity for HIV/AIDS control	Tourism office should be involved due to sex tourism but is not yet active in HIV/AIDS control and capacity should be improved
4 Urgent situations	Rising number of HIV/AIDS orphans

PLWHA, people living with HIV/AIDS; ARV, antiretrovirals; IDUs, injecting drug users; FSWs, female sex workers; MSM, men having sex with men.

meetings, the process of strategic planning and the results were presented and division of tasks for implementation of programmes was discussed. Some respondents from NGOs stated that they were not aware of the yearly operational plans. At the province level, those involved in the meetings received the strategic document, but further dissemination to other stakeholders (e.g. local AIDS commissions) was limited.

Publication of the document was postponed for 1 year due to a change in format required by the local planning board to implement programmes at different government offices. The government offices seemed to have more complete information on the plans than that of the NGOs, as some stated that they were absent from follow-up meetings. At the province level, the strategic plan was published to the public through discussions on radio and television, and a press conference, but mostly examples of programmes were discussed and not the decision-making process and rationales for decisions. The public could access the strategic plan document by request at the AIDS commissions' office. One expert was concerned about whether the public was indeed aware of the programmes and the reasons for prioritization. At both levels, the reasons for programme prioritization were not published to stakeholders; however, some instances included underlying data to illustrate the reasons for setting priorities.

Publicity was also influenced by the sensitivity of programmes due to local political, cultural and social values. For example, the condom and MSM programmes are considered sensitive programmes and a challenge to the AIDS commission regarding open implementation.

*"The strategic document is not open regarding the details; we have to be cautious."*—Health Office staff member

#### **Appeals and revision condition**

During strategic planning, there were no formal (i.e. registered) mechanisms to deal with disagreements related to priority setting decisions. Participants at both city and province levels explained that there were enough opportunities to make appeals during meetings. Albeit, respondents from NGOs and health care institutions expressed concerns on whether appeals during meetings were taken into account and stressed the importance of lobbying for programmes. Respondents from NGOs and HIV clinics were not involved in all meetings and described their desire for better opportunities to make appeal.

*"Our complaint is that after the strategic planning meetings, our group was not invited again to see the new revised document and we didn't get any information on the result of the meeting. So we do not know what is going on and can therefore not comment on activities and plans"*—NGO worker

Respondents said that consensus was easily reached in meetings and voting was rarely used.

*"In the meeting, there is some discussion but there is no conflict at all. It is very easy to reach consensus. It is usually difficult to reach a consensus with the religious office, for example about condom distribution, but in Bandung city they did not make any appeal. They didn't say anything, the condom plan was there but they didn't disapprove it."*—Bandung AIDS commission secretariat member

After the final document was signed by the mayor or governor a formal appeal mechanism through the House of Representatives could be used by all stakeholders (including the public), but the respondents considered this process to be time consuming.

*"The public can make an appeal to the government about HIV/AIDS activities, but it is a dream. If you have comments or suggestions, you can send them through the House of Representatives and then they will discuss it internally. And then they will invite the Ministry of Health. But it will take a lot of time, and there are a lot of delays. Another option is to have demonstrations."*—NGO worker

#### **Enforcement condition**

There was no formal regulation to ensure that the first three A4R conditions were met. The National AIDS Commission recommends to follow the national guideline for strategic planning in Indonesia, which recommends a participatory and bottom-up process. Respondents expressed concerns about leadership, as the AIDS commission had to co-ordinate all parties and as well run their own programmes. Respondents stated that the Bandung mayor was more committed to HIV/AIDS control than the governor from West Java, because the former allocated a substantial budget (1 billion IDR or US\$ 104 177) to the Bandung AIDS commission for 2011.

*"The mayor of Bandung is the head of the AIDS commission and since he is very concerned with HIV/AIDS, he allocated one billion Indonesian Rupiah (US\$ 100000) to the Bandung AIDS commission in 2010. This money was used to improve the capacity of government offices to start creating HIV/AIDS programs."*—Bandung AIDS commission secretariat member

The secretariat of the AIDS commissions described co-ordination challenges due to the number of parties involved, their lack of commitment and the inefficient annual funding procedure for programmes in the government offices. Figure 2 shows the complexity of funding flows of different HIV programmes in West Java programmes. The strategic plans, including task divisions, were only guidelines and government offices and NGOs were not obligated to implement the programmes. Furthermore, it was expressed that additional priority setting processes were required, as the budget received by the government offices from the local budget was insufficient for all proposed activities. In 2012, a provincial local HIV/AIDS regulation was launched that enables enforcement of decisions made by provincial stakeholders in all districts (Governor West Java 2012). For example, if the provincial health office aims to scale up testing services in the province, they can instruct the districts to install testing facilities in all community clinics.

