The Transnational Legal Process of Global Health Jurisprudence: HIV and the Law in Indonesia

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Abstract

The Transnational Legal Process of Global Health Jurisprudence: HIV and the Law in Indonesia

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Chair of the Supervisory Committee:

Walter J. Walsh

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As one of the most pressing global health priorities, HIV disruption requires effective transnational work. There is growing confidence among experts about ending AIDS by 2030. In Indonesia, a country with one of Asia's fastest-growing HIV epidemics, the law is instrumental to achieve that goal. Nonetheless, national laws and policies that undermine HIV prevention are continuously being adopted or preserved. This suggests that the presence of global health jurisprudence does not necessarily lead to national legal processes to enable HIV prevention policies. This situation raises the central question of whether the perpetuation of national legal barriers to HIV prevention is associated with Indonesia's internalization of global health jurisprudence. This study uses Professor Harold Koh's transnational legal process theory to examine the transfer of global health jurisprudence by looking at Indonesia's interaction at the global level, interpretation of norms, and domestic internalization thereof. As a multi-method study with an inductive reasoning approach, this research utilizes a qualitative data analysis of international organizations' laws and policies, public/private institutions' policies, international treaties, Indonesian laws, and relevant public

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records. The study explores both the spatial and temporal development of global health jurisprudence throughout the HIV epidemic in Indonesia. At the national level, the study examines the laws and policies that are significant to HIV prevention and discusses the legal processes by taking the identified norms on global HIV prevention into account. After decades of Indonesia's participation in the global HIV response, this dissertation discusses a legal barrier that is prevalent across twenty-three out of thirty-four provinces in the country: HIV criminalization. Knowing that HIV criminalization is a legal impediment to a mainstream HIV reduction and eradication program, this dissertation concludes that the country's internalization is rather deficient.

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Dedication

This dissertation is dedicated in loving memory to my beloved sister,

Suzana Murni (1972-2002).

Thank you for your teaching me that *it's not the label, it's how you wear it.*

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List of Abbreviations

ACLU	American Civil Liberties Union
AIDS	Acquired Immune Deficiency Syndrome
ALTERLAW	Alternative Law Research and Development Center
APPGA	All-Party Parliamentary Group on AIDS
ARV	Antiretroviral Drugs
ART	Antiretroviral Therapy
APCASO	Asia Pacific Council of AIDS Service Organisations
APN+	Asia Pacific Network of People Living with HIV/AIDS
ASAP	Aids Society in Asia Pacific
AusAID	Australian Aid Agency
AWARE	Action for West Africa Region
CHALN	Canadian HIV/AIDS Legal Network
CHPM	Center for Health Policy and Management Universitas Gadjah Mada
CHC	Primary Healthcare Center
CIDA	Canadian International Development Agency
CSO	Community Service Organization
CMHDCA	Coordinating Ministry for Human Development and Cultural Affairs
CCM	Country Coordinating Mechanism
ECHR	European Court of Human Rights
FCGH	Framework Convention on Global Health

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FDC	Fixed Dose Combination
FKLOPA	The Communication Forum for AIDS Service NGOs
GATT	The General Agreement on Tariffs and Trade
GAVI	The Global Alliance for Vaccine and Immunization
GFATM	The Global Fund to Fight AIDS, Tuberculosis, and Malaria
GIPA	Greater Involvement of People Living with HIV and AIDS
GKNMAN	National Candlelight Memorial Movement
GNP+	Global Network of People Living with HIV/AIDS
GTZ	German Technical Cooperation Agency
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Users
IFPPD	Indonesian Forum of Parliamentarians on Population and Development
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICW+	International Community of Women Living with HIV/AIDS
IHR	International Health Regulation
ILO	International Labor Organization
IPU	Inter-Parliamentary Union
JICA	Japan International Cooperation Agency
JOTHI	The Indonesian PLHIV Network
LACCASO	Latin American & Caribbean Council of NGOs with HIV/AIDS Services
LBH	Legal AIDS Service
LGBT	Lesbian Gay Bisexual Transgender

