Perceptions of and barriers to HIV testing of women in Indonesia

(Penulis pertama dan Korespondensi), Scopus Q2

https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1848003

[korespondensi dalam system]

History for Manuscript Number: ZRHM-2019-0193 - Google Chrome

editorialmanager.com/zrhm/DotNetPopUps/AuthorCorrHist.aspx?docID=1139&msid={A46C5E0C-9879-451C-AA0E-A56F486E7916}

History for Manuscript Number: ZRHM-2019-0193

Close

Correspondence History

Correspondence Date	Letter	Recipient	Revision
Nov 05, 2020	Editor Decision - Accept	Najmah -, Ph.D.	3
Oct 13, 2020	Author Sends Attachment to Editor	ZRHM-peerreview@journals.tandf.co.uk	3
Jul 22, 2020	Author Submits Revision Confirmation	Najmah -, Ph.D.	3
Jul 22, 2020	PDF Built and Requires Approval	Najmah -, Ph.D.	3
Jul 17, 2020	Editor Decision - Conditional Accept	Najmah -, Ph.D.	2
Jun 11, 2020	Author Submits Revision Confirmation	Najmah -, Ph.D.	2
Jun 11, 2020	PDF Built and Requires Approval	Najmah -, Ph.D.	2
Jun 09, 2020	Author Sends Attachment to Editor	ZRHM-peerreview@journals.tandf.co.uk	2
May 20, 2020	Editor Decision - Major Revision	Najmah -, Ph.D.	1
Apr 24, 2020	Author Submits Revision Confirmation	Najmah -, Ph.D.	1
Apr 24, 2020	PDF Built and Requires Approval	Najmah -, Ph.D.	1
Mar 12, 2020	Author Notice - Due date for revision extended	Najmah -, Ph.D.	0
Mar 12, 2020	Author Requests Deadline Extension on Revision	ZRHM-peerreview@journals.tandf.co.uk	0
Mar 04, 2020	Editor Decision - Major Revision	Najmah -, Ph.D.	0
Dec 23, 2019	Author Returns Unsubmitted Paper Confirmation	Najmah -, Ph.D.	0
Dec 23, 2019	PDF Built and Requires Approval	Najmah -, Ph.D.	0
Dec 23, 2019	PDF Built and Requires Approval	Najmah -, Ph.D.	0
Dec 22, 2019	Author Notice - EM Technical Check failure	Najmah -, Ph.D.	0
Dec 18, 2019	Author Submits New Manuscript Confirmation	Najmah -, Ph.D.	0
Dec 18, 2019	PDF Built and Requires Approval	Najmah -, Ph.D.	0
Dec 18, 2019	PDF Built and Requires Approval	Najmah -, Ph.D.	0

Activate Windows
Go to Settings to activate Windows.

[masukan dari reviewer 1 dan 2]

View Letter - Google Chrome

editorialmanager.com/zrhm/ViewLetter.aspx?id=31051&lsid=672eb2c9-e277-4e96-a180-3ace5c5828f7&prod=&sgTask=0&cm=

View Letter

Close

Date: Mar 04, 2020
To: "Najmah Najmah" najem240783@gmail.com
From: "Sexual and Reproductive Health Matters" ZRHM-peerreview@journals.tandf.co.uk
Subject: Decision on your submission (ZRHM-2019-0193) to Sexual and Reproductive Health Matters
Attachment(s): ZRHM-2019-0193_reviewer track changes.docx
SRHM HIV positive married women testing- review.pdf

Ms. Ref. No.: ZRHM-2019-0193
Title: "I told you so, doctor! It is not possible for my wife to get infected with HIV":
HIV testing (or not) among married women in Indonesia
Corresponding Author: Mrs Najmah Najmah
Sexual and Reproductive Health Matters

Dear Najmah Najmah,

Thank you for your submission to Sexual and Reproductive Health Matters. The evaluation and peer review of your manuscript are now complete. Your paper addresses an interesting and important question and we would like to consider your manuscript further. However, the reviews brought to light some important concerns that will need to be addressed in a revised version before the article can be considered again. The reviewers' comments are provided below. In addition, please address the following points:

- Please ensure that the report is sufficiently framed within a UHC context
- Please include a statement on informed consent for participation
- Please provide more detail/citation of the "larger study"
- Please ensure that all potential study limitations are discussed in full in the discussion section

Although we cannot offer acceptance of this manuscript in its current form, carefully revising the manuscript to address the reviewers' concerns will increase your chances for acceptance. Please include changes to the body of your narrative according to the reviewers' concerns. Clearly mark (using track changes or highlighting text) each change in your revised manuscript. Your revision should include a separate document, briefly explaining, point by point, how your manuscript was changed to address the concerns of each of the reviewers, and indicating where you have made changes in the manuscript. Once we have received your revision, we may return it to the reviewers for re-evaluation.

Please submit your revision by Mar 25, 2020 by going to https://www.editorialmanager.com/zrhm/ and logging in as an Author. You will see the menu item [Submissions Needing Revision]. You will find your submission record there.

I look forward to receiving your revised manuscript.

Activate Windows
Go to Settings to activate Windows.

View Letter - Google Chrome

editorialmanager.com/zrhm/ViewLetter.aspx?id=33219&lid=693db75e-3b7a-40db-9eff-ca0e2f363258&prod=&sgTask=0&cm=

View Letter

Close

Date: Apr 24, 2020
To: "Najmah Najmah" najem240783@gmail.com
From: "Sexual and Reproductive Health Matters" ZRHM-peerreview@journals.tandf.co.uk
Subject: Submission Confirmation for ZRHM-2019-0193R1

Ms. Ref. No.: ZRHM-2019-0193R1
Title: "I told you, doctor! It's not possible for my wife to get HIV":
HIV testing (or not) among married women in Indonesia
Corresponding Author: Mrs Najmah Najmah
Sexual and Reproductive Health Matters

Dear Najmah Najmah,

Thank you for revising your submission following comments from the guest editors on this issue. We will now send the paper out for peer review.

This notice is coming to you via the publisher's online submission system. If the system generates further emails at this point, no further action should be required from you at present as you have already sent your revised manuscript to Sexual and Reproductive Health Matters. We will resubmit this to the system by proxy on your behalf. However, if you wish to confirm anything, please do not hesitate to send a message in response to this email, or directly to me at editorial@rhmjournal.org.

You may check the status of your manuscript by logging onto Editorial Manager at (https://www.editorialmanager.com/zrhm/).

Best wishes

Pathika

Pathika Martin
Editorial Office
Sexual and Reproductive Health Matters

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/zrhm/login.asp?a=r). Please contact the publication office if you have any questions.

Activate Windows
Go to Settings to activate Windows.

Close

Decision on your submission (ZRHM-2019-0193R1) to Sexual and Reproductive Health Matters

Inbox ×

Sexual and Reproductive Health Matters <em@editorialmanager.com> May 20, 2020, 5:29 PM
to me

Ms. Ref. No.: ZRHM-2019-0193R1
Title: "I told you, doctor! It's not possible for my wife to get HIV":
HIV testing (or not) among married women in Indonesia
Corresponding Author: Mrs Najmah Najmah
Sexual and Reproductive Health Matters

Dear Najmah Najmah,

Thank you for your submission to Sexual and Reproductive Health Matters. The evaluation and peer review of your manuscript are now complete. Your paper addresses an interesting and important question and we would like to consider your manuscript further. However, the reviews brought to light some important concerns that will need to be addressed in a revised version before the article can be considered again. The reviewers' comments are provided below.

Although we cannot offer acceptance of this manuscript in its current form, carefully revising the manuscript to address the reviewers' concerns will increase your chances for

Please submit your revision by Jun 10, 2020 by going to https://www.editorialmanager.com/zrhm/ and logging in as an Author. You will see the menu item [Submissions Needing Revision]. You will find your submission record there.

I look forward to receiving your revised manuscript.

Yours sincerely

Pete Chapman
Managing Editor
Sexual and Reproductive Health Matters

Editor/Reviewer comments:

Editor:
- Please consider rewording the title (e.g. Perceptions of and barriers to HIV testing among married women in Indonesia)
- A statement specifying that informed consent for participation in the present research was obtained (not just asked for) must be included in the methods
- Please move the ethics approval statements (including approval numbers) to the methods section of the manuscript

Reviewer #1: Dear Authors

Thank you for addressing many of my comments on your first draft. The paper is much improved and reads well. As I mentioned previously, this is an important paper and it fits the SRHM special issue on UHC and Sexual and Reproductive Rights. I have some recommendations for minor revisions that will make the paper even stronger.

The Introduction includes a clear identification of the problem and you say what you will do in the paper. Important statistics and other information have been added since the 1st draft.

The Methodology section is much more informative than in the first draft. The pilot, field research and data analysis are clearly explained with sufficient detail to assess reliability and validity of research and to evaluate your use of a Feminist Participatory Approach that is well suited to your research goals. You still do not provide any rationale for why Palembang was selected for this study.

I recommend that you include a rationale for your site selection of Palembang in your Methodology section.

The Results and Discussion reflect the comprehensive analysis described in the Methodology section. The analysis is well structured and convincing and important issues are identified that demand the attention of policy makers and health providers. Central to your analysis is the comment made on p. 12 line 5: 'Men's support is key to women's reproductive health and the prevention of STIs and HIV transmission from mother to child.' You also make an excellent point about testing for men and how and why this is apparently not even considered by healthcare workers, including the obstetrician Dr Didi. I'm not sure you provide enough evidence to back the statement that STI is always considered the woman's fault. Is this related to Islam? To the idealized image of the Ibu Rumah Tangga - and where does that idealized image come from?

I recommend you strengthen the evidence for STIs always being considered the woman's fault in Indonesia.

I recommend that you include a direct quotation from Nika - perhaps at p. 14 lines 8-17.

I have the following suggestions to improve the text:

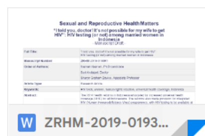
p.3 lines 21 - 27: suggested rewording to clarify the contrast between Indonesia and Sub-Saharan Africa that the authors draw attention to- original is unclear:
'Mothers and children have long been the populations at highest risk of HIV in Indonesia leading to a focus on prevention of mother-to-child transmission. This is in contrast to 21 sub-Saharan African countries where HIV is prevalent within their general population.'

p.3 lines 51-55: please state date of Muhaimin and Besral (9) study (2011), the date of their predicted estimates and the date of your study so the reader can make sense of this statement. How do you explain the gap between the study estimate of 9,000 and your estimate of 1,000 new HIV cases in children each year?
p. 4 line 10: suggested edit 'several international conventions'
p. 4 line 23: define generalized and concentrated epidemics
p.4 line 39: what do you mean by a service? At a puskesmas? At a district hospital? 30 sound like a very small number for a country the size of Indonesia. Perhaps you could indicate the number of sub-districts providing these services?
p.4 line 40: Are the 547 VCT services part of the 30 PMCMT services?
p.4 line 42: promoted by whom? At the global level or in Indonesia?
p.5 line 4: So in all provinces? Perhaps say 'in all 34 provinces'
p. 5 line 21: Are you referring only to bidan? What about dukun bayi? Do/can they play a role in referral?
p. 5 line 25: aren't midwives healthcare providers? Or do you mean specifically providers of VCT?
p. 5 line 52: isn't HIV a sexually transmitted infection? Do you mean 'other sexually transmitted infections? Or do you mean 'not on mother-to-child transmission of HIV'?
p. 5 line 54: For clarity, instead of 'This study implies….' I suggest 'Our study regarded participants as experts….'
p. 7 line 6: For clarity, I suggest the following order: 6 were widows. The remaining 12 were married. Of these 8 were in their 2nd marriage, their former husband having died from HIV

Reviewer #3: Please see comments in the uploaded manuscript. I think the MS is improved in terms of evidence and methodology, but there are still a few things to improve and consider. I think it needs some sort of discussion to wrap up rather than going straight to recommendations. Why don't reproductive rights guide the HIV response in Indonesia?

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanage om/zrhm/login.asp?a=r). Please contact the publication office if you have any questions.

One attachment • Scanned by Gmail



ZRHM-2019-0193...

[komentar dari reviewer]

[judul diubah sesuai masukan reviewer]

View Letter - Google Chrome

editorialmanager.com/zrhm/ViewLetter.aspx?id=37561&lsid=268bac62-de74-425a-a675-6b7dbae1817a&prod=&sgTask=0&cm=

View Letter

Close

Date: Jul 17, 2020
To: "Najmah Najmah" najem240783@gmail.com
From: "Sexual and Reproductive Health Matters" ZRHM-peerreview@journals.tandf.co.uk
Subject: (Sexual and Reproductive Health Matters) A revise decision has been made on your submission

Ms. Ref. No.: ZRHM-2019-0193R2
Title: Perceptions of and barriers to HIV testing among married women in Indonesia
Corresponding Author: Mrs Najmah Najmah
Sexual and Reproductive Health Matters

Dear Najmah Najmah,

Your manuscript "Perceptions of and barriers to HIV testing among married women in Indonesia" has now been reviewed. Please make revisions in line with the reviews and our own suggestions. Please mark all your changes in the manuscript using track changes or the highlight function.

Comments from the editor and the reviewers can be found below.

Please revise the manuscript and submit it through our Editorial Manager system by Aug 07, 2020.

You can access the system at https://www.editorialmanager.com/zrhm/.

Thanks again for submitting your work to Sexual and Reproductive Health Matters.

Kind regards

Pete Chapman
Managing Editor
Sexual and Reproductive Health Matters

Editorial comments:
- The dates of ethics approval are listed as 7 and 15 March 2017, whereas the field research began in February 2017. Please could you clarify this?

Reviewers' comments:
Reviewer #1: Dear Authors
Thank you for addressing all of the comments I made on your second draft.
Your reframing of the Introduction is now much clearer and you provide adequate evidence and supporting literature to make your arguments.
The Methodology includes all needed information, is clear and convincing. I especially appreciate the details of

Activate Windows
Go to Settings to activate Windows.

(Sexual and Reproductive Health Matters) A revise decision has been made on your submission Inbox ×

Sexual and Reproductive Health Matters <em@editorialmanager.com> Fri, Jul 17, 2020, 8:49 PM
to me

Ms. Ref. No.: ZRHM-2019-0193R2
Title: Perceptions of and barriers to HIV testing among married women in Indonesia
Corresponding Author: Mrs Najmah Najmah
Sexual and Reproductive Health Matters

Dear Najmah Najmah,

Your manuscript "Perceptions of and barriers to HIV testing among married women in Indonesia" has now been reviewed. Please make revisions in line with the reviews and our own suggestions. Please mark all your changes in the manuscript using track changes or the highlight function.

Comments from the editor and the reviewers can be found below.

Please revise the manuscript and submit it through our Editorial Manager system by Aug 07, 2020.

You can access the system at https://www.editorialmanager.com/zrhm/.

Editorial comments:
- The dates of ethics approval are listed as 7 and 15 March 2017, whereas the field research began in February 2017. Please could you clarify this?

Reviewers' comments:
Reviewer #1: Dear Authors
Thank you for addressing all of the comments I made on your second draft.
Your reframing of the Introduction is now much clearer and you provide adequate evidence and supporting literature to make your arguments.
The Methodology includes all needed information, is clear and convincing. I especially appreciate the details of how the participants chose their own groups for the focus groups and also selected the setting for the focus groups and interviews.
Findings and Discussion - I appreciate your inclusion of 2 more case studies including the voices of 2 more of your interviewees. I appreciate the inclusion of the poignant and cutting direct quotation from Nika.
This section is also strengthened by the inclusion of the relevant Indonesian laws in the context of the violation of specific rights. This clarifies that the problem lies less with the legal framework and more with it interpretation and implementation.
The Recommendation section is now much clearer. Particularly important is the reference to the normalization of institutionalized stigma.
Overall, you make good use of high quality data to make some very important points about the context of HIV testing in Indonesia and what needs to be done to improve access for women.

Please see track changes for suggested important edits to improve clarity.

Thank you for your hard work,

Priscilla Magrath, PhD

[manuscript diterima untuk publikasi]

View Letter - Google Chrome
editorialmanager.com/zrhm/ViewLetter.aspx?id=41932&lsid=352b5b90-7ef7-49a8-8167-bfd2bfb9607f&prod=&sgTask=0&cm=

View Letter

Close

Date: Nov 05, 2020
To: "Najmah Najmah" najem240783@gmail.com
From: "Sexual and Reproductive Health Matters" ZRHM-peerreview@journals.tandf.co.uk
Subject: (Sexual and Reproductive Health Matters) Your submission has been accepted

Ms. Ref. No.: ZRHM-2019-0193R3
Title: Perceptions of and barriers to HIV testing among married women in Indonesia
Corresponding Author: Mrs Najmah Najmah
Sexual and Reproductive Health Matters

Dear Najmah,

Thank you again for submitting your manuscript to Sexual and Reproductive Health Matters. Your manuscript "Perceptions of and barriers to HIV testing among married women in Indonesia" has now been reviewed and we are pleased to inform you that it is accepted for publication.

Your paper will now be taken to production and you should receive further instructions from the publisher. During this time, you will receive a proof of the manuscript within two weeks, which will require a quick turn-around time from you, as the author. If you are travelling or expecting other delays during this period, please do let us know so that we can plan accordingly.

Thanks again for submitting your work to Sexual and Reproductive Health Matters.

Best regards,

Pathika Martin
Monitoring Editor
Sexual and Reproductive Health Matters

In compliance with data protection regulations, you may request that we remove your personal registration details at any time. (Use the following URL: https://www.editorialmanager.com/zrhm/login.asp?a=r). Please contact the publication office if you have any questions.

Close

Activate Windows
Go to Settings to activate Windows.

[bukti terbit]

Taylor & Francis Online   Log in | Register

Home ▶ All Journals ▶ Sexual and Reproductive Health Matters ▶ List of Issues ▶ Volume 28, Issue 2 ▶ Perceptions of and barriers to HIV testi ....