## **Discussion**

Here, we evaluated the priority setting process for HIV/AIDS control at the decentralized level in West Java, using the A4R framework. Our results show that structures are in place for

most A4R conditions, but improvements are needed to ensure fair priority setting.

In evaluating relevance, we found that AIDS commissions in Indonesia involved multi-sectorial stakeholders. Indonesia performs better on this condition compared with other countries that have only limited stakeholder involvement in decision making (Kapiriri *et al.* 2007; Greenberg *et al.* 2009; Maluka *et al.* 2010; Mori and Kaale 2012). However, governmental institutions might not be as legitimate as possible, as the quality of stakeholder involvement especially the public and PLWHA seems to be limited. At this moment, the public's values are not reflected and the views of PLWHA mainly through NGO representatives. For public involvement, various methods exist although the effectiveness has hardly been evaluated. (Abelson *et al.* 2003; Mitton *et al.* 2009; Alderman *et al.* 2013). Therefore, we recommend investigating the appropriateness of public engagement mechanisms in the context of Indonesia including the existing 'Musrenbang' mechanism. Sometimes involved stakeholders (from governments, NGOs and HIV clinics) lacked commitment and HIV expertise, partly due to the frequent staff rotations in Indonesia, and the dominant role of donors in HIV/AIDS control (Desai *et al.* 2010). Moreover, HIV/AIDS could be a low priority for policy makers due to the low burden compared with other diseases (World Health Organization 2012). Also for PLWHA, although they seemed to be involved through the NGOs, the quality should be further investigated and ensured in planning processes as stakeholder understanding, acceptance and satisfaction are important for successful priority setting (Sibbald *et al.* 2009). Ideally, all relevant stakeholders should be involved in all steps of the process; however, this is challenging due to the high number of parties related to HIV/AIDS control and most efficient ways should be determined.

Programme inclusion in the strategic plan was based on many different reasons, which were not explicitly explained, reducing the transparency of strategic decisions. Daniels (2008) states that criteria that fair-minded people agree with are relevant for priority setting. However, as this is hard to operationalize we propose to use the World Health Organization health systems framework as a conceptual underlying framework for selection of criteria for priority setting which was put forward by Tromp and Baltussen (2012). Based on the framework, the criteria 'reducing the impact of the epidemic', 'past effectiveness' and 'cultural, political and religious barriers' used implicitly in West Java seem to be valid reasons for priority setting. It is debatable whether 'alignment with national/provincial strategy' should be used, as policy making should be context-based and higher-level policies could be incompatible with the situation at the local level. However, in the context of Indonesia's political system and culture, it might be inappropriate to ignore higher-level instructions and it would be not feasible on the short term to start provincial programmes instead of aligning with the national programmes and related policies. (Hofstede 2001; Heywood and Harahap 2009). For all criteria, improved use of (scientific) evidence could help systematically compare programmes for priority setting, which should be guided by more evidence than only the HIV prevalence in risk groups. The strategic document scarcely prioritizes programmes, but primarily functions as a guideline presenting all possible activities. The Indonesian culture has a strong community system, and

therefore it is an important norm to take care of everyone (Hofstede 2001). However, the small budget necessitates priority setting rather than trying to do everything for everybody (Baltussen 2006).