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LFU	Lost to Follow Up
MAPAN	National AIDS Care Society
MPAI	Indonesian AIDS Care Society
MSM	Men Who have Sex with Men
MDGs	Millennium Development Goals
MOH	Ministry of Health
NAC	National AIDS Commission
NAP+	Network of African People Living with HIV/AIDS
NCPI	National Composite Policy Index
NGO	Non-governmental Organization
OHCHR	Office of the United Nations High Commissioner for Human Rights
PDPAI	The Indonesian Physician Association for AIDS
PKBI	The Indonesian Planned Parenthood Association
PLHIV	People Living with HIV
PLHA	People Living with HIV and AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient
RKUHP	The Penal Code Bill
SIHA	HIV/AIDS Information System
SSR	Sub Sub-Recipient
SR	Sub-Recipient
SDGs	Sustainable Development Goals

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SUFA	Strategic Use of Antiretrovirals
TASO	The AIDS Service Organization
TRIPS	The Agreement on Trade-Related Aspects of Intellectual Property Rights
USAID	The United States Agency for International Development
UN	United Nations
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UPR	Universal Periodic Review
VCT	Voluntary HIV Counseling and Testing
WHA	World Health Assembly
WHO	World Health Organization
WTO	World Trade Organization

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1. Introduction

1.1. Problem Statement and Research Question

As a country interested in addressing its considerable human immunodeficiency virus (HIV) burden, Indonesia has shown a degree of compliance with global institutions and norms. Indonesia has ratified the health-related core of human rights conventions, especially the International Covenant on Economic, Social, and Cultural Rights (ICESCR) and General Comment No. 14 on the Right to the Highest Attainable Standard of Health (Article 12). Indonesia uses the law as a tool to create an environment where these norms can operate. There are at least sixteen health-related laws reflect components of the human right to health. It displays Roscoe Pound's definition of law; an experience developed by reason, backed by the society's experience.[1]

In the presence of global health jurisprudence and human rights obligations, it is intriguing to see that there are also at least fifteen laws that pose a substantive threat to the success of HIV prevention in Indonesia.[2] Five laws are known to be barriers to social functions among key populations.[3] Seven laws are known to be barriers to HIV prevention among children

[1] ROSCOE POUND, THE TASK OF LAW 62 (1944).
[2] NATIONAL CONSULTATION ON LEGAL AND POLICY BARRIERS TO HIV IN INDONESIA (2015).
[3] *Id.* at 13.

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and youth.[4] Three laws are known to be barriers to HIV prevention among women.[5] Two laws are an obstacle to HIV prevention among people who use drugs.[6] At least one law endangers HIV prevention among men who have sex with men (MSM) and the transgender population.[7] Also, there are social welfare policies that are disadvantageous to sex workers.[8] Indonesia adopted these laws between 2000 and 2012, with the exceptions of the Marriage Law 1974 and the Penal Code 1946.

As an example of this contradiction, Health Ministerial Decree No. 567/2006 on Harm Reduction of Narcotic, Psychotropic, and Addictive Substances enables a needle exchange program that is known to be effective in reducing HIV prevalence among injecting drug users. Nonetheless, at program is hard to scale up because a higher law (Narcotics Law 2009) criminalizes personal use of narcotics.

In the absence of a specific national HIV law, local lawmakers use law as one of their tools to ensure that public health strategies are in place. Since 2001, there has been an increasing trend of HIV-specific laws being adopted by the local governments. This situation poses an intellectual challenge to investigate further whether legal barriers to HIV prevention are constructed at the local level. Should such legal barriers exist, this dissertation intends to find out whether they have a detrimental relationship with the transnational transfer of HIV public health norms.

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[4] *Id.* at 17.
[5] *Id.* at 22.
[6] *Id.* at 36.
[7] *Id.* at 27.
[8] *Id.* at 29.

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The emerging notion of "global health jurisprudence" shows the attempt to capture the dynamics of normative approaches in public health within and between countries.[9] Guided by the same intention, this study also seeks to learn why, after decades of Indonesia's participation in the global HIV response, laws and policies that undermine HIV prevention are continuously being adopted or preserved in the country. By taking the global context into account, this study poses the following research question: Is the perpetuation of national legal barriers to HIV prevention associated with Indonesia's internalization of global health jurisprudence?