Sexual and Reproductive Health Matters >
Volume 28, 2020 - Issue 2: Universal Health Coverage: Sexual and Reproductive Rights in Focus

Submit an article | Journal homepage

Enter keywords, authors, DOI, ORCID etc | This Journal

0
Views
3
CrossRef citations to date
8
Altmetric

Listen

Open access

Research Articles

Perceptions of and barriers to HIV testing of women in Indonesia

Najmah, Sari Andajani & Sharyn Graham Davies

Article: 1848003 | Published online: 14 Dec 2020

Download citation | https://doi.org/10.1080/26410397.2020.1848003 | Check for updates

LAMPIRAN-LAMPIRAN REVISI DI SISTEM

Sexual and Reproductive Health Matters

“I told you, doctor! It’s not possible for my wife to get HIV”: HIV testing (or not) among married women in Indonesia

--Manuscript Draft--

Full Title:	“I told you, doctor! It’s not possible for my wife to get HIV”: HIV testing (or not) among married women in Indonesia
Manuscript Number:	ZRHM-2019-0193R1
Order of Authors:	Najmah Najmah, Ph.D candidate
	Sari Andajani, Doctor
	Sharyn Graham Davies, Associate Professor
Article Type:	Research Article
Keywords:	HIV tests, women, human rights violation, universal health coverage, Indonesia
Abstract:	The 2014 health reforms in Indonesia advocated for increased universal health coverage (UHC) for all Indonesians. The reforms also made provision for integrated HIV (Human Immunodeficiency Virus) programmes, with HIV testing to be available at community health centres and hospitals for pregnant women and women of childbearing age. These reforms aimed to increase HIV testing and early diagnosis of HIV. The question remains, though, as to whether the implementation of HIV testing has been effective and met women’s needs, especially those of child-bearing age. Of particular focus in this article is what barriers women face accessing HIV testing. The article shows that a key barrier is social and institutional stigma. This article presents findings from the experiences of 18 HIV-positive women. This article examines barriers to pregnant women’s access to HIV tests and these barriers all relate to women not having a right to reproductive health. This article highlights key reproductive health rights and violations noted in the Respectful Maternity Care (RMC) Charter, which is relevant to HIV testing in pregnancy. Five commonly reported rights violation include: women unable to access information; not being able to make independent informed decisions; no right to confidentiality and privacy; ongoing discrimination; and no right to timely HIV testing. The findings show that policy makers must make change to ensure health services are improved, that there is an increase in the training of health professionals, and that women’s socio-cultural and political contexts be taken into consideration.
Response to Reviewers:	Editor: Your paper addresses an interesting and important question and we would like to consider your manuscript further. Authors: Thank you for your consideration for this manuscript, very appreciated for this chance to revise this paperThank you for your consideration for this manuscript, very appreciated for this chance to revise this paper Reviewer 1: The paper addresses an important topic that deserves a higher profile in the literature: linkages between access to services and attitudes rooted in religion, culture and social norms. It demonstrates the importance of understanding the social and cultural context in the development of health policy and the provision of health services. The paper is highly relevant to this journal but needs substantial revision Authors: Thank you so much and thank you for your comments. We hope we have addressed them all satisfactorily but if more information is needed, we are happy to revise further. Reviewers 2: The paper has a clear focus, some interesting data and provides an interesting focus on the social complexities around HIV testing for married women. The main

Powered by Editorial Manager® and ProduXion Manager® from Aries Systems Corporation

	improvements that I think it needs are more evidence, more diverse evidence, and some clearer presentation/structuring in the findings section. I feel like part of the data might be missing, so it is hard to review the manuscript. Authors: Thank you for your consideration for this manuscript, very appreciated for this chance to revise this paper

Powered by Editorial Manager® and ProduXion Manager® from Aries Systems Corporation

General Comments from Managing editor	**Actions**
Your paper addresses an interesting and important question and we would like to consider your manuscript further.	Thank you for your consideration for this manuscript, very appreciated for this chance to revise this paper
The reviews brought to light some important concerns that will need to be addressed in a revised version before the article can be considered again. The reviewers' comments are provided below. In addition, please address the following points: - Please ensure that the report is sufficiently framed within a UHC context - Please include a statement on informed consent for participation - Please provide more detail/citation of the "larger study" - Please ensure that all potential study limitations are discussed in full in the discussion section	Thank you, we added the information -UHC context in the Introduction -Informed consent in Methodology -Citation for large study-Methodology (Najmah, 2019) -Study limitation in Discussion

Reviewer one comment on email	**Actions**
The paper addresses an important topic that deserves a higher profile in the literature: linkages between access to services and attitudes rooted in religion, culture and social norms. It demonstrates the importance of understanding the social and cultural context in the development of health policy and the provision of health services. The paper is highly relevant to this journal but needs substantial revision	Thank you so much and thank you for your comments. We hope we have addressed them all satisfactorily but if more information is needed, we are happy to revise further.
Strong points of the paper: The title is catchy and draws reader in. The case studies illustrate the difficulties faced by physicians offering HIV testing and by women accessing HIV testing in Palembang, Indonesia. Insights into the social and legal environment are provided and this allows the reader to understand the context and interpretation of the case studies. The sexual and reproductive rights framework is an appropriate lens for interpreting the findings. The paper provides a basis for developing interventions to address some of the barriers identified.	Thank you so much

REVIEWER PDF

1. The biggest problem with this paper is the lack of consistency between the stated approach (Feminist Participatory Action Research) and the presentation of the method, findings, discussion and conclusions. A feminist approach would suggest the female participants in the research are given a voice, yet we do not hear any direct quotations from any of the women interviewed.	Thank you we simplified the methodology approach, feminist approach and added reference for the larger study that used Feminist Participatory Action Research. Some direct quotation from the women have been added, as per request
2. The second problem is that, although the paper is quite well written, I found the text confusing and difficult to read in places. Sentence construction should be simplified. A common pattern is as follows: A + B maps onto C + D The reader is not sure if A maps to C and B maps to D or if both A + B map to both C + D or some other combination. Example 1 (p. 4 line28-34): "The 2014 ICPD country report noted the need for Indonesia to increase contraceptives and significantly scale up PMTCT services, to decrease the risks of maternal mortality and morbidity from complications during pregnancy and delivery, and halt the spread of HIV among women (8, 14, 16)." Are the contraceptives expected to decrease maternal mortality…and the PMTCT services to halt the spread of HIV? Or will both do both? Given the focus of the paper on PMTCT services and halting the spread of HIV I suggest omitting the reference to contraceptives and focus only on the impact of PMTCT services. Example 2 (p.9 lines 37 - 41): "We chose Anti's and Lela's stories as recalled by an obstetrician, and Nika's story as she told it, in focus groups and informal interviews." Does the reference to focus groups and interviews refer to all 3 stories or only to Nika's story? I suggest two sentences, one for Anti's and Lela's stories and one for Nika's story.	Thank you. We have revised it to ensure the patterns of the writing and deleted unncessary information.

REVIEWER PDF

3. More attention needs to be paid to agency. In several places agency is misplaced. For example: "An STI diagnosis also limits health workers' ability to exercise their professionalism by providing information about the importance of HIV testing…." This implies the diagnosis has agency to limit health workers. The statement is ambivalent - who/what is providing information about HIV testing - the STI diagnosis or the health worker? I suggest you rephrase to state what it is that limits the health workers - the policy? The culture? The training?	Thank you for the comments, we have rephrased the sentences, as per request.
4. The structure of the paper is clear and logical	Thank you for your feedback
5. Recommendations should be more specific and actionable	Thank you, we have revised recommendation.
METHODOLOGY	
1. Justification - much of the rationale for using Feminist-Participatory Action Research is in the last 2 paragraphs of the Introduction. Some justification is needed in the Methodology section. Why is it important to acknowledge the women as experts and real knowers of their own situations and contexts? Why do you mention social transformation? Is that your objective? If so, be explicit and tell us.	Thank you we have simplified the methodology for this paper, and refered the larger study for the more information about the methodology.
2. You state briefly what a FPAR approach is, but you do not provide evidence that you actually followed this. You state: "The research questions acknowledge the importance of women in presenting critical insights of their lives, and hence, that they are the actors for any social transformation in current practice." (p.6 lines 19 - 22). You do not tell us how development of your research questions, selection of participants, conduct of interviews and focus groups, analysis and writing up were influenced by the FPAR approach. In what ways was the research methodology participatory? What role did the participants play in research design, implementation, analysis or writing up? How did you create a safe space for open dialogue? (p.6 lines 28-29)	Thank you, we have refered the larger study for the more information about the methodology. We also add information how to create a safe space for open dialogue.
3. I do not think that you fulfill the promise of FPAR in your presentation of Findings and Discussion. I did not get a strong sense that I was hearing the voices of Anti, Lela and Nika. We hear a little more of Dr Didi's voice and the dilemmas he experiences. But for the most part you tell their stories and then interpret them using an externally imposed lens that you have chosen - that of sexual and reproductive rights as developed by the UN.	Thank you for your comments. We have revised the Discussion chapter and added the women's voices.
What you present appears to be a fairly typical PhD dissertation research design where the principal author conducted interviews and focus groups and then used her own theoretical framework to interpret the data. If this is not the case we need more evidence.	Yes, you are right. It is a part of PhD dissertation research design of the first auhtor under intensive

REVIEWER PDF

	supervisons of the second and third authors.
FINDINGS and DISCUSSION	
4. The authors present three case studies relating to married women's access to HIV testing. The discussion focuses on the outcomes of the three cases: In the first case the mother, Anti, has an HIV test but the husband objects verbally; in the second case the mother, Lela, is denied an HIV test by her husband; and in the third case the mother, Nika, and her husband and children are ostracized from the village when Nika's HIV status is revealed through gossip. The authors claim that "This article, however, focuses mainly on the narratives produced by the 18 HIV+ women and a few health workers" (p. 6 line 56)" In fact, only one of the three narratives is from one of the 18 participants. We therefore get very little access to the narratives of the 18 HIV+ women. The first two "narratives" are reported speech apparently drawn from an interview with a physician referred to as Dr Didi. These narratives include short quotations from the husbands of the women who are the subjects of the stories. Neither Anti nor Lela speak in these narratives, rather they are presented as patients who came for services. Similarly, in the third narrative, also presented in reported speech, the only direct quotation is from Nika's husband and we do not hear Nika's voice at all. This does not seem to reflect a feminist approach.	Thank you, we have added two more stories of the women (Bunga and Oneng), besides Nika and refered two other stories of the women in our other articles. We also added more women's quotation voices.
5. Nika's is a case where her confidentiality is violated and she is not adequately informed about the HIV test. The presentation of this case is preceded by some general comments about the research participants. I think the paper would be strengthened by more specific references to findings from some of the other participants that reinforce the arguments being made, including direct quotations giving voice to some of these participants. You could refer to Table 3 in this discussion.	Thank you, we have revised the consents of the first reviewer.
6. Some interesting findings are presented in table 2 but these findings are not well integrated into the text. There should be more discussion of the findings presented in the table.	Thank you, we have revised it and depict Table 2 (now Table 3) in the opening paragprah of Findings and Discussion

REVIEWER PDF

Conclusions and Recommendations	
Final paragraph needs reworking. I suggest omitting the first sentence and starting with "There is a need…services to ensure improved access. The following sentence needs to be broken up, perhaps using bullets or numbers The final sentence - you need to explain what you mean by im/moral health care. Your recommendations are vague - what specifically could HIV programmers do to fulfil rights of women, health workers, men etc	Thank you, we have revised it
References Inclusion of recent material is good. Some references are rather old. Reference (9) referred to in the Introduction is dated 2011 and refers to data from 2003 - 2010 yet it is used in reference to estimates of incidence of HIV in babies. It seems likely incidence has changed since 2010. lease add comments you don't mind the author seeing.	Thank you, we have revised it and deleted some old references.
Recommend publication of the paper with revisions	Thank you for the chance for us, particularly for the first author who still learn how to write the paper in a high-rank journal, like RHM.

Reviewer one comments in the document	Action
Recommend publication of the paper with revisions. Please see attached document with my review.	Thank you so much and thank you for your comments.
Abstract I suggest omitting because it is not clear and complicates the sentence – do you mean ensuring the training is respectful or ensuring health professionals are trained to provide respectful services It is not clear in the paper how you mean to address the local customs – or do you just mean that providers should be aware of them?	We have made it clearer. Thank you for your feedback.

REVIEWER PDF

Table 1: These notes are very interesting but under-used in the article. Perhaps a paragraph discussing the context of these women's lives before presenting the case studies would be useful.	As per the comments from reviewer 1, thank you, we have added the information
Table 2: Again, the information in this table is underused in the text and analysis. These are very strong findings.	Thank you, we have revised it
INTRODUCTION Line 13 Tell us the point of the paper earlier. We do not know why we are being provided with this background.	Thank you for pointing this out. We have added it
Line 15-Paragraph 1 "unlike" in what way? This paragraph is confusing – it is not clear why Indonesia was selected for PMTCT. You need to contextualize your numbers: 50% of new cases of HIV – how many cases of HIV are there in Indonesia?	Thank you for the comments, we have added the information in Table 1
Line 27-Paragraph 1: We need to know (i) population of Indonesia (ii) incidence and prevalence of HIV in different regions (urban, rural, by province) and populations (male, female, age groups, high risk groups). Number of pregnancies and births. This data could be in tabular form.	Thank you for the comments, we have added the information in table 1.
Line 51-Paragraph 3 This article is dated 2011 and refers to data from 2003 – 2010. This seems too out of date for you to use it as a basis for estimating future costs	Thank you, we decided to delete for the cost.
Line 11-Paragraph 4: Rephrase "An agreement of some sort key"	Thank you for the comments, we have revised it.
Line 23-Paragraph 4: What is distinctive about Papua and West Papua if your point applies to 30/34 provinces?	We have revised it, as per request
Line 29-Paragraph 4: What is the relationship between contraceptives and PMTCT?.	Thank you for the comments, we deleted contraceptives
Line 40-Paragraph 5: Types of services or numbers of services?	We have specified on antenatal HIV testing
Line 12: Challenging for whom? Health care workers? Mothers?	For mothers, thank you we have added the information

REVIEWER PDF

Line 39: What is the gap?	As per the comment, we have clarified the gap, in the final paragraphs in the introduction section.
Line 41: How? Is this part of the method?	Thank you, we have moved to methodology section as per the comment.
Line 45: Who has this belief? Services don’t have beliefs, people do.	Thank you we have revised it, as per request
Line 54: What implies this? You need to provide evidence for this claim.	Thank you for the feedbacks, we added gap.
Line 1: I do not see this view manifested in the findings, discussion and recommendations. I do not hear the voices of the women participants.	Thank you for pointing this out. We have added some direct quotation from the women to support this findings.
METHODOLOGY	
Line 33: Selection of Participants would be a more fitting title	Thank you very much, as per request
Line 47: Concerns about HIV+ women?	Thank you for the feedbacks, we have make this clear by pointing out HIV+ women. We also did triangulation with health workers and NGO workers for understanding more women’s experiences.
Line 55: This is not reflected in the presentation of findings. 2/3 case studies were from an interview with a physician	Thank you for the comments. What are our understanding about the methodology that we applied in this research that Feminist PAR focus not only on women’s voices but also women’s experiences that retold by other

REVIEWER PDF

	parties, like an obstetrican who treated HIV-positive women.
Line 17: Several were in polygamous marriages – is this significant?	Thank you. We have mention it now there are 3 men who did polygamous. We referred a story of women in polygamous marriage in another published article by the authors.
Line 24: What kind of implication is this? How sure can we be that the stillborn babies died from an opportunistic infection given that stillborn occurs in non-HIV babied as well. Perhaps a reference is needed.	We have revised it and add reference (Londi et al, 20110
Line 5: Is Palembang especially suited to this research? Or only selected because the first author is from there? More justification of the site selection is needed. Why was Palembang selected?	We have clarified the information.
Line 13: I would number these for clarity (i) NZ pilot (ii) Palembang pilots	We have clarified the information.
Line 37: Did you notice a difference in results depending on where the interviews and focus groups were held? What was the rationale for selecting sites for interviews and focus groups? Were the sites chosen by the participants?	Thank you. We have added information.
Line 44: Better than what?	Thank you, we have deleted it.
Line 50 This is great but under-used in your presentation of findings – we do not have access to this data.	Thank you, we have deleted it and referred to our larger study.
Line 14: I am not sure that regular meetings can ensure accuracy – do you mean consistency?	Thank you, we have revised it as per request.
Line 22: Did you use any data analysis software?	Thank you. We have added information in data analysis section. We did the coding manual.
FINDING AND DISCUSSION	

REVIEWER PDF

A deductive framework; Inductive identification of themes – perhaps make this explicit to demonstrate FPAR approach	Thank you, we have make it clearer.
But we don't hear it as she told it – I suggest adding some direct quotes!	Thank you, we have added some direct quotes
Stories of Anti and Lela's I suggest you begin with an overview para summarizing the findings in Table 2 and 3 before going to your particular case studies. I think this would strengthen your arguments as you would not be relying so much on 3 cases.	Thank you we have revised it as per request.
RECOMMENDATION	
'Findings revealed' or 'in this paper I have presented analyses'	Thank you we have revised it as per request.
I suggest you omit or relocate "along with other reprod health concerns" – this is confusing.	Thank you we have revised it as per request.
You do not provide a historical perspective so we don't know if they "continue" we only know how they were at the time of your research – unless to reference other work stating they existed in previous eras	Thank you we have revised it as per request.
I suggest 'at least for HIV services' as the reader has no way to compare with other services.	Thank you we have revised it as per request.
Did you provide evidence for this? Who was the HIV specialist? Dr Didi?	Thank you we have deleted it
Rephrase – what exactly is it that limits the health workers? I don't think it is the diagnosis.	Thank you we have revised it as per request.
Specify what these rights are	Thank you we have revised it
Can you be more specific? What aspects of women's lives? Relationships with their husbands?	Thank you we have revised it as per request.
How could they be addressed in programming?	Thank you we have revised it as per request.

REVIEWER PDF

Country specific programmes. Define im/moral healthcare.	Thank you we have deleted it and refer to the original paper.

Reviewer two comments	**Actions**
The paper has a clear focus, some interesting data and provides an interesting focus on the social complexities around HIV testing for married women. The main improvements that I think it needs are more evidence, more diverse evidence, and some clearer presentation/structuring in the findings section. I feel like part of the data might be missing, so it is hard to review the manuscript.	Thank you for your consideration for this manuscript, very appreciated for this chance to revise this paper
1. The paper has a clear focus, some interesting data and provides an interesting focus on the social complexities around HIV testing for married women. The main improvements that I think it needs are more evidence, more diverse evidence, and some clearer presentation/structuring in the findings section. I feel like part of the data might be missing, so it is hard to review the manuscript.	Thank you we have some information and make clear the structuring in the finding section.
2. Indonesia, despite its achievements with improved availability of reproductive health services since 1994 and the consequent decline in the total fertility rate, has not yet managed to stabilise the spread of HIV, with some provinces now having a generalised epidemic; Papua and West Papua and the majority provinces in Indonesia (over 30 out of 34 provinces) now have concentrated epidemics among key populations such as injecting drug users, men who have sex with men, and female sex workers (14, 15). – Maybe this is just a wording issue – Papua and West Papua do have a generalised epidemic.	Thank you we have revised, as per request.
3. This study examines barriers to pregnant women's access to HIV tests and treatment, by examining key reproductive health rights and violations. -This is not a major issue, but to note that the paper focuses on testing rather than treatment, or so it would seem	Thank you we have revised, as per request.
4. Although Butt (32) considered HIV-positive women's voices, they did not specifically focus on PITC and PMTCT services; furthermore, Bennett (33) particularly focussed on sexually transmitted infections	Thank you we have revised, as per request.