In evaluating publicity, we found that despite dissemination meetings and media exposure, respondents were not aware of all decisions and the reasons. Explanation of strategic decisions is difficult and should be done using easily understandable language. In West Java, especially for the public, the current strategic plans seem difficult to understand as it contains technical HIV/AIDS and law terminology. Sparse publication of reasons is seen in all countries that have conducted A4R evaluations (Kapiriri *et al.* 2007; Greenberg *et al.* 2009; Maluka *et al.* 2010; Tuba *et al.* 2010; Youngkong *et al.* 2012a) and we recommend to develop a formal publicity plan in West Java to effectively inform all stakeholders. Finding more effective methods for communicating policy decisions for HIV/AIDS control in Indonesia to different types of stakeholders could help improve the transparency of the process. It should be evaluated whether the current publication mechanisms to the public through sub-district leaders (already involved in HIV programmes) are effective and potentially can be expanded to all leaders. As social media is extensively used in Indonesia and is a low cost communication channel, this might be an efficient way to inform the public and we recommend investigating its potential. The Citizens AIDS (Warga Peduli AIDS) programme of the city AIDS commission establishes organizations comprised of local sub-district leaders, which could potentially inform the public about strategic decisions; however, this may require substantial resources (Kurniawan 2011). Lack of openness on sensitive issues, such as condom distribution and MSM programmes, reduces policy making transparency; however, this is difficult to change due to Indonesia's cultural values (Hofstede 2001). Still, options for improved transparency regarding sensitive programmes should be investigated. Furthermore, delays in strategy development should be prevented, as they prevent timely informing of stakeholders.

Our evaluation of appeals and revision revealed that, although no formal mechanisms are installed in the strategic planning, respondents feel that they can appeal and reach consensus through discussions during the process. This is in line with the five principles of Pancasila (Indonesia's state principles introduced by president Sukarno in 1945) that name democracy as a core value, and state that disagreements should be resolved through discussions, with a voting procedure considered a last option (Sukarno 1945). The general formal process through the House of Representatives seems to be insufficient as it is time-consuming and not specifically for HIV/AIDS policies. Some respondents said that the dominant use of lobbying harms the transparency of the decisions. Therefore, the use of appeals and revision mechanisms should be more transparent and formally reported and we recommend holding a survey among stakeholders to propose the most appropriate mechanism in the context of Indonesia. Still, it is difficult to judge whether selected mechanisms by stakeholders will also be the most appropriate ones to contribute to fair priority setting. Although stakeholders might perceive giving opinions during meetings a proper mechanism, dominance in discussions is excessive in Indonesia which affects opportunities for appeals



and the fairness of the priority setting process. In countries that have undergone A4R evaluation, formal appeals and revisions mechanisms are seen in high-income countries (Norway and Canada) but not in low- and middle-income countries (Tanzania, Uganda and Thailand), with the exception of Israel, which also has no formal mechanism (Kapiriri *et al.* 2007; Greenberg *et al.* 2009; Maluka *et al.* 2010; Tuba *et al.* 2010; Mori and Kaale 2012; Youngkong *et al.* 2012a).

Our evaluation of enforcement revealed that formal regulations for ensuring fairness of decision making were apparent, as observed in other A4R-evaluated countries (Kapiriri *et al.* 2007; Greenberg *et al.* 2009; Maluka *et al.* 2010; Tuba *et al.* 2010; Mori and Kaale 2012; Youngkong *et al.* 2012a). Therefore, we recommend that the National AIDS Commission develops guidelines for HIV strategic planning in Indonesia that incorporate the four conditions of A4R and that the local AIDS commissions will be trained to use these. With regard to implementation, we found that the HIV/AIDS control funding system is fragmented and that the preference of individual institutions determines the programme implementation and the actual priority setting. Ideally, all funding should be pooled and assigned by one decision body. However, this would require a total reorganization of Indonesia's HIV/AIDS control, and necessitate the agreement of international donors to not earmark funding for specific HIV/AIDS programmes. As an alternative, we recommend openness regarding the available local government budget for HIV/AIDS activities and the commitment of every local government department to execute activities. With regard to leadership, our investigation revealed more effective organization of HIV/AIDS control at the Bandung level than at the provincial level. This could be related to greater commitment and leadership of Bandung's mayor than West Java's governor. The importance of leadership in priority setting has been proven in a hospital setting, but has not yet been investigated on provincial or national government levels (Reeleder *et al.* 2006).

To our knowledge, extensive evaluations of priority setting processes within and outside the HIV/AIDS field in settings outside of West Java province have not yet been done. The deficits identified in the four A4R conditions are not limited to HIV/AIDS control but may represent a structural problem of accountability in government institutions in Indonesia (Heywood and Harahap 2009). Many districts have not yet developed the capacity to plan and manage their health budgets, to identify local health needs with use of available knowledge and to set targets and monitor progress (Overseas Development Institute 2011).