This dissertation's systematic structure starts with Chapter 1. Introduction to convey the background, theoretical framework, research methods, and projected significance of the study. Subsequently, Chapter 2. Placing Transnational Legal Process in the Global Health Jurisprudence Context exposes the existing scholarship relevant to this dissertation. The review includes discussions on the transnational legal process as the central theoretical framework, the scholarship regarding HIV legal issues, and relevant aspects of Indonesian law.

Chapter 3. The Transnational Legal Process of Global HIV Norms in the Indonesian Context exhibits the historical timeline of Indonesian HIV law. This chapter builds from a macro-historical overview, then narrows to the development of local HIV laws since 2001.

Chapter 4. Tracing and Prospecting Transnational Legal Process is where the pinnacle of the scholarly discussion takes place. This chapter takes into account the historical development of HIV norms at the global level. Insights from this process will segue to the internalization process. As a part of the analytical rigor, this chapter proceeds with a reverse tracing of norms to see the flow of norms by using a river plot. This procedure separates the insular norm from the

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[9] David Fidler, *Global Health Jurisprudence: A Time of Reckoning*, 96 GEO. L. J. 393, 394 (2008).

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mainstream norms across the vertical belt of norms. Subsequently, this chapter probes the insular norm (i.e., criminalization) and determines whether it acts as a legal barrier using Jonathan Mann and Lawrence Gostin's test. Lastly, the chapter will use all the derived insights to arrive at conclusions.

Chapter 5: Conclusion crafts all the claims of this dissertation, which are followed by several recommendations. Finally, the Appendices follow to provide a collection of supporting information.

1.2. Theoretical Framework

In answering the research question, this study uses the theory of transnational legal process.[10] The existence of legal barriers to HIV prevention provokes further investigation regarding global health norms' diffusion. This deep study of national internalization requires the rigor of understanding the social, political, and legal narratives that shape the current legal environment of Indonesian HIV policies.

The political prominence of global health institutions is recognized because they produce the rules, with inherent non-legal consequences for any failure to comply with them, and self-claim their authority to do so.[11] From the lens of institutionalism, this study also frames global health jurisprudence as an institution (defined here as a collection of rules produced by

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[10] Harold Hongju Koh, *Transnational Legal Process: The 1994 Roscoe Pound Lecture*, 75 NEB. L. REV. 181–208, 184 (1996); Robert O. Keohane, *Global Governance and Legitimacy*, 18 REV. INT'L AL POL. ECON. 99–109 (2011).
[11] Allen Buchanan & Robert O. Keohane, *The Legitimacy of Global Governance Institutions*, 20 ETHICS & INT'L AFF. 405–437, 406 (2006).

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organizations).[12] By assessing the authority of global health jurisprudence, the study will attempt a complete description of how global health institutions relate to Indonesia as a nation-state. The dissertation focuses on the disparity that exists between the ideals of global health jurisprudence on HIV prevention and the national reality, as well as the internal contradictions between laws in the Indonesian legal environment, taking into account the interpretive position of international human rights law.

This identified disparity between global and national ideals is a suitable object for a novel study based on transnational legal process theory. Koh introduces transnational legal process as a framework to identify the transfer of law as ideas from the international to the national level with the involvement of a legal process.[13] Koh's transnational legal process theory has three dimensions: (1) Interaction; (2) Interpretation of norms; and (3) Domestic internalization.

1.3. Research Methods

This dissertation adheres to methodological pluralism with an inductive reasoning approach. It uses documentary, survey, and interview data collection methods. The documentary research portion of this study implements an extensive review of international human rights law literature, transnational legal process literature, global health literature, and HIV response literature. This study utilizes a qualitative approach to analyze the following documents: (1) International human rights instruments; (2) Research reports from AIDS research institutes; (3) Country reports; (4) Reports and policy documents from global health institutions; (5) Reports

[12] Sven Steinmo, *Historical Institutionalism*, *in* APPROACHES AND METHODOLOGIES IN THE SOCIAL SCIENCES: A PLURALIST PERSPECTIVE, 118 (Donatella Della Porta & Michael Keating eds., 2008).
[13] Koh, *supra* note 10 at 184.