REVIEWER PDF

and not on HIV. -There is an article by Munro and McIntyre 2016 in Culture, health and sexuality – though it focuses on West Papua it does look at barriers to PMTCT	
5. In the methodology participant observation is mentioned – any more details on what was observed, where, etc?	Thank you we have deleted it and refered to our larger study for further information about the methodology
6. “participatory visual methods”, including the creation of song lyrics and dramas as a means of expression or presentation of their ideas and narratives. - These don’t seem to be actually in the paper and its not clear how they were transcribed	Thank you we have deleted it and refered to our larger study for further information about the methodology
7. Five main themes of rights violations emerged: rights to information, rights to independent informed decision making, rights to confidentiality, rights to respectful services, and rights to relevant and timely services (see Table 2). Findings are presented according to the domains used in the Respectful Maternity Care (RMC) Charter and Reproductive and Sexual and Reproductive Health and Rights (SRHR). The findings, to me, skip straight to applying a framework or rights model without presenting data, reflecting on that data. I think its ok to say that the themes that emerged were accounts of rights violations (though the authors may want to consider whether that is all that emerged or if there are other aspects), but it seems awkward to me at least to apply these domains from the outset.	Thank you for the comment. We have make it clearer.
8. In this study, in the experiences of the 18 HIV+ female participants, not a single case emerged in which clinicians proactively requested potentially HIV affected family members to have an HIV test -What are the laws and norms around partner notification in this context. Is this statement more about how doctors did not tell husbands to get a test, or did not tell wives to get a test? Would this be considered breaking confidentiality because it indirectly reveals the HIV status of one partner to the other?	Thank you we added the information.

REVIEWER PDF

9. Case study 1: Anti and Lela: HIV testing procedures for married women and the dilemma about their implementation Dr Didi recalled a similar story. Lela asked Dr Didi for an HIV test as she was suspicious that her husband was having extramarital relationships. She was also worried about her reproductive health as she had three previous miscarriages. However, her husband did not permit Lela to undertake the HIV test. Lela's husband, a high-profile local member of parliament, insisted that "never in my life... I am not badly behaved." Case study 2: Lela's story: Rejection by her husband for having HIV testing procedures Is there any more evidence to add that comes from a different participant that shows the complexities of providing testing or women accessing testing due to their husband's? This is from the doctor as participant, not the women. 2 . Not clear about the formatting here – in my experience a case study is a longer presentation of information. In this section, there is one very short 'case study' and then there is also a title that doesn't seem to have a case study under it. – Lela's story seems to be missing so it's a bit hard to review the analysis/findings without this	1. Thank you, we have referred to our larger study and our other published articles. 2. We have separated the stories in paragraph to make it clearer
10. Women are required by law to obtain spouse's, parent's or guardian's consent for some sexual and reproductive health services, even if they are diagnosed with an STI (40). – I think a better reference would be preferable here. I'd like to see more specific evidence pertaining to Indonesia and what the laws are	Thank you for the comment. We have make it clearer.
11. Their stories highlight three main reasons that women encounter non-consented care issues, and disrespectful PITC services: 1) difficulties implementing HIV testing; 2) unequal rights in decisions relating to their own reproductive and sexual health; and 3) the silenced voices of health professionals. It is not clear whether women needed the approval of their husbands, partners, parents or health authorities because they were married, or simply because they were women. I feel like more evidence is needed of non-consented care issues and disrespectful services.	Thank you we added Anti and Lela's stories as a part of triangulation procedures. We added two more stories of women, Bunga and Oneng, besides Nika, and referred two

REVIEWER PDF

This analysis also seems a bit upside down – perhaps it is the presentation – is it meant to convey that difficulties with testing, unequal rights, and silences among health professionals *lead to* care issues (whatever these are) and disrespectful services? Overall, the section on Anti and Lela needs more evidence to back up the claims being made. I think given the feminist methodology it makes more sense to include women's narratives here rather than what the male doctor has conveyed. This doesn't feel sufficient to me. The doctor does provide an insight, but it's not enough on its own to make claims about the women or other women's experiences.	other women's stories in our published articles.
12. Case study 3: Nika's experience: Trauma and humiliation following an HIV test at a local *puskesmas* during pregnancy – I don't understand if this is a sub-heading or a dot point, or why it is in this position in the paper	Thank you, we have revised it to make it clearer.
13. Future HIV training needs to somehow emphasise the need for respect and protection of patients' confidentiality within the social norm of *kepo* in Indonesia. – could perhaps elaborate on this – if cultural norms test confidentiality rules how will training help?	We have elaborated it in the text as per request
14. In the section on health workers – is there a bit too much use of one doctor's perspectives in the paper? Could this be balanced out with other data? A paper that mainly presents an insider account of these complexities from a doctor would be fine and useful, but this paper is packaged up as something else – an account of women's stories	Thank you, we have added two stories of HIV-positive women
15. Strong socio-cultural and religious stigmas against women with HIV, expressed in words such as "sinful" and "immoral", extend to all HIV related services (32, 49, 54, 55). Institutionalised stigmas surrounding HIV – is there any data from this study that could be presented in the paper to demonstrate this?	Thank you, we have added direct quotation from Nika about this concern.

REVIEWER PDF

Manuscript - with author details

"I told you, doctor! It's not possible for my wife to get HIV": HIV testing (or not) among married women in Indonesia

Najmah, SKM, MPH, PhD

Sriwijaya University (UNSRI)

Dr Sari Andajani

Auckland University of Technology

Assoc Prof Sharyn Graham Davies

Auckland University of Technology

Corresponding authors: sari.andajani@aut.ac.nz

REVIEWER PDF

ABSTRACT[1]

The 2014 health reforms in Indonesia advocated for increased universal health coverage (UHC) for all Indonesians. The reforms also made provision for integrated HIV (Human Immunodeficiency Virus) programmes, with HIV testing to be available at community health centres and hospitals for pregnant women and women of childbearing age. These reforms aimed to increase HIV testing and early diagnosis of HIV. The question remains, though, as to whether the implementation of HIV testing has been effective and met women's needs, especially those of child-bearing age. Of particular focus in this article is what barriers women face accessing HIV testing. The article shows that a key barrier is social and institutional stigma. This article presents findings from the experiences of 18 HIV-positive women. To triangulate findings, interviews were conducted with 26 health workers, 9 Non-Governmental Organisation (NGOs) workers and 12 HIV stakeholders.

This article examines barriers to pregnant women's access to HIV tests and these barriers all relate to women not having a right to reproductive health. This article highlights key reproductive health rights and violations noted in the Respectful Maternity Care (RMC) Charter, which is relevant to HIV testing in pregnancy. Five commonly reported rights violation include: women unable to access information; not being able to make independent informed decisions; no right to confidentiality and privacy; ongoing discrimination; and no right to timely HIV testing. The failure of Indonesia to protect these rights directlycontributes to women being denied HIV testing.

Findings from this study show the need for increased HIV testing services for pregnant women, and asserts that health personnel and programme policy makers be held accountable for the protection and fulfilment of women's rights in respect to HIV testing. The findings show that policy makers must make change to ensure health services are improved, that there is an increase in the training of health professionals, and that women's socio-cultural and political contexts be taken into consideration.

[1] Waiver code ZRHM-2019-UHC. http://www.srhm.org/call-for-papers/

REVIEWER PDF

Key words: HIV tests, women, human rights violation, universal health coverage, Indonesia

INTRODUCTION

The 2014 health reforms in Indonesia advocated for increased universal health coverage (UHC) for all Indonesians, including the provision of integrated HIV (Human Immunodeficiency Virus) programmes, with HIV testing to be available at community health centres and hospitals for pregnant women and women of childbearing age (1-3). Annually in Indonesia, 40% of new HIV cases occur in women of childbearing age (4). These women fall outside prescribed high risk groups [i.e. commercial sex workers (CSWs), injecting drug users (IDUs) and men who have sex with men (MSM) (Table 1)]. The steep increase in HIV prevalence among women in the general population in the last decade is a proxy indicator for HIV transmission to children, and HIV policies and programmes cannot remain ignorant of HIV transmission in women, especially among pregnant women (5).[Table 1 around here]

Pregnancy occurs among women living with HIV (WLWH) (5, 9), and as such infants are vulnerable to HIV transmission from their mothers, through pregnancy, delivery, and/or breastfeeding [Indonesian Ministry of Health (MoH) (10, 11)]. An HIV prevalence of 0.4% in pregnant women explains that approximately 25,000 women, out of six million pregnant women, are HIV positive at any one time in Indonesia (12). Of concern is that pregnant women often find out their HIV status in the late stage, resulting in late treatment for preventing mother to child transmission (PMTCT) (11, 13). Without timely and effective HIV treatment during pregnancy, a half of HIV positive pregnant women will give birth to HIV positive babies (14, 15). Further, without Antiretroviral therapy (ARV) those infants will likely die before their second birthday (11, 16). Less than 10% of pregnant women in Indonesia access PMTCT services (10) and missed opportunities for early HIV screening and treatment for pregnant women remain a huge challenge.

The promotion and protection of women's rights to healthcare, including early HIV screening and timely and relevant HIV treatment, is central to the UHC goal (17, 18). At the global level, women's rights to healthcare is well recorded in a number of international covenants including the 1985 International Convention of the Elimination of All Forms of Discrimination Against Women (CEDAW), the Cairo International Conference on Population and Development Programme of Action ICPD (PoA) in 1994 (19). At the national level, the Indonesian government passed a number of regulations between 2013 and 2017, including the 2014 UHC

REVIEWER PDF

to include integrated HIV testing in antenatal clinics and ARV treatment for women and children in PMTCT programmes (20-22). Other regulations include compulsory HIV screening in Antenatal care (ANC) services; Provider-Initiated HIV Testing and Counselling (PITC); comprehensive PMTCT and guidance to services; and the fiscal responsibilities for all parties and ministries involved (1, 23, 24). With continuing high HIV prevalence in a number of provinces, like Papua (a generalised epidemic) and Jakarta, Bali, East Java, West Java and Riau (concentrated epidemics) amongst MSM, CSWs, IDUs, Indonesia needs to significantly scale up its HIV screening and ARV treatment in PMTCT (11, 25, 26). Nevertheless, widespread inequalities in accessing health services remain (20). For example, in Palembang, our study field, compulsory HIV screening in ANC was only introduced in 2017; at the time of this study in early 2017, there were only 16 VCT centres, mostly located in hospital-based settings, with only three in *puskesmas* (local community health clinics) settings. At the end of 2017, all 41 *puskesmas* in Palembang provided HIV testing as a part of PMTCT services, and 12 new VCT centres were established (27).

While Indonesia has implemented policies on HIV testing, uptake remains poor. There are various challenges, such as poor referral mechanisms (2, 28). For instance, when a pregnant woman gets referred, she may find it difficult to travel to the VCT clinic (e.g. the clinic is too far, or the clinic's opening hours do not work for women) (2, 28, 29). At the same time, women living with HIV are highly stigmatized in Indonesian societies, making healthcare providers feel hesitated or reluctant to refer women to have HIV test; they do not want to shame or insult their clients (28, 30).

In the remainder of this article, we examine challenges that pregnant women face in accessing HIV testing during pregnancy using a framework of women's sexual and reproductive rights. The Respectful Maternity Care Charter (RMCC) introduced in Indonesia and worldwide by the White Ribbons Alliance, adopting 10 universal human rights indicators for women's and new-borns' rights in maternity health care. The RMCC was chosen as the best platform for our examination because it allows analysis of the rights violation women faced in accessing HIV tests in Indonesia (31, 32). Some of the 10 universal rights include:1) rights to information; 2) right to independent informed decision-making; 3) rights to privacy and confidentiality; 4) right to respectful services (non-discrimination and dignity and care); and 5) right to timely treatment and attainable health care.

REVIEWER PDF

This article offers a systematic analysis of barriers women face in Indonesia in accessing an HIV test. A clear understanding of these barriers will provide a platform for the development of policies and programmes that will support women. For example, our findings can information policies and programmes that aim to: raise awareness of women's rights; guarantee health care delivery; increase capacity for health advocates to participate in human rights processes; and support health care professionals in providing respectful care and holding the government to account to fulfil these rights (31). While there has been a number of studies on barriers to HIV testing and HIV positive women, such as Badriah, Tahangnacca (29), Butt (33), Lumbantoruan, Kermode (34), and Munro and McIntyre (35), studies on the examination of how women's sexual and reproductive rights have been violated in respect to accessing HIV tests has been overlooked.

Commented [A1]: Married women? Women in Sumatra or western Indonesia? Because of the differences in implementing testing locally is this too general? It is also a small qualitative study – is it systematic and was it intended to exhaustively examine all the possible barriers? It seems to me it was more exploratory and reports on issues that emerged from women's experiences

Commented [A2]: I would say that what is different is that this paper is analyzing the barriers using a rights framework. These earlier studies would reveal rights violations, but that was not their analytical focus. They have been analysed to reveal other aspects.

METHODOLOGY

This study acknowledges HIV positive women as experts in respect to their own HIV journeys. Women in this research were central to the production of knowledge and understanding of existing policies and practices regarding HIV testing. Following Brinton M. Lykes andAlison Crosby (2014), women in this study were given a safe and collective space, and trustworthy partnerships with the researchers, to have an open dialogue and critical discussion on matters relevant to HIV testing (36). The voices of HIV positive women were honoured, as well as those of other participants, like health workers, NGO workers and policy makers, to triangulate knowledge of how women were accessing HIV testing during pregnancy (27).

REVIEWER PDF

Selection of participants

Participants in this study, included 18 HIV positive women, aged 21-47 years, and 26 health providers (12 midwives, 11 medical doctors, 2 obstetricians and 1 paediatrician), 12 policymakers, and 9 NGO peer-support workers. Participants were recruited through purposive sampling. The inclusion criteria of the HIV-positive women were: 1) of reproductive age; 2) living in Palembang, South Sumatra; and 3) available to join a series of FGDs (Focus Group Discussions) or interviews. An advertisement was sent to Non-Governmental Organisations (NGOs) and health services workers and included at local VCT clinics. For other groups, a formal letter of invitation was sent to each targeted institution related to HIV programmes for women. This article, however, focuses mainly on the narratives produced by the 18 HIV+

women and a few health workers, to best illustrate examples of the violations of women's reproductive health rights in respect to accessing HIV testing.

Ethical issues, including asking for consent to use interview/FGD transcripts from participants, respecting participants' rights to privacy and confidentiality, and minimising risks for both the participants and the researcher were discussed. Protection of participants from any deceit, harm, and coercion was taken seriously in this research; it was essential to be able to keep to the cultural values, social, and ethnic diversities of the participants.

The women's context of life

Table 2 presents the demographic and reproductive status of the 18 HIV positive women who participated in this study. Twelve were married and six were widowed. Of those 12 who were married, eight were in their second marriage. Of these eight, all of their first husbands had died due to HIV. Of the 12 women who were married, four had husbands who were confirmed as HIV negative.

All 18 women were aware of their vulnerability to HIV. Twelve women believed that they were infected by their husbands who were either former IDUs (n=6), and/or frequent customers of commercial sex workers (n=5), and/ or living in a polygamous marriage (n=3), and/ or having sex with men (n=1). All 18 women, except two, were not aware of their having high risk sexual behaviour. Two women had histories of IDUs and having multiple sexual partners without practicing safe sex (Table 2).

The women had between one and six children and had lived with HIV for at least two years (based on the CD4 level -the level of white blood cells- at first HIV test) (37). Three women had HIV positive children. Two had experienced stillbirths but they were not aware of what had caused it. Four women had their children taking ARV - prophylactic treatment to reduce MTCT and they were all under 18 months old.

Most of these women had completed at least 12 years of schooling and they were stay-home housewives or *ibu rumah tangga*. Most were of low socio-economic background and had become the breadwinner of their families. Only 7 of these women owned houses; 6 shared accommodations with parents or siblings, and 5 were renting the place. [Table 2 around here]

Commented [A3]: Perhaps some explanation of the category of 'housewife' is needed, given that they are also the breadwinner in the family

REVIEWER PDF

Field research

The field research, in Palembang, South Sumatra, was conducted over four months from February to July 2017, and included a series of group discussion, interviews, and participant observations by the first author (NA). The first author was born and raised in Palembang and she has had a number of years of working with various organisations working with IDUs and HIV in this city. Being aware of the sensitive nature of research with women living with HIV and having a former connection with relevant persons and institutions working with HIV programmes would enhance the success of the field research. All interviews and communications with participants were conducted in Bahasa Indonesia and local Palembang dialect.

Prior to the field research, two pilot trials were conducted to examine the relevance of the research plan, recruitment of participants, research instruments and any local norms and customs that the researchers should respect. These trials were conducted in Auckland (New Zealand) and in Palembang (Indonesia). The Auckland trial included group discussions with two groups of Indonesian women living and or studying in Auckland. The trial in Palembang included two HIV positive women, in a few meetings. The research plan, interview schedules was finalised following these two trials.

Of the 18 HIV positive women in this study, 11 formed two focus groups: Group A (5 members) and Group B (6 members). Women chose their own groups with no input from the researchers. Up to six focus group sessions of two hours each, were conducted with each group. Up to 12 group discussions were carried out over a two-month period. The remaining seven women opted for individual interviews. Each woman was visited one to three times, depending on their availability. Each visit lasted for about an hour. Some also asked for follow-up online communication using Facebook and WhatsApp. Places for interviews and group discussion were on the discretion of participants, and included participants' house, office, community health centres, hospitals, restaurants, and parks. All interactions with women, were conducted in a 'safe physical environment' chosen by the women. This allowed for all participants to have more control of their space and place where they felt safe and comfortable, at the same time, maintaining their confidentiality and privacy [see for example Ponic, Reid & Frisby (38), Najmah (27)].