Also for settings outside Indonesia, implementation of the A4R framework will be instrumental to improve priority setting processes. It will empower institutions to systematically and continuously evaluate the quality of the process against the four A4R conditions. The framework will help to identify all relevant stakeholders and criteria for priority setting, to increase the uptake of evidence in decision making and to identify and implement formal mechanisms for appeal and publicity. Implementation of the framework may also lead to better health outcomes as with better use of evidence the programmes with highest health impact might get priority.

Although our findings of the Indonesian case should be generalized with caution, it provides lessons for the pitfalls that institutions in other settings may encounter and should overcome during implementation of the A4R framework. An essential component of any successful implementation of A4R is leadership and this should be ensured. Embedding of the priority setting process in a government regulation may improve commitment and participation of institutions. All relevant stakeholders should participate in the process, and effective and context-based mechanisms should be used to involve the public and PLWHA. Dominance in discussions should be solved with culturally accepted measures. To optimize the democratic learning process, we recommend that the same person who represents an institution participates in all meetings.

We learned from the West Java case that formal appeal mechanisms should be installed, which are considered effective by the stakeholders. Also, no technical terminology should be used so that the public and PLWHA have opportunity to appeal. Stakeholders should be involved that have power to allocate resources to the prioritized programmes. Ideally, resources should be pooled as a fragmented system increases the risk that high priority programmes are not funded. To improve understanding and acceptance of the framework, local government capacity should be established to facilitate priority setting processes. The government could be supported by local universities for education on the framework and facilitation of the process.

To further improve fairness and legitimacy in strategic planning, we recommend the use of an integrated multi-criteria decision analysis and A4R approach recently put forward by Baltussen *et al.* (2013). Both methods have been successfully applied in various countries but have potentially more impact in complementing each other (Baltussen *et al.* 2007; Kapiriri *et al.* 2007; Jehu-Appiah *et al.* 2008; Greenberg *et al.* 2009; Maluka *et al.* 2010; Tuba *et al.* 2010; Youngkong *et al.* 2012a,b; Mori and Kaale 2012). This method starts a (long term) democratic learning process and includes all relevant stakeholders, identifies a comprehensive set of rational criteria for priority setting and, uses evidence to compare the performance of all programmes on those criteria. The method has not been tested in the context of Indonesia and this is a topic for further study.

### Study limitations

From our present study results, we can identify a few risks for biases. Our respondents were selected through purposive sampling, which might have caused selection bias. We also did not interview the public directly, which limited our ability to verify whether they think the strategies are well published and whether they had adequate ability to appeal. Some respondents could have given politically correct answers; however, we received many critical opinions of the process, indicating that they felt free to respond honestly. The meetings took place a few years before the interviews, which could have caused recall bias.

### Conclusion

To increase the fairness and legitimacy of HIV/AIDS priority setting, West Java should make improvements on all conditions

of the A4R framework. More specifically, explicit priorities should be made among HIV/AIDS programmes, with the use of explicit criteria that are transparent for and agreed upon by all involved stakeholders. Although many stakeholders participate in the priority setting process, the quality of their involvement should be ensured, especially regarding PLWHA and the public. An improved publication strategy should be developed and implemented to inform stakeholders about decisions. The use of appeals and revision mechanisms should be more transparent and formally stated. Finally, public regulations should be developed to ensure that fair priority setting processes in HIV control will be installed.

## Acknowledgements

The authors gratefully thank University Padjadjaran and the AIDS commissions West Java and Bandung for supporting their research. At the Padjadjaran University they would like to thank Professor Tri Hanggono Achmad (Dean of Medical Faculty Padjadjaran University), Dr M. Rizal Chaidir (Director of Hasan Sadikin General Hospital), Dr Bachtis Alisjahbana (Head of Health Research Unit Padjadjaran University) and Dr Ardini Raksanagara (Head Public Health Department). At West Java AIDS commission, they would like to thank Mr Arry Lesmana and Mr Pantjawidi. At Bandung AIDS commission, they would like to thank Mr Songka and Ms Sis. They would like to thank Dr Bagus Rahmat Prabowo from the World Health Organization Indonesia for his advice.

## Funding

The work was supported by the Radboud University Medical Center. The funding agreement ensured the authors' independence in designing the study, interpreting the data and, writing and publishing the report.