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from non-governmental organizations; (6) National laws and laws including their relevant public records; (7) National HIV program reports; (8) Case laws; and (9) Conference reports.

This dissertation uses codes to analyze the documents. The categorization starts from the local HIV laws and continues to the global level. This bottom-up categorization creates and uproots the tracing of HIV norms. Rather than tracing the norms from global to local, this reverse uprooting helps to separate the linked norms throughout the different levels of lawmaking. The Appendices section of this dissertation provides details about data sources, the sampling frame, and the plan for categorization (coding).

This study starts with Harold Koh's transnational legal process theory to examine the transfer of global health jurisprudence by looking at Indonesia's interaction at the global level, its interpretation of norms, and its domestic internalization.[14] The study conducts four works involving both library and field research:

(1) Examining HIV legal history: This work describes the evolution of Indonesian national and local HIV prevention policies and laws since the 2001 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS. By using the historical process tracing approach, this portion will determine Indonesia's interaction within the global health governance on HIV and AIDS over the years.

[14] TRANSNATIONAL LEGAL PROCESSES AND HUMAN RIGHTS (Kyriaki Topidi & Lauren Fielder eds., 2013); Michael Zisuh Ngoasong, *Transcalar Networks for Policy Transfer and Implementation: The Case of Global Health Policies for Malaria and HIV/AIDS in Cameroon*, 26 HEALTH POL'Y PLAN 63–72 (2011); HAROLD HONGJU KOH, *Jefferson Memorial Lecture—Transnational Legal Process after September 11th* (2004); Harold Koh, *How Is International Human Rights Law Enforced?* 74 IND. L. J. 1397 (1999); Koh, *supra* note 10.

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(2) Parsing the content of HIV-specific local laws: This study collects HIV-specific local laws in Indonesia that exist at the provincial and regency levels. Since not all of these local laws are available online, this study uses personal correspondence outreach with local informants in Indonesia. To date, the study has gathered seventy-one local laws. The study parses the content of these selected local laws into fourteen categories and 244 codes. The parsing helps track the flow and deviation of HIV norms from global to local lawmaking processes (interpretation). To better convey this flow of norms, this dissertation uses a web application to generate an interactive Sankey Chart to visualize this flow of HIV norms.

(3) Surveying HIV-positive peer groups: People living with HIV (PLHIV) have the strongest personal interest because they are the central beneficiaries of HIV programs. In the period of February to April 2019, the study rolled out an online survey to HIV-positive peer support groups in Indonesia. That survey was intended to gather data about their roles in and perspectives on local lawmaking processes. The study focuses on the Implementing Units of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), which represent around three hundred smaller peer support groups in 184 regencies in thirty-one provinces in Indonesia. Supported by expert interviews, the data from this survey would be useful in spotting the gaps in the interaction among actors in local legal processes (internalization).

(4) Data triangulation: To raise the credibility of the findings, the study performs data triangulation regarding the central topic of the legal process of HIV jurisprudence. The process cross-examines the findings from the above three methods before concluding.

In sum, the study will be conducted in the following sequence:

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(1) This study describes the forms of laws and policies provided by global health institutions, including both state and non-state actors (*documentary research*);

(2) This study determines Indonesia's position in the interaction of the global health governance on HIV/AIDS (e.g., ratification, regional fora, accountability channeling, and moral acceptability) (*documentary research*);

(3) This study describes the national HIV prevention policy in Indonesia (*documentary research*);

(4) This study determines the laws and policies at the national level that have presupposed implications for HIV prevention (e.g., anti-discrimination laws, criminalization of specific populations, strategic use of antiretrovirals, intellectual property law, and HIV exposure laws) (*documentary research*);

(5) This study determines the legal and political processes (including the interaction among actors, lawmaking processes, judicial processes, and policy reforms) that shape the current legal and policy environment of HIV prevention (*documentary research and interview*); and

(6) This study determines the level and the route of substantive consistency of global health jurisprudence on the national legal process (*coding, analysis, and conclusion*).

Based on the description above, this dissertation takes several approaches, including normative legal research, historical institutionalism, and institutional ethnography. With that in mind, this dissertation seeks to make significant and optimal scholarly contribution to the socio-legal school.