Commented [A4]: Section should state exactly how many focus groups were conducted not 'up to'

REVIEWER PDF

Data analysis

The focus group discussions, interviews and visual outcomes were transcribed verbatim. Field notes were recorded in both Bahasa Indonesia and English. All visual and digital productions were presented with Bahasa Indonesia captions. The interpretations of the women's reflections, and presentations were coded in their original language by the first author. The second author (SA) was also born in Indonesia and speaks fluent Bahasa Indonesia. SA had nearly 30 years of working in the area of gender health and SRH rights particularly in Indonesia, and other parts of the Asia and Pacific region. The first two authors worked closely together on the Indonesian transcription throughout the coding stages, making meaning of the contexts presented by the women, and developing themes from the coding, before translating relevant quotes into English. The third author [SGD] was born in Australia and has worked for over 15 years in research projects in Indonesia, relating to gender and identity.

To ensure consistency, regular fortnightly meetings were conducted between the authors to discuss emerging themes, categorisation, and links between codes and meanings, to enhance data interpretation. Transcriptions produced during the focus groups and interviews were cross-checked with field notes and visual images. Five main themes of rights violations emerged: right to information, right to information and informed decision making, right to confidentiality and privacy, right to dignity and care, and right to timely services (Table 3). Thematic analysis was performed by applying the steps of coding set out by Saldana (39) across different themes of women's sexual and reproductive rights iterated in the RMC Charter.

FINDINGS AND DISCUSSION

Table 3 depicts domains of disrespect and abuse and associated human rights violations against participants living with HIV. Out of 18 women, 12 felt they were lacking information with regards to HIV result of their husband, their children or their own. Of these 12 women, 5 had never been aware of any available HIV testing nor that had they ever received any information that raised their awareness to the importance of HIV testing. These 5 women only found out about their HIV in late stages, after the death or illness of their husbands, children, or they themselves had fallen ill. Six of 18 women reported their privacy and confidentiality were breached by health workers, when their HIV testing results were shared with other health workers, family members, or neighbors without their permission. Next section, we present stories of Bunga, Oneng, Nika, retold by HIV-positive women through interviews and/or FGDs

Commented [A5]: This has not been introduced as a method of data collection in the earlier section

Commented [A6]: See question from first review about partner disclosure policies in this context – are providers supposed to make spouses aware, or is it up to the spouse and the doctor is supposed to keep it confidential?

REVIEWER PDF

Anti and Lela, retold by a health worker (an obstetrician) through interview. [Table 3 around here]

Stories of Bunga and Oneng: Not getting the right information

Oneng (41 years old, low-income family, a widow living in an urban area), and Bunga (30 years old, middle-income family, second marriage, living in an urban area) shared stories during focus group discussions and interview respectively. All HIV-positive women in this study were dependent on their husband's income during a matrimonial relationship, including Oneng and Bunga. From their stories, we learned about the manifestation of the breach of women's right to information, confidentiality and privacy and how these rights are intertwined.

Bunga recalled her caesarean operation was cancelled in a private hospital, and she was referred to a public hospital. Upon her arrival at the public hospital, one of the doctors asked her husband "do you know why your wife was referred to us?". My husband said that the doctor at the private hospital was only saying that our baby was in a breech position. The doctor replied "No, your wife is HIV positive and Hepatitis B positive" (Bunga). In shocked, Bunga cried for three days while she was waiting for caesarean surgery's schedule in this public hospital.

Oneng's story was about her shock after being told by her doctor that her youngest daughter was HIV positive:

> Angrily, I asked the doctor 'How come my daughter got this HIV?' The doctor replied *Bu* (Mam), you should know better than me how HIV was transmitted to your daughter (Oneng).

Both Bunga and Oneng were shocked when they received the news of their positive HIV test. Both were made aware of their HIV status in late stages, only after Bunga's got HIV test before she delivered her baby or after Oneng's child had become sick. In both cases, the doctors were not coming straightforward with their information, instead they referred their patients (Bunga) to another hospital without giving the right information for referral, while Oneng was offered for an HIV testing after her youngest daughter got ill and diagnosed with HIV. It was one year after Oneng's husband passed away due to diseases related to AIDS. In other women's stories, husband's family, such as mother's in law, brother's in-law who may have been informed HIV status of their husbands in health settings, but they chose not to disclose HIV status of her

REVIEWER PDF

husband to the women [read Bulan's story -46 years old, middle-income family, 2nd marriage-polygamous from urban area- in Najmah, Davies, Andajani (40)]

Story of Nika: Breach of privacy and confidentiality

Nika (22 years old, low-income family, first marriage, living in a rural area) recalled how a midwife had disclosed her HIV status to her (Nika's) neighbours during series of FGDs. In 2016, Nika was referred by her midwife to have a blood test. Not until later did Nika learn that she was also tested for HIV. The results came back, and she was HIV positive. To her horror and surprise, news about her HIV status spread vastly in her neighbourhood. A midwife who was her next-door neighbour and worked at the local *puskesmas,* gossiped about Nika's HIV status with neighbours. Angry neighbours then forced Nika and her husband (Maman) and two children to move out of the village. The family then rented a small one-room accommodation in Palembang city. Nika believed that she and her family were victims of social gossiping and social stigma.

> Social stigma … had cornered me …failed me… punished me …as if I were not a good woman…not a good mother… watch your mouth… those people working in health … get the right education (Nika).

Maman often expressed his regrets, telling Nika,

> Had I known that you were asked to have an HIV test in that *puskesmas* (community health centre), I would have had forbidden you to take it (Nika).

Maman continued to support Nika and Nika adhered to ARV treatment. Their baby was given prophylactic treatment after birth. Nika decided to have a tubectomy following the birth of her third child because it was the only way doctors would allow her to access PMTCT services and a caesarean delivery.

Nika's story revealed negative and traumatic experiences that she and her family went through following an HIV test. Nika's privacy was breached by her midwife. Nika's experience was later shared with groups of healthcare workers such as NGO workers, midwives, medical doctors, and HIV policymakers, to illustrate the violation of Nika's rights to confidentiality and privacy in HIV testing. Upon discussing Nika's story, opinions of health workers and policy makers were somehow divided. One group believed that the 'breach of privacy' was 'normal' as health workers, in the spirit of solidarity, want to protect her peers to be cautious of HIV positive patients. This opinion could reflect a manifestation of institutionalized stigma

Commented [A7]: Its also important that this seems to be about lack of informed consent for the testing and this idea that provider initiated testing means compulsory testing without informing the person.

REVIEWER PDF

against people living HIV, within Indonesia health services. The other group was supportive of the patients' right to confidentiality and privacy. Ministry of Health Regulations, No. 74/2014 on Guidelines for HIV Testing and Counselling (VCT), notes that it is unethical to disclose patients' information without patients' approval' (41). Violations of patients' confidentiality in HIV testing have also been reported in Sub-Saharan Africa and some Asian countries, such as Vietnam and India (42-44). Moral judgement, socio-cultural stigma are argued to be roots of the violation of patients' right to confidentiality and privacy as well as the right for getting correct information (33, 45) (also read Mira's story in Najmah, Davies and Andajani (46)] .

Stories of Anti and Lela: Needing a husband permission to HIV testing

Commented [A8]: Section below should be clear who has provided the information. Is it according to the doctor, Anti visited the clinic after experiencing discharge?

Anti and Lela were patients of Doctor Didi (a pseudonym), a senior male obstetrician in a private hospital in Palembang. Anti visited his clinic after experiencing a yellow and white milky discharge from her vagina. She was initially treated by another physician for her STI and referred to Didi for a follow-up HIV test. Anti came to him with her husband. He recalled seeing Anti looking very weak. Following an individual consultation for HIV and suggested for Anti to have an HIV test. Anti's husband was very upset and insisted that "it was impossible for his wife to have HIV". Didi explained to him that it was important to have the HIV test done so Anti could get the right treatment. Anti's husband finally agreed and Anti' test was negative. In a separate occasion, disgusted at Didi, Anti's husband said: I told you so! It is not possible for my wife to get infected with HIV",

In another story, Lela came to doctor Didi's practice to ask for an HIV test. She was suspicious that her husband was having an extramarital affair. She was concerned of her sexual reproductive health as she had three previous miscarriages. Lela's husband refused to give a permission for Lela for the test. Lela's request for HIV testing was then denied. Lela's husband, a high-profile local member of parliament, told Lela and Didi: "Never in my life I would let you have that [HIV] test … I am not naughty".

The Ministry of Health Regulation No. 74/2014 on Guidelines of HIV Testing and Counselling reiterates that HIV tests and counselling should consider the principles of providing informed consent, maintaining confidentiality, offering counselling and HIV testing, and providing HIV treatment and prevention services. Denial of Lela' s request for HIV testing, however, was associated with fears from health professional to causing marriage break ups, disharmonies,

REVIEWER PDF

insults, and shame to their patients and consequently to lose their patients, as reported elsewhere (28). Here, Didi were faced with dilemmas. He recognized the right of his patients to HIV testing and understood that by law the women needed not permission from the husbands. However, he was also aware that he could jeopardize his reputation and that of his institution, if women were given HIV test without husbands' permission. Didi recalled an experience of one of his colleagues who were blackmailed after performing an HIV test without the patient's husband's permission.

Women's subordination in marriage is a key reason why women are denied a right to healthcare (47, 48). Anti and Lela were aware of their health needs, yet were powerless to take control of, or exercise, their rights. Their ability to make informed decision was impeded by patriarchal values that position married women as subordinate to their husbands. The limitations of this study include a small sample size. Further the study was just conducted in one field site location. Further studies can both expand the sample size and the location.

Commented [A9]: This section ends rather abruptly with the limitations of the study

Suggest to include a 'discussion' that connects back to literature raised in the introduction

RECOMMENDATION

A primary finding of this study is that the violation of women's reproductive rights in respect to HIV testing contribute to barriers to access HIV services in Indonesia. Violations of women's rights to information, informed decision-making, privacy and confidentiality, and timely service were evident in this study. Existing socio-cultural and ideological values, such as HIV stigma against people living with HIV, the normalization of institutional stigma, and patriarchal values intersected to contribute to difficulties for women to access HIV testing in the general population.

Overcoming rights violation requires acknowledgment that rights violation exist, and making government accountable to the address those human rights violations. Multiple and inter-sectoral approaches are needed at individual and interpersonal level, institutional and public policies. First, at the individual and interpersonal level, women and partners need to be aware of women's rights to information, informed decision, privacy and confidentiality, non-discrimination, timely and best health care. Second, training of healthcare professions need to highlight the connection between HIV testing services and human rights guarantees. Third, human rights activists, programme leaders and policy makers, need to build capacities for advocates for a right-based approach in HIV testing. Fourth, monitoring and evaluation of HIV testing in Indonesia, must accommodate relevant human rights indicators that serves a

REVIEWER PDF

foundation for holding government accountable to the fulfilment of women's rights to health in HIV testing. Lastly, a supportive healthy working environment is central to ethical professionalism in HIV testing services and to reduce institutionalised stigmatization. For example, an open discussion within health care delivery, recognition of the need to use simple, relevant, non-loaded language in HIV testing services, could be a good step in reducing HIV stigma across health services.

Declaration

Ethics approval and consent to participate

The Auckland University of Technology Ethics Committee (AUTEC) on 7 March 2017 (Reference No. 17/22)

The Research Ethics Committee of the Faculty of Medicine, of Sriwijaya University (Reference No. 39/keprsmhfkunsri/2017) on 15 March 2017

Consent to publish

None declared

Availability of data and materials

None declared

Competing interests

The authors declare that they have no competing interests

Funding

NJ received scholarship from the New Zealand Government, Ministry of Foreign Affair and Trade (MFAT)-New Zealand Asean Scholarship for her Ph.D. NA also received research funding from Auckland University of Technology (Auckland) and UNSRI (Indonesia).

Authors' Contributions

NA conducted the field work and extracted, coded, and interpreted data and wrote the first draft of the manuscript. SA helped code and interpret data. SA and SGD assisted with the conceptualisation and writing of the manuscript.

All authors read and approved the final manuscript

Acknowledgements

REVIEWER PDF

We would like to thank to NZAid-MFAT of New Zealand for funding the first author for her PhD at AUT. Special thanks to Margaret Leniston for being a great friend and allowing discussion about gender issues and analysis. We would acknowledge of School of Public Health, librarians, and learning advisors at AUT; as well as the Dean of the Public Health Faculty, and the Centres of Research and Community and the Rector of UNSRI for supporting NA.

REFERENCES

1. MoH. MoH regulation of basic standard services in health number 43 in 2016 (Permenkes no. 43 tahun 2016). Jakarta, Indonesia: MoH & Ministry of Law and Human Rights.; 2016.

2. Wulandari LPL, Lubis DS, Widarini P, Widyanthini DN, Wirawan IMA, Wirawan DN. HIV testing uptake among pregnant women who attending private midwife clinics: challenges of scaling up universal HIV testing at the private sectors in Indonesia. The International journal of health planning and management. 2019.

3. UNAIDS. Start free stay free AIDS free. Geneva, Switzerland: UNAIDS; 2017. Available from: http://www.unaids.org/sites/default/files/media_asset/JC2923_SFSFAF_2017progressreport_en.pdf.

4. MoH. Report of situation analysis of HIVAIDS in 2018. Jakarta, Indonesia: MoH.; 2018.

5. Rahmalia A, Wisaksana R, Meijerink H, Indrati AR, Alisjahbana B, Roeleveld N, et al. Women with HIV in Indonesia: Are they bridging a concentrated epidemic to the wider community? BMC Research Notes. 2015;8(1):1.

6. UNAIDS. Country Factsheets in Indonesia: HIV and AIDS Estimates in 2018 Geneva: UNAIDS; 2020 [Available from: https://www.unaids.org/en/regionscountries/countries/indonesia.

7. UNAIDS. UNAIDS data 2018. Geneva, Switzerland: UNAIDS; 2019. Available from: https://www.unaids.org/sites/default/files/media_asset/unaids-data-2018_en.pdf.

8. MoH. Size Estimation of HIV Key Population in Indonesia 2016. Jakarta: MoH; 2017. Available from: https://drive.google.com/file/d/1CBS2t_bL2m2Pg9EI3w6KjHXUScdndK89/view.

9. Anindita M, Shaluhiyah Z. Non disclosure of HIV positive status of women to their partners: Implication for PMTCT in Central Java Indonesia. Jurnal Promosi Kesehatan Indonesia (Journal of Health Promotion Indonesia). 2016;8(1):39-48.

10. MoH. National action plan of Prevention of Mother to Child Transmission (PMTCT) program, Indonesia 2013-2017. Jakarta, Indonesia: MoH; 2013.

11. MoH. National management guidelines of prevention of HIV and Syphilis from mothers to children. Jakarta, Indonesia: Directorate of Maternal and Children Health; 2015.

REVIEWER PDF

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65

12. Muhaimin T, Besral. HIV prevalence among pregnant women in eight provincial capitals in Indonesia in 2003-2010. Makara Kesehatan. 2011;15(2):93-100.

13. INAC. National strategy and plan 2015-2019. Jakarta: INAC (Indonesian National Aids Commission); 2018. Available from: http://siha.depkes.go.id/portal/files_upload/SRAN_2015_2019_FINAL.pdf.

14. Tudor Car L, van-Velthoven MH, Brusamento S, Elmoniry H, Car J, Majeed A, et al. Integrating prevention of a mother to a child HIV transmission (PMTCT) programmes with other health services for preventing HIV infection and improving HIV outcomes in developing countries. The Cochrane Library. 2011;15(6 (CD008741)):1-10.

15. De Cock KM, Fowler MG, Mercier E, de Vincenzi I, Saba J, Hoff E, et al. Prevention of mother-to-child HIV transmission in resource-poor countries: Translating research into policy and practice. Jama. 2000;283(9):1175-82.

16. UNAIDS. Children and HIV: Fact sheet 2016. Available from: https://www.unaids.org/sites/default/files/media_asset/FactSheet_Children_en.pdf.

17. Davies SG, Najmah. Im/moral healthcare: HIV and universal health coverage in Indonesia Sexual and Reproductive Health Matters (in process). 2020.

18. Ooms G, Latif LA, Waris A, Brolan CE, Hammond R, Friedman EA, et al. Is universal health coverage the practical expression of the right to health care? BMC Int Health Human Rights. 2014;14(3):1-7.

19. UN WOMEN. Indonesia Geneva: UN WOMEN; n.d. [Available from: http://asiapacific.unwomen.org/en/focus-areas/cedaw-human-rights/indonesia.

20. Mahendradhata Y, Trisnantoro L, Listyadewi S, Soewondo P, Marthias T, Harimurti P, et al. The Republi c of Indonesia health system review. Geneva, Switzerland: WHO; 2017. Available from: https://apps.who.int/iris/bitstream/handle/10665/254716/9789290225164-eng.pdf?sequence=1&isAllowed=y.

21. Pisani E, Olivier Kok M, Nugroho K. Indonesia's road to universal health coverage: A political journey. Health policy and planning. 2017;32(2):267-76.

22. Agustina R, Dartanto T, Sitompul R, Susiloretni KA, Achadi EL, Taher A, et al. Universal health coverage in Indonesia: concept, progress, and challenges. The Lancet. 2019;393(10166):75-102.

23. MoH. MoH regulation of health services before and after pregnancy, contraception sand sexual health services, no 97, year of 2014 (Permenkes no. 97 tahun 2014). Jakarta, Indonesia: MoH & Ministry of Law and Human Rights.; 2014.

24. MoH. MoH regulation of elimination of HIV, Syphilis and Hepatitis B from mother to children number 52 in 2017 (Permenkes no.52 tahun 2017). Jakarta, Indonesia: MoH & Ministry of Law and Human Rights.; 2017.

25. UN ESCAP, WHO, ICPD. Bangkok: United Nations Publication; 2014. Available from: https://www.unescap.org/sites/default/files/SDD_PUB_ICPD-report-e_0.pdf.

REVIEWER PDF

26. UNFPA Indonesia. Indonesia: The ICPD+20 and the unfinished agenda 2014 [Available from: https://indonesia.unfpa.org/en/news/indonesia-icpd20-and-unfinished-agenda.

27. Najmah. My baby deserves love, not HIV: Enabling HIV-positive women to access Prevention of Mother-to-Child Transmission of HIV services. Auckland: Auckland University of Technology; 2019.

28. Lubis DS, Wulandari L, Suariyani NLP, Adhi KT, Andajani S. Private midwives' perceptions on barriers and enabling factors to Voluntary Counselling and HIV Test (VCT) in Bali, Indonesia. National Public Health Journal (Kesmas). 2019;14(1).