*Conflict of interest statement:* None declared.

## References

- Abelson J, Forest P, Eyles J *et al.* 2003. Deliberations about deliberative methods: issues in the design and evaluation of public participation processes. *Social Science & Medicine* **57**: 239–51.
- AIDSdatahub. 2013. *Indonesia Country Profile 2013*. <http://www.aidsdatahub.org/en/country-profiles/indonesia>, accessed 13 January 2014.
- Alderman K, Hipgrave D, Jimenez-Soto E. 2013. Public engagement in health priority setting in low- and middle-income countries: current trends and considerations for policy. *PLoS Medicine* **10**: 8.
- Baltussen R. 2006. Priority setting of public spending in developing countries: do not try to do everything for everybody. *Health Policy* **78**: 149–56.
- Baltussen R, Mikkelsen E, Tromp N *et al.* 2013. Balancing efficiency, equity, feasibility of HIV treatment in South Africa—development of programmatic guidance. *Cost Effectiveness and Resource Allocation* **11**: 1.
- Baltussen R, Niessen L. 2006. Priority setting of health interventions: the need for multi-criteria decision analysis. *Cost Effectiveness and Resource Allocation* **4**: 14.
- Baltussen R, ten Asbroek AH, Koolman X *et al.* 2007. Priority setting using multiple criteria: should a lung health programme be implemented in Nepal? *Health Policy and Planning* **22**: 178–85.
- Bandung AIDS Commission. 2007. *Strategy for HIV and AIDS Program in Bandung 2007–2011*. Bandung: Bandung AIDS Commission.
- Chalkidou K, Levine R, Dillon A. 2010. Helping poorer countries make locally informed health decisions. *British Medical Journal* **341**: c3651.
- Daniels N. 2002. *Setting Limits Fairly: Can We Learn to Share Medical Resources?* New York: Oxford University Press.
- Daniels N. 2008. *Just Health: Meeting Health Needs Fairly*. Cambridge: Cambridge University Press.
- Daniels N, Sabin J. 1997. Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers. *Philosophy and Public Affairs* **26**: 303–50.
- Daniels N, Sabin J. 1998. The ethics of accountability in managed care reform. *Health Affairs (Millwood)* **17**: 50–64.
- Desai M, Rudge JW, Adisasmito W, Mounier-Jack S, Coker R. 2010. Critical interactions between Global Fund-supported programmes and health systems: a case study in Indonesia. *Health Policy and Planning* **25(Suppl.1)**: i43–7.
- Governor West Java. 2012. *West Java Provincial Regulation No. 12 of 2012 on the Prevention and Control of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)*.
- Greenberg D, Siebzehner MI, Pliskin JS. 2009. The process of updating the National List of Health Services in Israel: is it legitimate? Is it fair? *International Journal of Technology Assessment in Health Care* **25**: 255–61.
- Guindo LA, Wagner M, Baltussen R *et al.* 2012. From efficacy to equity: literature review of decision criteria for resource allocation and healthcare decisionmaking. *Cost Effectiveness and Resource Allocation* **10**: 9.
- Heywood P, Harahap NP. 2009. Public funding of health at the district level in Indonesia after decentralization—sources, flows and contradictions. *Health Research Policy and Systems* **7**: 5.
- Hofstede G. 2001. *Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations across Nations*. 2nd edn. Thousand Oaks, CA: Sage Publications.
- Jehu-Appiah C, Baltussen R, Acquah C *et al.* 2008. Balancing equity and efficiency in health priorities in Ghana: the use of multicriteria decision analysis. *Value Health* **11**: 1081–7.
- Kapiriri L, Norheim OF, Martin DK. 2007. Priority setting at the micro-, meso- and macro-levels in Canada, Norway and Uganda. *Health Policy* **82**: 78–94.
- Kapiriri L, Norheim OF, Martin DK. 2009. Fairness and accountability for reasonableness. Do the views of priority setting decision makers differ across health systems and levels of decision making? *Social Science & Medicine* **68**: 766–73.
- Kurniawan M. 2011. Active Participation of 30 Sub-Districts “WPA” in Bandung City on HIV-AIDS Response. *Poster presentation ICAAP10 Conference*. Busan. [http://www.icaap10.org/program/program\\_08.asp?sMenu=pro8](http://www.icaap10.org/program/program_08.asp?sMenu=pro8), accessed 13 January 2014.
- Maluka S, Kamuzora P, San Sebastian M *et al.* 2010. Decentralized health care priority-setting in Tanzania: evaluating against the accountability for reasonableness framework. *Social Science & Medicine* **71**: 751–9.
- Ministry of National Development Planning. 2012. *Effective Public Spending: The Case of Infrastructure*. Presentation on 2012 OECD Global Forum on Development. <http://www.oecd.org/site/oecdgfd/49793186.pdf>, accessed 13 January 2014.
- Mitton C, Donaldson C. 2004. Health care priority setting principles, practices and challenges. *Cost Effectiveness and Resource Allocation* **2**: 3.