29. Badriah F, Tahangnacca M, Alkaff R, Abe T, Hanifah L. Implementation of Prevention of Mother to Child Transmission of HIV program in South Jakarta. Kesmas: National Public Health Journal. 2018;12(4):159-64.

30. Liem A, Adiyanti MG. "Bidan cantik": Psychoeducation on HIV and AIDS to improve the service quality of midwives at Yogyakarta public health center. HIV & AIDS Review. 2013;12(1):8.

31. White Ribbon Alliance (WRA). Respectful Maternity Care: The Universal Rights of Childbearing Women. Washington DC: White Ribbon Alliance; 2011. Available from: https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf.

32. Jolly Y, Aminu M, Mgawadere F, van den Broek N. "We are the ones who should make the decision"–knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers. BMC pregnancy and childbirth. 2019;19(1):42.

33. Butt L. Sexual tensions HIV-positive women in Papua. In: Bennett LR, Davies SG, editors. Sex and sexualities in contemporary Indonesia: Sexual politics, health, diversity and representations. London,UK: Routledge Taylor &Francis Group; 2015. p. 109-28.

34. Lumbantoruan C, Kermode M, Giyai A, Ang A, Kelaher M. Understanding women's uptake and adherence in option B+ for prevention of mother-to-child HIV transmission in Papua, Indonesia: A qualitative study. PloS ONE. 2018;13(6:e0198329):1-17.

35. Munro J, McIntyre L. (Not) getting political: Indigenous women and preventing mother-to-child transmission of HIV in West Papua. Culture, Health & Sexuality. 2015;18(2):157-72.

36. Lykes MB, Crosby A. Feminist practice of action and community research. In: Hesse-Biber SN, editor. Feminist research practice: A primer. Thousand Oaks, California: SAGE publications; 2014. p. 145-81.

37. Lodi S, Phillips A, Touloumi G, Geskus R, Meyer L, Thiébaut R, et al. Time from human immunodeficiency virus seroconversion to reaching CD4+ cell count thresholds< 200,< 350, and< 500 cells/mm3: Assessment of need following changes in treatment guidelines. Clinical Infectious Diseases. 2011;53(8):817-25.

38. Ponic P, Reid C, Frisby W. Cultivating the power of partnerships in feminist participatory action research in women's health. Nursing Inquiry. 2010;17(4):324-35.

REVIEWER PDF

39. Saldana J. The coding manual for qualitative researchers. Los Angeles, LA: SAGE; 2016.

40. Najmah, Davies SG, Andajani S. Wives and mothers and HIV Jakarta, Indonesia: Insider Indonesia; 2020 [Available from: https://www.insideindonesia.org/wives-and-mothers-and-hiv.

41. MoH. MoH regulation of the application of counselling and HIV test number 74 in 2014 (Permenkes no.74 tahun 2014). Jakarta, Indonesia: MoH & Ministry of Law and Human Rights.; 2014.

42. Turan JM, Nyblade L. HIV-related stigma as a barrier to achievement of global PMTCT and maternal health goals: A review of the evidence. AIDS and Behavior. 2013;17(7):2528-39.

43. Nguyen TA, Oosterhoff P, Pham YN, Hardon A, Wright P. Health workers' views on quality of prevention of mother-to-child transmission and postnatal care for HIV-infected women and their children. Human Resources for Health. 2009;7(39):1-11.

44. Panditrao M, Darak S, Kulkarni V, Kulkarni S, Parchure R. Socio-demographic factors associated with loss to follow-up of HIV-infected women attending a private sector PMTCT program in Maharashtra, India. AIDS care. 2011;23(5):593-600.

45. Butt L. Can you keep a secret? Pretences of confidentiality in HIV/AIDS counseling and treatment in Eastern Indonesia. Medical Anthropology. 2011;30(3):319-38.

46. Najmah, Davies SG, Andajani S. Getting married to a suspected bisexual man: A silent mode of HIV transmission among married women in Indonesia. indian Journal of Public Health & Development. 2019;10(7):976-80.

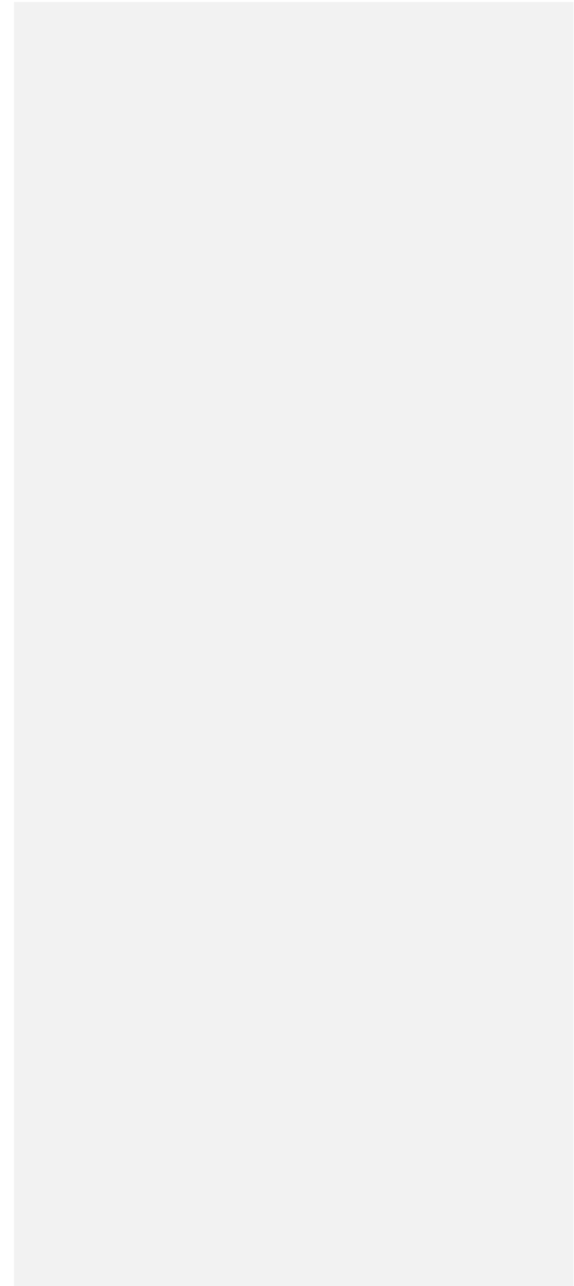
47. Bennett LR. Sexual morality and the silencing of sexual helath within Indonesian infertility care. In: Bennett LR, Davies SG, editors. Sex and sexualities in contemporary Indonesia: Sexual politics, health, diversity and representations. London, UK: Routledge; 2015. p. 148-66.

48. White S, Anshor MU. Islam and gender in contemporary Indonesia: Public discourses on duties, rights, and morality. In: Greg Fealy, Sally White, editors. Expressing Islam: Religious life and politics in Indonesia. Singapore, Singapore: Institute of Souteast Asian Studies Singapore 2008.

REVIEWER PDF

15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65

REVIEWER PDF



REVIEWER PDF

Table

Table.1: HIV prevalence in different groups in Indonesia (population of 270 million)

	Prevalence Risk	Estimated number PLWHIV[1)]/high risk groups[2)]
General population		
All adults aged 15 and over	0.4 %	0,000[1]
Women	0.3 %	0,000[1]
Men	0.5%	0,000[1]
High-risk group		
IDUs	28.8 %	33,500[2)]
MSM	25.8 %	4,300[2]
FSW	7.2 %	6,800[2]
Transgender	24.8 %	38,900[2)]
Men access prostitutes	-	5,244,064[2)]

Source: (6-8)

Note: [2)] estimated number of high risk groups to contracted HIV (not all HIV-positive); Prevalence risk of HIV in the general population in Papua > 4 %.

REVIEWER PDF

Table.2: Demographic profile and HIV related status of the 18 HIV+ participants

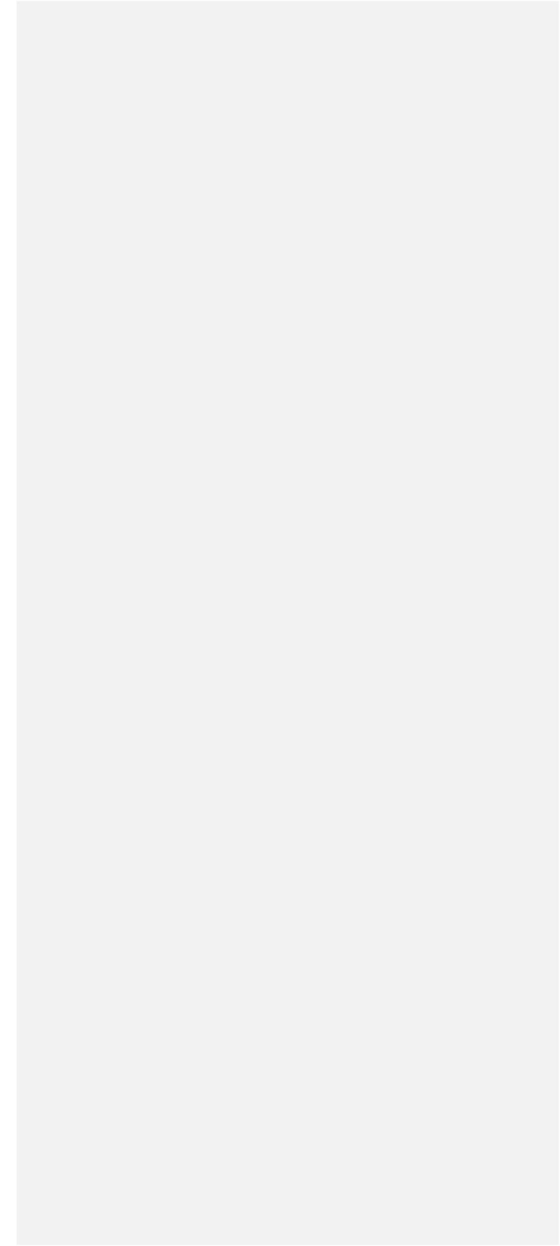
No	Pseudonym	First CD4* (cells/mm^3)	Year of HIV diagnosis	Age	Marital status	PMTCT access**	HIV status of husband	Number of children alive	Education level	Notes
1	Mira	350	2015	21	Married	Yes	Positive	2	Senior High School	1st marriage, monogamous; 1st child HIV free; 2nd child took prophylaxis, vaginal delivery, confirmed HIV free in December 2017; Bisexual husband
2	Bulan	40	2013	46	Widow	No	Positive	1	Senior High School	Divorced from 1st husband; 2nd husband deceased, was HIV+; 2nd marriage, polygamous.
3	Nika	292	2016	22	Married	Yes	Negative	3	Elementary School	1st marriage, monogamous; 1st and 2nd child HIV free; 3rd child taking prophylaxis.
4	Alung	100	2012	37	Married	No	Negative	3	Elementary School	2nd marriage as a 2nd wife; One HIV+ child and one deceased child.
5	Rini	400	2011	41	Widow	No	Positive	3	Senior High School	Deceased husband was HIV+.
6	Mawar	300	2011	41	Married	No	Negative	2	Senior High School	2nd marriage; polygamous; 1st deceased husband was HIV+; 2nd husband HIV neg.; Former IDU.
7	Mela	300	2014	42	Widow	No	Positive	3	Senior High School	Deceased husband was HIV+; Husband was an IDU.
8	Nina	329	2012	32	Married	No	Negative	3	Senior High School	2nd marriage; monogamous; 1st husband deceased, was HIV+; 1st husband was an IDU; 2nd husband HIV neg.
9	Mano	300	2016	25	Widow	No	Positive	1	Senior High School	Deceased husband was HIV+; One child was HIV neg.; Former prostitute.
10	Oneng	155	2016	41	Widow	No	Positive	6	Senior High School	Deceased husband was HIV+; Children 1-5 were HIV neg.;

REVIEWER PDF

11	Sinta	-	2012	41	Widow	No	Unknown	1	Senior High School	Sixth child was HIV+. Deceased husband never took an HIV test. Former IDU.
12	Mona	500	2012	30	Married	Yes	Negative	2	University	2nd marriage, monogamous; 1st husband deceased, was HIV+; 1st husband was an IDU; 2nd husband HIV neg.; 1st child was HIV free; 2nd child taking prophylaxis.
13	Putri	292	2007	35	Married	Yes	Positive	2	Senior High School	1st marriage; monogamous; 1st and 2nd children were HIV free; (2nd child taking prophylaxis); Husband was former IDU.
14	Maya	400	2015	33	Married	No	Negative	3	Elementary School	1st husband divorced, was HIV neg.; 2nd husband HIV neg.; Former prostitute.
15	Oda	290	2017	30	Married	No	Negative	3	Senior High School	1st marriage, monogamous; 1st and 2nd children were HIV free; 3rd child was HIV+.
16	Xani	300	2007	35	Married	Yes	Positive	3	University	1st marriage, monogamous. Husband was former IDU.
17	Bunga	350	2017	30	Married	Yes	Negative	1	Senior High School	2nd marriage, monogamous; 1st husband deceased, unknown HIV status; 1st child taking prophylaxis.
18	Mulan	400	2012	28	Married	Yes	Negative	1	Senior High School	2nd marriage, polygamous; 1st husband deceased, HIV+; 1st child died of pneumonia, a sign of HIV; 2nd child taking prophylaxis; 2nd husband was former IDU.

Notes:
* CD4 (cells/mm^3): CD4 cell count, the level of white blood cells, is frequently used to measure how long someone has been infected with HIV. PLWHIV who had a CD4 of less than 200 cell/mm^3, 200-350 cells/mm^3 and over 350 cells/mm^3 were estimated to have contracted HIV about eight, four and one year prior, respectively (37)
**PMTCT access relates to comprehensive PMTCT services, including antenatal HIV testing, antiretroviral treatment during pregnancy and after delivery, prophylaxis treatment for babies born to HIV-positive mothers, and formula feeding

REVIEWER PDF



REVIEWER PDF

Table 3. Associated human rights' violations in HIV testing HIV of 18 HIV-positive women

Pseudonym	Violations of human rights in reproductive health and HIV services				
	Rights to information[1]	Rights to informed decision-making[1]	Rights to confidentiality[2]	Rights to dignity and non-discrimination [3]	Rights to timely and best services[4]
Mira			v	v	v
Bulan	v				v
Nika	v	v	v	v	
Alung	v				v
Rini	v				v
Mawar	v			v	v
Mela	v				v
Nina					v
Mano	v		v	v	
Oneng	v			v	v
Sinta	v		v	v	
Mona			v	v	
Putri			v	v	v
Maya	v				v
Oda				v	v
Xani				v	v
Bunga	v	v		v	
Mulan	v				v

Notes:

[1] Rights to information may include rights to informed consent, reasons for referral, reasons for denied services, information on choices of services available, and the rights to bring support person/s to services.

[2] Right to confidentiality and privacy

[3] Right to equality, freedom from discrimination, equitable care & right to dignity and respect

[4] Right to timely healthcare and to the highest attainable level of health

Adopted from: (31, 32)

REVIEWER PDF

REVIEWER PDF

Cover Letter

AUT – Top 1% of universities | Mail - Najmah - - Outlook | Facebook | Laju Sumatera Selatan | Editorial Manager® | Search results - najem240

editorialmanager.com/zrhm/default.aspx

Taylor & Francis
Taylor & Francis Group

Sexual and Reproductive Health Matters

Editorial Manager

Message from Aries Systems: We experienced a significant increase in user traffic over the past several days which caused a brief downtime and subsequent slowness. We have restored performance on our servers and will be monitoring closely to ensure stability. We apologize for any disruption experienced.

HOME • LOGOUT • HELP • REGISTER • UPDATE MY INFORMATION • JOURNAL OVERVIEW
MAIN MENU • CONTACT US • SUBMIT A MANUSCRIPT • INSTRUCTIONS FOR AUTHORS • PRIVACY

Role: Author Username: najem240783

Incomplete Revisions for Author Najmah Najmah, Ph.D candidate

The 'Edit Revision' link allows you to fix or alter your revised submission. Please use Edit Revision to make changes to the meta-data and to remove and upload new files that make up your revised submission.

The 'Decline to Revise' link moves your submission to the Declined Revisions folder. Please use this ONLY if you do not intend to submit a Revision.

Page: 1 of 1 (1 total incomplete revisions) Display 10 results per page.

Actions	Manuscript Number	Title	Date Revision Began	Date Revision Due	Status Date	Current Status
Action Links	ZRHM-2019-0193R1	"I told you, doctor! It's not possible for my wife to get HIV": HIV testing (or not) among married women in Indonesia	Apr 23, 2020	Apr 25, 2020	Apr 23, 2020	Incomplete

Page: 1 of 1 (1 total incomplete revisions) Display 10 results per page.

<< Author Main Menu

Your Time: 07:41, 24 April • **Site Time:** 20:41, 23 April

REVIEWER PDF

Cover Letter

AUT – Top 1% of universities | Mail - Najmah - - Outlook | Facebook | Laju Sumatera Selatan | Kabu | Editorial Manager®

editorialmanager.com/srhm/default.aspx

Taylor & Francis
Taylor & Francis Group

Sexual and Reproductive Health Matters

Editorial Manager

HOME • LOGOUT • HELP • REGISTER • UPDATE MY INFORMATION • JOURNAL OVERVIEW
MAIN MENU • CONTACT US • SUBMIT A MANUSCRIPT • INSTRUCTIONS FOR AUTHORS • PRIVACY

Role: Author Username: najem240783

Article Type Selection | Attach Files | General Information | Review Preferences | Additional Information | Comments | Manuscript Data

When possible these fields will be populated with information collected from your uploaded submission file. Steps requiring review will be marked with a warning icon. Please review these fields to be sure we found the correct information and fill in any missing details.

Insert Special Character

– Title

Full Title (required)

Word Count: 22

"I told you, doctor! It's not possi...

HIV testing (or not) among marri...

Error

You cannot complete your submission until the following items are corrected (click on the bold text to open the appropriate item):

File-related information is missing.