- Mitton C, Smith N, Peacock S, Evoy B, Abelson J. 2009. Public participation in health care priority setting: a scoping review. *2009. Health Policy* **91**: 219–28.
- Mori AT, Kaale EA. 2012. Priority setting for the implementation of artemisinin-based combination therapy policy in Tanzania: evaluation against the accountability for reasonableness framework. *Implementation Science* **7**: 18.
- National AIDS Commission. 2009. *Strategy of the National Action Plan for HIV/AIDS 2010–2014*. Jakarta: National AIDS Commission. <http://www.aidsindonesia.or.id/elib/home/detail/240>, accessed 13 January 2014.
- National AIDS Commission. 2011. *Guide on the Organization and Function of the Local AIDS Commissions*.
- Overseas Development Institute. 2011. *The Political Economy of Policy-Making in Indonesia. Opportunities for Improving the Demand and Use of Knowledge*. London: Overseas Development Institute.
- Reeleder D, Goel V, Singer PA, Martin DK. 2006. Leadership and priority setting: the perspective of hospital CEOs. *Health Policy* **79**: 24–34.
- Sibbald SL, Singer PA, Upshur R, Martin DK. 2009. Priority setting: what constitutes success? A conceptual framework for successful priority setting. *BMC Health Services Research* **9**: 43.
- Sukarno K. 1945. Lahirnya Pancasila (“the birth of Pancasila”) speech, Yogyakarta.
- Suzetta P. 2007. *Perencanaan Pembangunan Indonesia [Indonesian Development Planning]*. <http://ditpolkom.bappenas.go.id/basedir/Artikel/094.%20Perencanaan%20Pembangunan%20Nasional%20-%20Paskah%20Suzetta%20%2822%20Maret%202007%29.pdf>, accessed 13 January 2014.
- Tromp N, Baltussen R. 2012. Mapping of multiple criteria for priority setting of health interventions: an aid for decision makers. *BMC Health Services Research* **12**: 454.
- Tuba M, Sandoy IF, Bloch P, Byskov J. 2010. Fairness and legitimacy of decisions during delivery of malaria services and ITN interventions in Zambia. *Malaria Journal* **9**: 309.
- UNGASS. 2012. *Republic of Indonesia Country Report on the Follow up to the Declaration of Commitment on HIV/AIDS. Reporting Period 2010–2011*. Jakarta: National AIDS Commission.
- West Java AIDS Commission. 2009. *Strategy for HIV and AIDS Program in West Java Province 2009–2013*. Bandung: West Java AIDS Commission.
- West Java AIDS commission. 2013a. *Estimation on HIV Prevalence Based on Asian Epidemic Model Version 2013*. Bandung: West Java AIDS Commission.
- West Java AIDS commission. 2013b. *Local Monitoring Data on Coverage of Various HIV/AIDS Programs. 2013*. Bandung: West Java AIDS Commission.
- World Health Organization. 2012. *Indonesia Country Profile 2012*. <http://www.who.int/countries/idn/en/>, accessed 13 January 2014.
- Youngkong S, Baltussen R, Tantivess S, Mohara A, Teerawattananon Y. 2012a. Multicriteria decision analysis for including health interventions in the universal health coverage benefit package in Thailand. *Value Health* **15**: 961–70.
- Youngkong S, Teerawattananon Y, Tantivess S, Baltussen R. 2012b. Multi-criteria decision analysis for setting priorities on HIV/AIDS interventions in Thailand. *Health Research Policy and Systems* **10**: 6.