OK

+ Next

+ Abstract

+ Keywords

+ Authors

+ Funding Information

← Back | Save & Submit Later | Build PDF for Approval →

Your Time: 07:37, 24 April • **Site Time:** 20:37, 23 April

REVIEWER PDF

Sexual and Reproductive Health Matters

Perceptions of and barriers to HIV testing among married women in Indonesia

--Manuscript Draft--

Full Title:	Perceptions of and barriers to HIV testing among married women in Indonesia
Manuscript Number:	ZRHM-2019-0193R2
Order of Authors:	Najmah Najmah, Ph.D candidate
	Sari Andajani , Doctor
	Sharyn Graham Davies, Associate Professor
Article Type:	Research Article
Keywords:	HIV tests, women, human rights violation, universal health coverage, Indonesia
Abstract:	The 2014 health reforms in Indonesia advocated for increased universal health coverage (UHC) for all Indonesians. The reforms also made provision for integrated HIV (Human Immunodeficiency Virus) programmes , with HIV testing to be available at community health centres and hospitals for pregnant women and women of childbearing age. These reforms aimed to increase HIV testing and early diagnosis of HIV. The question remains, though, as to whether the implementation of HIV testing has been effective and met women's needs, especially those of child-bearing age. Of particular focus in this article is what barriers women face accessing HIV testing. The article shows that a key barrier is social and institutional stigma. This article presents findings from the experiences of 18 HIV-positive women. This article examines barriers to pregnant women's access to HIV tests and these barriers all relate to women not having a right to reproductive health. This article highlights key reproductive health rights and violations noted in the Respectful Maternity Care (RMC) Charter, which is relevant to HIV testing in pregnancy. Five commonly reported rights violation include: women unable to access information; not being able to make independent informed decisions; no right to confidentiality and privacy; ongoing discrimination; and no right to timely HIV testing. The findings show that policy makers must make change to ensure health services are improved, that there is an increase in the training of health professionals, and that women's socio-cultural and political contexts be taken into consideration.
Response to Reviewers:	Editor Please consider rewording the title (e.g. Perceptions of and barriers to HIV testing among married women in Indonesia) A statement specifying that informed consent for participation in the present research was obtained (not just asked for) must be included in the methods Please move the ethics approval statements (including approval numbers) to the methods section of the manuscript Answer: We have changed the title; We have added this statement; We have done this. Reviewer#1 You still do not provide any rationale for why Palembang was selected for this study. I recommend that you include a rationale for your site selection of Palembang in your Methodology section. Answer : We have now added this statement: "Palembang was selected because the first author was born and raised in Palembang and she has had a number of years of working with various organisations working with IDUs and HIV in this city. She has good community

Powered by Editorial Manager® and ProduXion Manager® from Aries Systems Corporation

	connections that facilitated the research. She is also fluent in the local language." p. 4 line 23: define generalized and concentrated epidemics Answer : We have now added: "A concentrated HIV epidemic means HIV has spread rapidly in one or more defined sub-populations but is not well-established in the general population. A generalised epidemic is where most new infections are from heterosexual contact in the general population." I would say that what is different is that this paper is analyzing the barriers using a rights framework. These earlier studies would reveal rights violations, but that was not their analytical focus. They have been analysed to reveal other aspects. Answer: We have now added All except one participant identified themselves as housewives (ibu rumah tangga). At the time of this study, one woman, Mona was working full time. The term ibu rumah tangga, in Indonesian context, is a generic term used to refer to married women who were either fully financially dependent on their husbands or those who involved in informal sectors. For example, participants who worked as an hourly paid housemaid {cleaning other people's houses) or running a small warung (a bric-brack stall) had called themselves as ibu rumah tangga. Although 17 participants declared themselves as ibu rumah tangga, seven were fully financially dependent on their husbands and 10 had worked in informal sector, having an online business and opening a small stall. Six participants who were widows also regarded themselves as ibu rumah tangga even when they were the primary income-earner or the breadwinner of their families.

Powered by Editorial Manager® and ProduXion Manager® from Aries Systems Corporation

Reviewer comments	Action
	We thank the editor and reviewers so much for their help with this article. The time you have taken to support us, and encouraging us, and providing ways to strengthen the article have been most appreciated. Thank you!
Editor Please consider rewording the title (e.g. Perceptions of and barriers to HIV testing among married women in Indonesia) A statement specifying that informed consent for participation in the present research was obtained (not just asked for) must be included in the methods Please move the ethics approval statements (including approval numbers) to the methods section of the manuscript	 We have changed the title. We have added this statement. We have done this.
Reviewer #1 You still do not provide any rationale for why Palembang was selected for this study. I recommend that you include a rationale for your site selection of Palembang in your Methodology section.	 We have now added this statement: "Palembang was selected because the first author was born and raised in Palembang and she has had a number of years of working with various organisations working with IDUs and HIV in this city. She has good community connections that facilitated the research. She is also fluent in the local language."
I recommend you strengthen the evidence for STIs always being considered the woman's fault in Indonesia.	We have added references to Bennett 2015 and Najmah 2019.
I recommend that you include a direct quotation from Nika - perhaps at p. 14 lines 8-17.	Included now.
p.3 lines 21 - 27: suggested rewording to clarify the contrast between Indonesia and Sub-Saharan Africa that the authors draw attention to- original is unclear: 'Mothers and children have long been the populations at highest risk of HIV in Indonesia leading to a focus on prevention of mother-to-child transmission. This is in contrast to 21 sub-Saharan African countries where HIV is prevalent within their general population.'	Thank you for these suggestions but we have now deleted this passage.

REVIEWER PDF

p.3 lines 51-55: please state date of Muhaimin and Besral (9) study (2011), the date of their predicted estimates and the date of your study so the reader can make sense of this statement. How do you explain the gap between the study estimate of 9,000 and your estimate of 1,000 new HIV cases in children each year?	We have deleted this passage now.
p. 4 line 10: suggested edit 'several international conventions'	Changed.
p. 4 line 23: define generalized and concentrated epidemics	We have now added: "A concentrated HIV epidemic means HIV has spread rapidly in one or more defined sub-populations but is not well-established in the general population. A generalised epidemic is where most new infections are from heterosexual contact in the general population."
p.4 line 39: what do you mean by a service? At a puskesmas? At a district hospital? 30 sound like a very small number for a country the size of Indonesia. Perhaps you could indicate the number of sub-districts providing these services?	We have deleted this passage now.
p.4 line 40: Are the 547 VCT services part of the 30 PMCMT services?	We have deleted this part now.
p.4 line 42: promoted by whom? At the global level or in Indonesia?	We have deleted this part now.
p.5 line 4: So in all provinces? Perhaps say 'in all 34 provinces'	We have deleted this part now.
p. 5 line 21: Are you referring only to bidan? What about dukun bayi? Do/can they play a role in referral?	We have deleted this part now.
p. 5 line 25: aren't midwives healthcare providers? Or do you mean specifically providers of VCT?	We have deleted this part now.
p. 5 line 52: isn't HIV a sexually transmitted infection? Do you mean 'other sexually transmitted infections? Or do you mean 'not on mother-to-child transmission of HIV'?	We have deleted this part now.

REVIEWER PDF

p. 5 line 54: For clarity, instead of 'This study implies … .' I suggest 'Our study regarded participants as experts … .'	We have deleted this part now.
p. 7 line 6: For clarity, I suggest the following order: 6 were widows. The remaining 12 were married. Of these 8 were in their 2nd marriage, their former husband having died from HIV.	We have clarified this.
p. 7 line 8: 'Most' were not working outside the home and 'most' were breadwinners? This appears to be a contradiction. Instead of 'Most' I suggest including the actual numbers here.	We have clarified this now.
p. 9 line 39: Why did you use the voice of the obstetrician rather than the women's voices, given your feminist approach?	We include the obstetrician's voice as a part of our triangulation process.
p. 10 line 39: Case Study 1: refers to Anti only, not to Lela - perhaps omit Lela from this heading.	We have deleted this passage.
p. 11 line 4: direct quotation requires page number in the in-text citation.	Thank you we have added this.
p. 13 line 31: 'One of the tests was for HIV' - was is omitted from author's text	Corrected thank you.
p. 13 line 54: I suggest omitting 'Of course' as Maman's behavior could not be assumed.	Deleted
p. 15 line 12: define 'anamnesis'	Deleted
p. 17 line 25: country specific what? Guidelines? Regulations?	Clarified.
Reviewer #3	
Married women? Women in Sumatra or western Indonesia? Because of the differences in implementing testing locally is this too general? It is also a small qualitative study - is it systematic and was it intended to exhaustively examine all the possible barriers? It seems to me it was	We have clarified that it refers to women in Palembang.

REVIEWER PDF

more exploratory and reports on issues that emerged from women's experiences	
I would say that what is different is that this paper is analyzing the barriers using a rights framework. These earlier studies would reveal rights violations, but that was not their analytical focus. They have been analysed to reveal other aspects.	Thank you for distilling this. We have now: Previous studies on barriers to HIV testing in women, such as Badriah, Tahangnacca (27) in Jakarta; Butt (31), Lumbantoruan, Kermode (32), and Munro and McIntyre (33) in Papua, would have revealed examples of human rights violations. Yet those studies did not use the framework of sexual and reproductive rights as their analytical focus.
Perhaps some explanation of the category of 'housewife' is needed, given that they are also the breadwinner in the family	We have now added All except one participant identified themselves as housewives (*ibu rumah tangga*). At the time of this study, one woman, Mona was working full time. The term *ibu rumah tangga,* in Indonesian context, is a generic term used to refer to married women who were either fully financially dependent on their husbands or those who involved in informal sectors. For example, participants who worked as an hourly paid housemaid (cleaning other people's houses) or running a small *warung* (a bric-brack stall) had called themselves as *ibu rumah tangga*. Although 17 participants declared themselves as *ibu rumah tangga,* seven were fully financially dependent on their husbands and 10 had worked in informal sector, having an online business and opening a small stall. Six participants who were widows also regarded themselves as *ibu rumah tangga* even when they were the primary income-earner or the breadwinner of their families.
Section should state exactly how many focus groups were conducted not 'up to'	We have now added: "Six focus group sessions of two hours each, were conducted with each group. Twelve group discussions were carried out over a two-month period."
This has not been introduced as a method of data collection in the earlier section	'Visuals methods' has been deleted.
See question from first review about partner disclosure policies in this context - are providers supposed to make spouses aware, or is it up to the spouse and the doctor is supposed to keep it confidential?	We have included discussion on this now, thank you!
Its also important that this seems to be about lack of informed consent for the testing and this idea that provider initiated testing means compulsory testing without	We have included discussion on this now, thank you!

REVIEWER PDF

informing the person.	
Section below should be clear who has provided the information. Is it according to the doctor, Anti visited the clinic after experiencing discharge?	Yes, it is according to the doctor.
This section ends rather abruptly with the limitations of the study. Suggest to include a 'discussion' that connects back to literature raised in the introduction	We have extended this now, thank you!

REVIEWER PDF

Perceptions of and barriers to HIV testing among married women in Indonesia

Najmah

Sriwijaya University

Sari Andajani

Auckland University of Technology

Sharyn Graham Davies

Auckland University of Technology

Corresponding authors: sari.andajani@aut.ac.nz

REVIEWER PDF

ABSTRACT

Indonesia's ~~The~~ 2014 health reforms advocated for universal health coverage (UHC) for all Indonesians. The reforms made provision for integrated HIV (Human Immunodeficiency Virus) programmes, with testing to be available at community health centres and hospitals for pregnant women and women of childbearing age. The question remains, though, as to whether testing has been effective. This article focuses on barriers women face accessing HIV testing and presents findings from experiences of 18 HIV-positive women. To triangulate findings, interviews were conducted with 26 health workers, 9 NGO workers and 12 HIV stakeholders.

This article examines barriers to pregnant women's access to HIV tests, showing that barriers relate to women not having reproductive health rights. This article highlights reproductive rights and violations noted in the Respectful Maternity Care Charter, relevant to HIV testing in pregnancy. Five reported rights violations include: women unable to access information; not being able to make informed decisions; no right to confidentiality and privacy; ongoing discrimination; and no right to timely HIV testing. The failure of Indonesia to protect these rights contributes to women being denied HIV testing.

Findings show the need for increased HIV testing services for pregnant women, and asserts that health personnel and programme policy makers need to be held accountable for the protection and fulfilment of women's rights in respect to HIV testing. The findings show that policy makers must make changes to ensure health services improve, that there is an increase in the training of health professionals, and that women's socio-cultural and political contexts be considered.

Key words: HIV tests, married women, human rights violation, reproductive rights, universal health coverage, Indonesia

INTRODUCTION

The 2014 health reforms in Indonesia advocated for increased universal health coverage (UHC) for all Indonesians, including the provision of integrated HIV (Human Immunodeficiency Virus) programmes, with HIV testing to be available at community health centres and hospitals for pregnant women and women of childbearing age (1-3). Annually in Indonesia, 40% of new HIV cases occur in women of childbearing age (4). These women fall outside prescribed high risk groups [i.e. commercial sex workers (CSWs), injecting drug users (IDUs) and men who have sex with men (MSM) (Table 1)]. The steep increase in HIV prevalence among women in the general population in the last decade is a proxy indicator for HIV transmission to children,

and HIV policies and programmes cannot remain ignorant of HIV transmission in women, especially among pregnant women (5).

[Table 1]

Pregnancy occurs among women living with HIV (WLWH) (5, 6), and as such, infants are vulnerable to HIV transmission from their mothers, through pregnancy, delivery, and/or breastfeeding [Indonesian Ministry of Health (MoH) (7, 8)]. An HIV prevalence of 0.4% in pregnant women explains that approximately 25,000 women, out of six million pregnant women, are HIV positive at any one time in Indonesia (9). Of concern is that pregnant women often find out their HIV status in the late stage, resulting in late treatment for preventing mother to child transmission (PMTCT) (8, 10). Without timely and effective HIV treatment during pregnancy, half of HIV positive pregnant women will give birth to HIV positive babies (11, 12). Further, without Antiretroviral therapy (ARV), those infants will likely die before their second birthday (8, 13). Less than 10% of pregnant women in Indonesia access PMTCT services (7), and missed opportunities for early HIV screening and treatment for pregnant women remain a huge challenge.

The promotion and protection of women's rights to healthcare, including early HIV screening and timely and relevant HIV treatment, is central to the UHC goal (14, 15). At the global level, women's rights to healthcare is well recorded in a number of international conventions including the 1985 International Convention of the Elimination of All Forms of Discrimination Against Women (CEDAW), the Cairo International Conference on Population and Development Programme of Action ICPD (PoA) in 1994 (16). At the national level, the Indonesian government passed a number of regulations between 2013 and 2017, including the 2014 UHC to include: integrated HIV testing in antenatal clinics and ARV treatment for women and children in PMTCT programmes (17-19). Other regulations include compulsory HIV screening in Antenatal care (ANC) services; Provider-Initiated HIV Testing and Counselling (PITC); comprehensive PMTCT and guidance to services; and the fiscal responsibilities for all parties and ministries involved (1, 20, 21). With continuing high HIV prevalence in a number of provinces, like Papua (a generalised epidemic) and Jakarta, Bali, East Java, West Java and Riau (concentrated epidemics) amongst MSM, CSWs, IDUs, Indonesia needs to significantly scale up its HIV screening and ARV treatment in PMTCT (8, 22, 23). A concentrated HIV epidemic means HIV has spread rapidly in one or more defined sub-populations but is not well-established in the general population. A generalised epidemic

Commented [A1]: It would be good to include this particular statistic in Table 1. Currently it only includes "women" not "pregnant women"

Commented [A2]: Isn't this a violation of right to choose and/or refuse health services? Seems to contradict the key message of the paper.

REVIEWER PDF

is where most new infections are from heterosexual contact in the general population (24). Nevertheless, widespread inequalities in accessing health services remain (17). For example, in Palembang, our study field, compulsory HIV screening in ANC was only introduced in 2017; at the time of this study in early 2017, there were only 16 VCT centres, mostly located in hospital-based settings, with only three in *puskesmas* (local community health clinics) settings. At the end of 2017, all 41 *puskesmas* in Palembang provided HIV testing as a part of PMTCT services, and 12 new VCT centres were established (25).

While Indonesia has implemented policies on HIV testing, uptake remains poor. There are various challenges, such as poor referral mechanisms (2, 26). For instance, when a pregnant woman gets referred, she may find it difficult to travel to the VCT clinic (e.g. the clinic is too far, or the clinic's opening hours do not work for women) (2, 26, 27). At the same time, women living with HIV are highly stigmatised in Indonesian societies, making healthcare providers feel hesitant or reluctant to refer women to have HIV test; they do not want to shame or insult their clients (26, 28).

REVIEWER PDF

In the remainder of this article, we examine barriers and challenges that pregnant women face in accessing HIV testing during pregnancy using a framework of women's sexual and reproductive rights. The Respectful Maternity Care Charter (RMCC) was introduced in Indonesia and worldwide by the White Ribbons Alliance, adopting 10 universal human rights indicators for women's and new-borns' rights in maternity health care. The RMCC was chosen as the best platform for our examination because it allows analysis of the rights violation women faced in accessing HIV tests in Indonesia (29, 30). Some of the 10 universal rights include:1) rights to information; 2) right to independent informed decision-making; 3) rights to privacy and confidentiality; 4) right to respectful services (non-discrimination and dignity and care); and 5) right to timely treatment and attainable health care.

In this article, we focus on common sexual and reproductive rights violations reflected in the experiences of 18 HIV positive women participants when accessing HIV testing in Palembang, South Sumatra. These women had either ~~ever~~ been married or were married to heterosexual men, at the time of the study. A clear understanding of these barriers will provide a platform for the development of policies and programmes that will support women. For example, our findings can inform policies and programmes that aim to: raise awareness of women's rights; guarantee health care delivery; increase capacity for health advocates to participate in human rights processes; and support health care professionals in providing respectful care and holding the

government to account to fulfil these rights (29). Previous studies on barriers to HIV testing in women, such as Badriah, Tahangnacca (27) in Jakarta; Butt (31), Lumbantoruan, Kermode (32), and Munro and McIntyre (33) in Papua, would have revealed examples of human rights violations. Yet those studies did not use the framework of sexual and reproductive rights as their analytical focus.

METHODOLOGY

This study acknowledges HIV positive women as experts in respect to their own HIV journeys. Women in this research were central to the production of knowledge and understanding of existing policies and practices regarding HIV testing. Following Brinton M. Lykes and Alison Crosby (2014), women in this study were given a safe and collective space, and trustworthy partnerships with the researchers, to have an open dialogue and critical discussion on matters relevant to HIV testing (34). The voices of HIV positive women were honoured, as well as those of other participants, like health workers, NGO workers and policy makers, to triangulate knowledge of how women were accessing HIV testing during pregnancy (25).

Selection of participants

Participants in this study included 18 HIV positive women, aged 21-47 years, and 26 health providers (12 midwives, 11 medical doctors, 2 obstetricians and 1 paediatrician), 12 policymakers, and 9 NGO peer-support workers. Participants were recruited through purposive sampling. The inclusion criteria of the HIV-positive women were: 1) of reproductive age; 2) living in Palembang, South Sumatra; and 3) available to join a series of FGDs (Focus Group Discussions) or interviews. An advertisement was sent to Non-Governmental Organisations (NGOs) and health services workers and included at local VCT clinics. For other groups, a formal letter of invitation was sent to each targeted institution related to HIV programmes for women. This article, however, focuses mainly on the narratives produced by the 18 HIV+ women and a few health workers, to best illustrate examples of the violations of women's reproductive health rights in respect to accessing HIV testing.

Ethical issues, including asking for consent to use interview/FGD transcripts from participants, respecting participants' rights to privacy and confidentiality, and minimising risks for both the participants and the researcher, were discussed. Protection of participants from any deceit, harm, and coercion was taken seriously in this research; it was essential to be able to keep to

Commented [A3]: Consent to use them for what? Publications? Social media?

Commented [A4]: Please clarify who discussed these issues with whom

REVIEWER PDF

the cultural values, social, and ethnic diversities of the participants. Informed consent was obtained from each participant.

Ethics approval was obtained from the Auckland University of Technology Ethics Committee (AUTEC) on 7 March 2017 (Reference No. 17/22) and from the the Research Ethics Committee of the Faculty of Medicine, of Sriwijaya University (Reference No. 39/keprsmhfkunsri/2017) on 15 March 2017.

The women's context of !ife

Table 2 presents the demographic and reproductive status of the 18 HIV positive women who participated in this study. Twelve were married and six were widows. Of those 12 who were married, eight were in their second marriage. Of these, 8 ~~were~~ in their second marriage, six had former husbands having died from HIV and two had divorced from their first husband, before they were diagnosed with HIV.

All 18 women were aware of their vulnerability to HIV. Twelve women believed that they were infected by their husbands who were either former IDUs (n=6), and/or frequent customers of commercial sex workers (n=5), and/ or living in a polygamous marriage (n=3), and/ or having sex with men (n=1). All 18 women, except two, were not aware of their having high risk sexual behaviour. Two women had histories of IDUs and having multiple sexual partners without practicing safe sex.

Commented [A5]: Meaning their own sexual behavior or that of their spouse/partner? Please clarify.

The women had between one and six children and had lived with HIV for at least two years (based on the CD4 level -the level of white blood cells- at first HIV test) (35). Three women had HIV positive children. Two had experienced stillbirths but they were not aware of what had caused it. Four women had their children taking ARV - prophylactic treatment- to reduce MTCT and they were all under 18 months old.

Commented [A6]: Please clarify whether the women were aware of their own HIV status or not

All except one participant identified themselves as housewives (*ibu rumah tangga*). At the time of this study, one woman, Mona was working full time. The term *ibu rumah tangga,* in Indonesian context, is a generic term used to refer to married women who were either fully financially dependent on their husbands or those ~~who~~ involved in informal employment sectors. For example, participants who worked as an hourly paid housemaid (cleaning other people's houses) or running a small *warung* (a bric-brack stall) ~~had called~~ referred to themselves as *ibu rumah tangga*. Although 17 participants declared themselves as *ibu rumah tangga,* seven were fully

REVIEWER PDF

financially dependent on their husbands and 10 had worked in informal sector, having an online business and opening a small stall. Six participants who were widows also regarded themselves as *ibu rumah tangga* even when they were the primary income-earner or the breadwinner of their families. Seven participants owned their houses; 6 lived in shared accommodation with their extended families (in-laws and siblings). Five rented a small room or a small house. The participants had completed at least 12 years of schooling.

[Table 2]

Field research

The field research, in Palembang, South Sumatra, was conducted over four months from February to July 2017, and included a series of group discussion, interviews, and participant observations by the first author (NA). Palembang was selected because the first author was born and raised in Palembang and she has worked for ~~had~~ a number of years ~~of working~~ with various organisations working with IDUs and HIV in this city. She has good community connections that facilitated the research. She is also fluent in the local language. Being aware of the sensitive nature of research with women living with HIV and having a former connection with relevant persons and institutions working with HIV programmes would enhance the success of the field research. All interviews and communications with participants were conducted in Bahasa Indonesia and local Palembang dialect.

Prior to the field research, two pilot trials were conducted to examine the relevance of the research plan, recruitment of participants, research instruments and any local norms and customs that the researchers should respect. These trials were conducted in Auckland (New Zealand) and in Palembang (Indonesia). The Auckland trial included group discussions with two groups of Indonesian women living and or studying in Auckland. The trial in Palembang included two HIV positive women, in a few meetings. The research plan and interview schedules were finalised following these two trials.

Of the 18 HIV positive women in this study, 11 formed two focus groups: Group A (5 members) and Group B (6 members). Women chose their own groups with no input from the researchers. Six focus group sessions of two hours each, were conducted with each group. Twelve group discussions were carried out over a two-month period. The remaining seven women opted for individual interviews. Each woman was visited one to three times, depending on their availability. Each visit lasted for about an hour. Some also asked for follow-up online

Commented [A7]: They were no longer working in the informal sector? If they still were, omit "had".

Commented [A8]: Great!

REVIEWER PDF

communication using Facebook and WhatsApp. Places for interviews and group discussion were on the discretion of participants, and included participants' house, office, community health centres, hospitals, restaurants, and parks. All interactions with women were conducted in a safe, physical environment chosen by the women. This allowed all participants to have more control of their space and be in a place where they felt safe and comfortable, while at the same time, maintaining confidentiality and privacy [see for example Ponic, Reid & Frisby (36), Najmah (25)].

Commented [A9]: Excellent approach

Data analysis

Narratives from interviews and group discussions were transcribed verbatim. Field notes were recorded in both Bahasa Indonesia and English. The interpretations of the women's reflections, and presentations were coded in their original language by the first author. The second author (SA) was also born in Indonesia and speaks fluent Bahasa Indonesia. SA had nearly 30 years of working in the area of gender health and SRH rights particularly in Indonesia, and other parts of the Asia and Pacific region. The first two authors worked closely together on the Indonesian transcription throughout the coding stages, making meaning of the contexts presented by the women, and developing themes from the coding, before translating relevant quotes into English. The third author [SGD] was born in Australia and has worked for over 15 years in research projects in Indonesia, relating to gender and identity.

To ensure consistency, regular fortnightly meetings were conducted between the authors to discuss emerging themes, categorisation, and links between codes and meanings, to enhance data interpretation. Transcriptions produced during the focus groups and interviews were cross-checked with field notes and visual images. Five main themes of rights violations emerged: right to information, right to information and informed decision making, right to confidentiality and privacy, right to dignity and care, and right to timely services (Table 3). Thematic analysis was performed by applying the steps of coding set out by Saldana (37) across different themes of women's sexual and reproductive rights iterated in the RMC Charter.

REVIEWER PDF

FINDINGS AND DISCUSSION

Table 3 depicts domains of disrespect and abuse and associated human rights violations against participants living with HIV. Out of 18 women, 12 felt they were lacking information with regards to HIV results of their husband, their children or their own. Of these 12 women, 5 had never been aware of any available HIV testing nor had they ever received any information that

raised their awareness to the importance of HIV testing. These 5 women only found out about their HIV in late stages, after the death or illness of their husbands, children, or they themselves had fallen ill. Six participants experienced breach of their privacy and confidentiality, when their HIV testing results were shared with other health workers, family members, or neighbours without their permission. In the next section, we present stories of Bunga, Oneng, Nika, shared during interviews and/or FGDs.

Commented [A10]: Might be worth pointing out that this is 1 in 3!

According to Indonesian MoH Regulations, it is not ethical to disclose patients' information without their approval (38). Patients may request for an HIV test voluntarily. A health worker or counsellor can also initiate and send a patient for an HIV test , known as 'providers 'initiated test'. In either case, patients have the rights to counselling and informed consent. Failures of the health providers to explain the following rights to the patients, is considered a breach of patient's rights to informed consent [*Permenkes* number 74 in 2014, Guidelines of HIV test and counselling] (38).

[Table 3]

Stories of Bunga and Oneng: Not getting the right information

Oneng (41 years old, low-income family, a widow living in an urban area), and Bunga (30 years old, middle-income family, second marriage, living in an urban area) shared stories during focus group discussions and interview, respectively. Both Oneng and Bunga were financially dependent on their husband. From their stories, we learned about ~~of~~ the breach of women's right to information, confidentiality, and privacy and how these rights are intertwined.

Bunga recalled her caesarean operation was cancelled in a private hospital, and she was referred to a public hospital. Upon her arrival at the public hospital, one of the doctors asked her husband "did you know why your wife was referred to us?". Bunga's husband said that the doctor at the private hospital was only saying that their baby was in a breech position. The doctor replied "No, your wife is HIV positive and Hepatitis B positive" (Bunga). In shock, Bunga cried for three days while she was waiting for caesarean surgery's schedule in this public hospital.

Oneng's story was about her shock after being told by her doctor that her youngest daughter was HIV positive:

REVIEWER PDF

> Angrily, I asked the doctor 'How come my daughter got this HIV?' The doctor replied *Bu* (Mam), you should know better than me how HIV was transmitted to your daughter (Oneng).

Both Bunga and Oneng were shocked when they received the news of their positive HIV test. Both were made aware of their HIV status in late stages, only after Bunga's HIV test before she delivered her baby or after Oneng's child had become sick. In both cases, the doctors were not coming straightforward with their information; instead they referred their patients (Bunga) to another hospital without giving the right information for referral, while Oneng was offered for an HIV testing after her youngest daughter got ill and diagnosed with HIV. ~~It~~ This occurred ~~was~~ one year after Oneng's husband passed away due to diseases related to AIDS. In other women's stories, the husband's family, such as mother-in-law and brother-in-law who may have been informed HIV status of their husbands in health settings, but they chose not to disclose the HIV status of her husband to the women [read Bulan's story - she was 46 years old, middle-income family, 2nd marriage-polygamous from urban area- in Najmah, Davies & Andajani (39)]

REVIEWER PDF

Story of Nika: Breach of privacy and confidentiality

Nika (22 years old, low-income family, first marriage, living in a rural area), during an FGD, retold to her peers, how a midwife had disclosed her HIV status to Nika's neighbours. In 2016, Nika was referred by her midwife to have a blood test in a *puskesmas*, including an HIV test, without Nika's consent. Nika did not know she was tested for HIV and to her horror the test result was positive and the news about her HIV status spread vastly in her neighbourhood.

> At first, I thought, I was just having a normal blood test. After I took the test, a health worker told me: 'please wait outside'. I was waiting for hours until the last patient had gone home. 'What happened with me? I asked myself wearily. I asked another health worker. She said 'No worries, just sit down, and a nurse will come to get you soon.' Finally, a counsellor came and told me that my HIV test was positive. To my shock and three days later, a midwife, who was my neighbour and work in that *puskesmas*, was gossiping with my neighbours about my HIV status. My family and I were expelled from our village straight away.

Angry neighbours then forced Nika and her husband (Maman) and two children to move out of the village. The family moved to Palembang city and rented a small one-bedroom or *kos-*

kosan (4x5 m2), with shared washing rooms. Nika said that she and her family were victims of social gossiping and social stigma.

> Social stigma ‗ had cornered me ‗ failed me ‗ punished me ‗ as if I were not a good woman ‗ not a good mother ‗ watch your mouth ‗ those people working in health ‗ get the right education (Nika).

Commented [A11]: This is a powerful quote

Maman often expressed his regrets, telling Nika,

> Had I known that you were asked to have an HIV test in that *puskesmas* (community health centre), I would have forbidden you to take it (Nika).

Maman continued to support Nika and Nika adhered to ARV treatment. Their baby was given prophylactic treatment after birth. Nika decided to have a tubectomy following the birth of her third child, suggested by her doctor. Nika consented.

Commented [A12]: Is it known whether Maman was HIV positive?

Nika's story revealed negative and traumatic experiences that she and her family went through following an HIV test. Nika's privacy was breached by her midwife. Nika's experience was later shared with groups of healthcare workers such as NGO workers, midwives, medical doctors, and HIV policymakers, to illustrate the violation of Nika's rights to confidentiality and privacy in HIV testing. Upon discussing Nika's story, opinions of health workers and policy makers were somehow divided. One group believed that the 'breach of privacy' was 'normal' as health workers, in the spirit of solidarity, want to protect her peers to be cautious of HIV positive patients. This opinion could reflect a manifestation of institutionalised stigma against people living HIV, within Indonesian health services. The other group was supportive of the patients' right to confidentiality and privacy. Ministry of Health Regulations, No. 74/2014 on Guidelines for HIV Testing and Counselling (VCT), notes that it is unethical to disclose patients' information without patients' approval', including to their spouse (38). Violations of patients' confidentiality in HIV testing have also been reported in Sub-Saharan Africa and some Asian countries, such as Vietnam and India (40-42). In these studies, moral judgement and socio-cultural stigma are argued to be roots of the violation of patients' right to confidentiality and privacy as well as the right for getting correct information (31, 43) (also read Mira's story in Najmah, Davies and Andajani (44)].

Commented [A13]: Please clarify if this was part of the research done by the authors. If so, you can be more specific than "such as" and specify who was involved in the discussions. You could also name this approach – a form of getting feedback on your preliminary results or testing your results with other research participants? This should also be specified in the Methodology section.

Stories of Anti and Lela: Needing a husband permission to mv testing

Stories of Anti and Lela were retold by a specialist obstetric gynecologist, who participated in

REVIEWER PDF

59 an interview. Anti and Lela were patients of Doctor Didi (a pseudonym), a senior male

60
61
62
63
64
65

obstetrician in a private hospital in Palembang. Anti visited his clinic after experiencing a yellow and white milky discharge from her vagina. She was initially treated by another physician for her STI and referred to Didi for a follow-up HIV test. Anti came to him with her husband. He recalled seeing Anti looking very weak. Following an individual consultation for HIV, Didi suggested that Anti have an HIV test. Anti's husband was very upset and insisted that "it was impossible for his wife to have HIV". Didi explained to him that it was important to have the HIV test done so Anti could get the right treatment. Anti's husband finally agreed and Anti' test was negative. In a separate occasion, disgusted at Didi, Anti's husband said: I told you so! It is not possible for my wife to get infected with HIV",

In another story, Lela came to doctor Didi's practice to ask for an HIV test. She was suspicious that her husband was having an extramarital affair. She was concerned aboutof her reproductive health as she had three previous miscarriages. Lela's husband refused to give permission for Lela for the test. Lela's request for HIV testing was then denied. Lela's husband, a high-profile local member of parliament, told Lela and Didi: "Never in my life I would let you have that [HIV] test - I am not naughty".

According to the Indonesian Ministry of Health Regulation No. 74, HIV tests and counselling, including voluntarily or provider initiated testing, should respect and protect patient's rights to informed consent, confidentiality across all services; -HIV testing, counselling, and HIV prevention and treatment (38). There is no requirement for a healthcare worker to seek permissions for any of those services to patients' partners.

REVIEWER PDF

Of interest here, often women would feel ashamed when presenting themselves to doctors' clinic with symptoms of STIs. Due to shame, the woman may choose to suffer in silence until the condition gets worse or becomes unbearable. Here, the comment made by Lela's husband that 'I am not naughty' indirectly suggested that Lela could be the one having sexual affairs and to be blamed. Studies by Bennett (2015) and Najmah (2019) also found the reluctance of doctors to offer test for STIs or HIV to women's husbands, due to fears of causing marriage breakups and exposing shaming to the couples [27, 47].

Denial of Lela' s request for HIV testing, however, was unacceptable. It was associated with fears from a health professional to causing marriage break ups, disharmonies, insults, and shame to their patients and consequently to lose their patients, as reported elsewhere (26). Here, Didi was faced with dilemmas. He recognized the right of his patients to HIV testing and

understood that by law the women did not need~~needed not~~ permission from the husbands. However, he was also aware that he could jeopardize his reputation and that of his institution, if women were given H N test without husbands' permission. Didi recalled an experience of one of his colleagues who was blackmailed after performing an H N test without the patient's husband's permission.

Women's subordination in marriage is a key reason why women are denied a right to healthcare (47, 48). Anti and Lela were aware of their health needs, yet were powerless to take control of, or exercise, their rights. Without obtaining husbands' permission, married women, like Anti and Lela, were denied to access to HIV testing. Their ability to make informed decisions was impeded by patriarchal values that position married women as subordinate to their husbands. Further research can extend our conclusions by~~ut~~ incorporating the voices of more women and the limits of rights they have to access healthcare. We anticipate women according Indonesia will have similar stories to tell.

REVIEWER PDF

RECOMMENDATYON

A primary finding of this study is that the violations of women's reproductive rights in respect to HIV testing contribute to barriers to access HIV services in Indonesia. Violations of women's rights to information, informed decision-making, privacy and confidentiality, and timely service were evident in this study. Existing socio-cultural and ideological values, such as HIV stigma against people living with HIV, the normalization of institutional stigma, and patriarchal values intersected to contribute to difficulties for women to access HIV testing in the general population.

Commented [A14]: Very important

Overcoming rights violation requires acknowledgment that rights violation exist, and making government accountable to address those human rights violations. Multiple and inter-sectoral approaches are needed at individual and interpersonal level, institutional and public policies. First, at the individual and interpersonal level, women and partners need to be aware of women's rights to information, informed decision, privacy and confidentiality, non-discrimination, timely and best health care. Second, training of healthcare professions need to highlight the connection between HIV testing services and human rights guarantees. Third, human rights activists, programme leaders and policy makers, need to build capacities for advocates for a right-based approach in HIV testing. Fourth, monitoring and evaluation of HIV testing in Indonesia, must accommodate relevant human rights indicators that serves a

foundation for holding government accountable to the fulfilment of women's rights to health in HIV testing. Lastly, a supportive healthy working environment is central to ethical professionalism in HIV testing services and to reduce institutionalised stigmatization. For example, an open discussion within health care delivery, recognition of the need to use simple, relevant, non-loaded language in HIV testing services, could be a good step in reducing HIV stigma across health services.

Consent to publish

None declared

Availability of data and materials

None declared

Competing interests

The authors declare that they have no competing interests

Funding

NA received scholarship from the New Zealand Government, Ministry of Foreign Affair and Trade (MFAT)-New Zealand Asean Scholarship for her Ph.D. NA also received research funding from Auckland University of Technology (Auckland) and UNSRl (lndonesia).

Authors' Contributions

NA conducted the field work and extracted, coded, and interpreted data and wrote the first draft of the manuscript. SA helped code and interpret data. SA and SGD assisted with the conceptualisation and writing of the manuscript.

All authors read and approved the final manuscript

Acknowledgements

We would like to thank to NZAid-MFAT of New Zealand for funding the first author for her PhD at AUT. Special thanks to Margaret Leniston for being a great friend and allowing discussion about gender issues and analysis. We would acknowledge of School of Public Health, librarians, and learning advisors at AUT; as well as the Dean of the Public Health Faculty, and the Centres of Research and Community and the Rector of UNSRl for supporting NA.

REVIEWER PDF

REFERENCES

1. MoH. MoH regulation of basic standard services in health number 43 in 2016 (Permenkes no. 43 tahun 2016). Jakarta, Indonesia: MoH & Ministry of Law and Human Rights.; 2016.

2. Wulandari LPL, Lubis DS, Widarini P, Widyanthini DN, Wirawan IMA, Wirawan DN. HIV testing uptake among pregnant women who attending private midwife clinics: challenges of scaling up universal HIV testing at the private sectors in Indonesia. The International journal of health planning and management. 2019.

3. UNAIDS. Start free stay free AIDS free. Geneva, Switzerland: UNAIDS; 2017. Available from: http://www.unaids.org/sites/default/files/media_asset/JC2923_SFSFAF_2017progressreport_en.pdf.

4. MoH. Report of situation analysis of HIVAIDS in 2018. Jakarta, Indonesia: MoH.; 2018.

5. Rahmalia A, Wisaksana R, Meijerink H, Indrati AR, Alisjahbana B, Roeleveld N, et al. Women with HIV in Indonesia: Are they bridging a concentrated epidemic to the wider community? BMC Research Notes. 2015;8(1):1.

6. Anindita M, Shaluhiyah Z. Non disclosure of HIV positive status of women to their partners: Implication for PMTCT in Central Java Indonesia. Jurnal Promosi Kesehatan Indonesia (Journal of Health Promotion Indonesia). 2016;8(1):39-48.

7. MoH. National action plan of Prevention of Mother to Child Transmission (PMTCT) program, Indonesia 2013-2017. Jakarta, Indonesia: MoH; 2013.

8. MoH. National management guidelines of prevention of HIV and Syphilis from mothers to children. Jakarta, Indonesia: Directorate of Maternal and Children Health; 2015.

9. Muhaimin T, Besral. HIV prevalence among pregnant women in eight provincial capitals in Indonesia in 2003-2010. Makara Kesehatan. 2011;15(2):93-100.

10. INAC. National strategy and plan 2015-2019. Jakarta: INAC (Indonesian National Aids Commission); 2018. Available from: http://siha.depkes.go.id/portal/files_upload/SRAN_2015_2019_FINAL.pdf.

11. Tudor Car L, van-Velthoven MH, Brusamento S, Elmoniry H, Car J, Majeed A, et al. Integrating prevention of a mother to a child HIV transmission (PMTCT) programmes with other health services for preventing HIV infection and improving HIV outcomes in developing countries. The Cochrane Library. 2011;15(6 (CD008741)):1-10.

12. De Cock KM, Fowler MG, Mercier E, de Vincenzi I, Saba J, Hoff E, et al. Prevention of mother-to-child HIV transmission in resource-poor countries: Translating research into policy and practice. Jama. 2000;283(9):1175-82.

13. UNAIDS. Children and HIV: Fact sheet2016. Available from: https://www.unaids.org/sites/default/files/media_asset/FactSheet_Children_en.pdf.

REVIEWER PDF

14. Davies SG, Najmah. Im/moral healthcare: HIV and universal health coverage in Indonesia Sexual and Reproductive Health Matters (in process). 2020.

15. Ooms G, Latif LA, Waris A, Brolan CE, Hammond R, Friedman EA, et al. Is universal health coverage the practical expression of the right to health care? BMC Int Health Human Rights. 2014;14(3):1-7.

16. UN WOMEN. Indonesia Geneva: UN WOMEN; n.d. [Available from: http://asiapacific.unwomen.org/en/focus-areas/cedaw-human-rights/indonesia.

17. Mahendradhata Y, Trisnantoro L, Listyadewi S, Soewondo P, Marthias T, Harimurti P, et al. The Republic of Indonesia health system review. Geneva, Switzerland: WHO; 2017. Available from: https://apps.who.int/iris/bitstream/handle/10665/254716/9789290225164-eng.pdf?sequence=1&isAllowed=y.

18. Pisani E, Olivier Kok M, Nugroho K. Indonesia's road to universal health coverage: A political journey. Health policy and planning. 2017;32(2):267-76.

19. Agustina R, Dartanto T, Sitompul R, Susiloretni KA, Achadi EL, Taher A, et al. Universal health coverage in Indonesia: concept, progress, and challenges. The Lancet. 2019;393(10166):75-102.

20. MoH. MoH regulation of health services before and after pregnancy, contraception sand sexual health services, no 97, year of 2014 (Permenkes no. 97 tahun 2014). Jakarta, Indonesia: MoH & Ministry of Law and Human Rights.; 2014.

21. MoH. MoH regulation of elimination of HIV, Syphilis and Hepatitis B from mother to children number 52 in 2017 (Permenkes no.52 tahun 2017). Jakarta, Indonesia: MoH & Ministry of Law and Human Rights.; 2017.

22. UN ESCAP, WHO, ICPD. Bangkok: United Nations Publication; 2014. Available from: https://www.unescap.org/sites/default/files/SDD_PUB_ICPD-report-e_0.pdf.

23. UNFPA Indonesia. Indonesia: The ICPD+20 and the unfinished agenda 2014 [Available from: https://indonesia.unfpa.org/en/news/indonesia-icpd20-and-unfinished-agenda.

24. UNAIDS. UNAIDS terminology guidelines. Geneva, Switzerland: UNAIDS; 2015. Available from: http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf.

25. Najmah. My baby deserves love, not HIV: Enabling HIV-positive women to access Prevention of Mother-to-Child Transmission of HIV services. Auckland: Auckland University of Technology; 2019.

26. Lubis DS, Wulandari L, Suariyani NLP, Adhi KT, Andajani S. Pr perceptions on barriers and enabling factors to Voluntary Counselling and HIV Test (VCT) in Bali, Indonesia. National Public Health Journal (Kesmas). 2019;14(1).

27. Badriah F, Tahangnacca M, Alkaff R, Abe T, Hanifah L. Implementation of Prevention of Mother to Child Transmission of HIV program in South Jakarta. Kesmas: National Public Health Journal. 2018;12(4):159-64.

REVIEWER PDF

28. Liem A, Adiyanti MG. "Bidan cantik": Psychoeducation on HIN and AIDS to improve the service quality of midwives at Yogyakarta public health center. HIV & AIDS Review. 2013;12(1):8.

29. White Ribbon Alliance (WRA). Respectful Maternity Care: The Universal Rights of Childbearing Women. Washington DC: White Ribbon Alliance; 2011. Available from: https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf.

30. Jolly Y, Aminu M, Mgawadere F, van den Broek N. "We are the ones who should make the decision"-knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers. BMC pregnancy and childbirth. 2019;19(1):42.

31. Butt L. Sexual tensions HIV-positive women in Papua. In: Bennett LR, Davies SG, editors. Sex and sexualities in contemporary Indonesia: Sexual politics, health, diversity and representations. London,UK: Routledge Taylor &Francis Group; 2015. p. 109-28.

32. Lumbantoruan C, Kermode M, Giyai A, Ang A, Kelaher M. Understanding women's uptake and adherence in option B+ for prevention of mother-to-child HIV transmission in Papua, Indonesia: A qualitative study. PloS ONE. 2018;13(6:e0198329):1-17.

33. Munro J, McIntyre L. (Not) getting political: Indigenous women and preventing mother-to-child transmission of HIV in West Papua. Culture, Health & Sexuality. 2015;18(2):157-72.

34. Lykes MB, Crosby A. Feminist practice of action and community research. In: Hesse-Biber SN, editor. Feminist research practice: A primer. Thousand Oaks, California: SAGE publications; 2014. p. 145-81.

35. Lodi S, Phillips A, Touloumi G, Geskus R, Meyer L, Thiebaut R, et al. Time from human immunodeficiency virus seroconversion to reaching CD4+ cell count thresholds< 200,< 350, and< 500 cells/mm3: Assessment of need following changes in treatment guidelines. Clinical Infectious Diseases. 2011;53(8):817-25.

36. Ponic P, Reid C, Frisby W. Cultivating the power of partnerships in feminist participatory action research in women's health. Nursing Inquiry. 2010;17(4):324-35.

37. Saldana J. The coding manual for qualitative researchers. Los Angeles, LA: SAGE; 2016.

38. MoH. MoH regulation of the application of counselling and HIV test number 74 in 2014 (Permenkes no.74 tahun 2014). Jakarta, Indonesia: MoH & Ministry of Law and Human Rights.; 2014.

39. Najmah, Davies SG, Andajani S. Wives and mothers and HIV Jakarta, Indonesia: Insider Indonesia; 2020 [Available from: https://www.insideindonesia.org/wives-and-mothers-and-hiv.

40. Turan JM, Nyblade L. HIV-related stigma as a barrier to achievement of global PMTCT and maternal health goals: A review of the evidence. AIDS and Behavior. 2013;17(7):2528-39.

REVIEWER PDF

41. Nguyen TA, Oosterhoff P, Pham YN, Hardon A, Wright P. Health workers' views on quality of prevention of mother-to-child transmission and postnatal care for HIV-infected women and their children. Human Resources for Health. 2009;7(39):1-11.

42. Panditrao M, Darak S, Kulkarni V, Kulkarni S, Parchure R. Socio-demographic factors associated with loss to follow-up of HIV-infected women attending a private sector PMTCT program in Maharashtra, India. AIDS care. 2011;23(5):593-600.

43. Butt L. Can you keep a secret? Pretences of confidentiality in HIV/AIDS counseling and treatment in Eastern Indonesia. Medical Anthropology. 2011;30(3):319-38.

44. Najmah, Davies SG, Andajani S. Getting married to a suspected bisexual man: A silent mode of HIV transmission among married women in Indonesia. indian Journal of Public Health & Development. 2019;10(7):976-80.

REVIEWER PDF

Table

Table.1: HIV prevalence in different groups in Indonesia (population of 270 million)

	Prevalence Risk	Estimated number PLWHIV[1)]/high risk groups[2)]
General population		
All adults aged 15 and over	0.4 %	620,000[1)]
Women	0.3 %	220,000[1)]
Men	0.5%	420,000[1)]
High-risk group		
IDUs	28.8 %	33,500[2)]
MSM	25.8 %	754,300[2)]
FSW	7.2 %	226,800[2)]
Transgender	24.8 %	38,900[2)]
Men access prostitutes	-	5,244,064[2)]

Source: (6-8)

Note: [2)] estimated number of high risk groups to contracted HIV (not all HIV-positive); Prevalence risk of HIV in the general population in Papua > 4 %.

REVIEWER PDF

Table.2: Demographic profile and HIV related status of the 18 HIV+ participants

No	Pseudonym	First CD4* (cells/mm^3)	Year of HIV diagnosis	Age	Marital status	PMTCT access**	HIV status of husband	Number of children alive	Education level	Notes
1	Mira	350	2015	21	Married	Yes	Positive	2	Senior High School	1st marriage, monogamous; 1st child HIV free; 2nd child took prophylaxis, vaginal delivery, confirmed HIV free in December 2017; Bisexual husband
2	Bulan	40	2013	46	Widow	No	Positive	1	Senior High School	Divorced from 1st husband; 2nd husband deceased, was HIV+; 2nd marriage, polygamous.
3	Nika	292	2016	22	Married	Yes	Negative	3	Elementary School	1st marriage, monogamous; 1st and 2nd child HIV free; 3rd child taking prophylaxis.
4	Alung	100	2012	37	Married	No	Negative	3	Elementary School	2nd marriage as a 2nd wife; One HIV+ child and one deceased child.
5	Rini	400	2011	41	Widow	No	Positive	3	Senior High School	Deceased husband was HIV+.
6	Mawar	300	2011	41	Married	No	Negative	2	Senior High School	2nd marriage; polygamous; 1st deceased husband was HIV+; 2nd husband HIV neg.; Former IDU.
7	Mela	300	2014	42	Widow	No	Positive	3	Senior High School	Deceased husband was HIV+; Husband was an IDU.
8	Nina	329	2012	32	Married	No	Negative	3	Senior High School	2nd marriage; monogamous; 1st husband deceased, was HIV+; 1st husband was an IDU; 2nd husband HIV neg.
9	Mano	300	2016	25	Widow	No	Positive	1	Senior High School	Deceased husband was HIV+; One child was HIV neg.; Former prostitute.
10	Oneng	155	2016	41	Widow	No	Positive	6	Senior High School	Deceased husband was HIV+; Children 1-5 were HIV neg.;

REVIEWER PDF

11 Sinta	-	2012	41	Widow	No	Unknown	1	Senior High School	Sixth child was HIV+. Deceased husband never took an HIV test. Former IDU.
12 Mona	500	2012	30	Married	Yes	Negative	2	University	2nd marriage, monogamous; 1st husband deceased, was HIV+; 1st husband was an IDU; 2nd husband HIV neg.; 1st child was HIV free; 2nd child taking prophylaxis.
13 Putri	292	2007	35	Married	Yes	Positive	2	Senior High School	1st marriage; monogamous; 1st and 2nd children were HIV free; (2nd child taking prophylaxis); Husband was former IDU.
14 Maya	400	2015	33	Married	No	Negative	3	Elementary School	1st husband divorced, was HIV neg.; 2nd husband HIV neg.; Former prostitute.
15 Oda	290	2017	30	Married	No	Negative	3	Senior High School	1st marriage, monogamous; 1st and 2nd children were HIV free; 3rd child was HIV+.
16 ani	300	2007	35	Married	Yes	Positive	3	University	1st marriage, monogamous. Husband was former IDU.
17 Bunga	350	2017	30	Married	Yes	Negative	1	Senior High School	2nd marriage, monogamous; 1st husband deceased, unknown HIV status; 1st child taking prophylaxis.
18 Mulan	400	2012	28	Married	Yes	Negative	1	Senior High School	2nd marriage, polygamous; 1st husband deceased, HIV+; 1st child died of pneumonia, a sign of HIV; 2nd child taking prophylaxis; 2nd husband was former IDU.

Notes:
* CD4 (cells/mm^3): CD4 cell count, the level of white blood cells, is frequently used to measure how long someone has been infected with HIV. PLWHIV who had a CD4 of less than 200 cell/mm^3, 200-350 cells/mm^3 and over 350 cells/mm^3 were estimated to have contracted HIV about eight, four and one year prior, respectively (37)
**PMTCT access relates to comprehensive PMTCT services, including antenatal HIV testing, antiretroviral treatment during pregnancy and after delivery, prophylaxis treatment for babies born to HIV-positive mothers, and formula feeding

REVIEWER PDF

REVIEWER PDF

Table 3. Associated human rights' violations in HIV testing HIV of 18 HIV-positive women

Pseudonym	Violations of human rights in reproductive health and HIV services				
	Rights to information[1]	Rights to informed decision-making[1]	Rights to confidentiality[2]	Rights to dignity and non-discrimination [3]	Rights to timely and best services[4]
Mira			v	v	v
Bulan	v				v
Nika	v	v	v	v	
Alung	v				v
Rini	v				v
Mawar	v			v	v
Mela	v				v
Nina					v
Mano	v		v	v	
Oneng	v			v	v
Sinta	v		v	v	
Mona			v	v	
Putri			v	v	v
Maya	v				v
Oda				v	v
ani				v	v
Bunga	v	v		v	
Mulan	v				v

Notes:

[1] Rights to information may include rights to informed consent, reasons for referral, reasons for denied services, information on choices of services available, and the rights to bring support person/s to services.

[2] Right to confidentiality and privacy

[3] Right to equality, freedom from discrimination, equitable care & right to dignity and respect

[4] Right to timely healthcare and to the highest attainable level of health

Adopted from: (31, 32)

REVIEWER PDF

REVIEWER PDF

Figure

editorialmanager.com/zrhm/default.aspx

Taylor & Francis — Sexual and Reproductive Health Matters — Editorial Manager

HOME • LOGOUT • HELP • REGISTER • UPDATE MY INFORMATION • JOURNAL OVERVIEW
MAIN MENU • CONTACT US • SUBMIT A MANUSCRIPT • INSTRUCTIONS FOR AUTHORS • PRIVACY

Role: Author Username: najem240783

Incomplete Revisions for Author Najmah Najmah, Ph.D candidate

The 'Edit Revision' link allows you to fix or alter your revised submission. Please use Edit Revision to make changes to the meta-data and to remove and upload new files that make up your revised submission.

The 'Decline to Revise' link moves your submission to the Declined Revisions folder. Please use this ONLY if you do not intend to submit a Revision.

Page: 1 of 1 (1 total incomplete revisions) Display 10 results per page.

Actions	Manuscript Number	Title	Date Revision Began	Date Revision Due	Status Date	Current Status
Action Links	ZRHM-2019-0193R1	"I told you, doctor! It's not possible for my wife to get HIV": HIV testing (or not) among married women in Indonesia	Apr 23, 2020	Apr 25, 2020	Apr 23, 2020	Incomplete

Author Main Menu

Your Time: 07:41, 24 April • Site Time: 20:41, 23 April

Figure

II ~Top 1% of universities × Mail - Najmah - - Outlook 11 Laju Sumatera Selatan | Kabu × Editorial Manager® ×

editorialmanager.com/srhm/default.aspx

Taylor & Francis
Taylor & Francis Group
Sexual and Reproductive Health Matters

Editorial Manager

HOME • LOGOUT • HELP • REGISTER • UPDATE MY INFORMATION • JOURNAL OVERVIEW
MAIN MENU • CONTACT US • SUBMIT A MANUSCRIPT • INSTRUCTIONS FOR AUTHORS • PRIVACY

Role: Author Username: najem240783

Article Type Selection | Attach Files | General Information | Review Preferences | Additional Information | Comments | Manuscript Data

When possible these fields will be populated with information collected from your uploaded submission file. Steps requiring review will be marked with a warning icon. Please review these fields to be sure we found the correct information and fill in any missing details.

Full Title (required)
Limit 50 words
Word Count: 22

Error
You cannot complete your submission items are corrected (click appropriate item):
File-related information is missing

"I told you, doctor! It's not possi
HIV testing (or not) among marri

+ Next

+ Abstract
+ Keywords
+ Authors
+ Funding Information

Build PDF for Approval

Your Time: 07:41, 24 April • Site Time: 20:41, 23 April