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Notably, this dissertation subscribes to Adriaan Bedner's "law in context" approach within the socio-legal school.[15] Bedner proposes law in context as a third socio-legal approach between "legal anthropological research" and "legal institutional studies."[16] Bedner proclaims that law in context comprises insights from both approaches, but it "pays much more attention to state law and to legal analysis."[17] He finds that this approach is most suitable for the Indonesian legal system:[18]

> Much of the body of "law in context" scholarship is primarily concerned with the analysis of legal texts, including court decisions. It is important to note that in Indonesia itself analysis of court decisions is rare and only recently have scholars and practitioners started to resume this practice. This has partly to do with the lack of availability of the legal materials required and partly with legal scholars being no longer used to conducting such doctrinal studies.[19]

He also claims the robust applicability of the approach to Indonesian land law and Islamic law.[20] This present dissertation embraces such approach and applying it to the emerging area of global health.

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[15] Adriaan Bedner, *Autonomy of Law in Indonesia*, 37 RECHT DER WERKELIJKHEID 10–36, 27 (2016).
[16] *Id.* at 27.
[17] *Id.*
[18] *Id.* at 28.
[19] Bedner, *supra* note 15 at 27; Adriaan Bedner, *Indonesian Legal Scholarship and Jurisprudence as an Obstacle for Transplanting Legal Institutions*, 5 HAGUE J. RULE L. 253–273 (2013).
[20] Bedner, *supra* note 15 at 28.

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1.4. Significance of the Study

The study will flourish Koh's transnational legal process by placing it in the global health context. This study will also clarify the interpretive position of international human rights law in the era of global health governance.

In pursuing a problem-solving end, the study will be a substantive contribution to the proposed Framework Convention on Global Health (FCGH) toward a global health treaty.[21] The study will produce concrete recommendations for global health institutions to be more effective in addressing structural hurdles like laws and policies. The study will also inform Indonesian policy actors to foster an efficient approach to using law as a public health tool in the era of global health governance.

This study will also produce an unprecedented annotated HIV-specific legal directory (project: HIVLaw.ID). The legal directory will be a valuable tool for Indonesian and global researchers in the field of HIV and the law. This study projects HIVLaw.ID to be a living directory where HIV stakeholders could provide development notes regarding a particular legal instrument in Indonesia.

[21] FCGH | Framework Convention for Global Health, http://www.globalhealthtreaty.org/ (last visited Jan 19, 2018).

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2. Placing Transnational Legal Process in the Global Health Jurisprudence Context

2.1. Introduction

This chapter explicates the foundational literature on transnational legal process theory. Subsequently, this chapter also introduces the overall situation of HIV in Indonesia as a case study in this dissertation. It starts by portraying the academic desert of HIV and law scholarship in Indonesia. Afterward, this chapter describes the more fertile landscape of the Indonesian HIV program in general. In the last part, this chapter surveys the larger terrain of the Indonesian legal system as the grounding jurisdiction in this study.

2.2. The Emergence of Transnational Legal Process Theory

Koh's idea of transnational legal process represents an interdisciplinary approach involving international law and international relations scholarship. In his seminal work, *Transnational Legal Process*, Koh rigorously establishes the notion.[22] To arrive at his theory of the transnational legal process, Koh went through the evolution that led to the establishment of the international law and international relations disciplines.[23] The transnational legal process

[22] Koh, *supra* note 10 at 184.
[23] *Id.* at 186.

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theory is his reaction to the allegedly false assumptions made by international relations theorists.[24]

First, Koh compares the domestic and international evolutions of legal process scholarship. He finds that the evolutions are of identical sequence and timeline. The American legal academy started after the Civil War with Christopher Columbus Langdell's legal formalism.[25] Langdell introduced the case book method and the approach of "law as science."[26] Subsequently, this theory was challenged at the onset of the 20th century by the legal realism school.[27] This latter movement provoked two major developments, especially in addressing the perceived indeterminacy of legal realism.[28] The first follow-up before World War II was towards codification through the development of the American Law Institute's Restatements and the Uniform Law Commission's Uniform Commercial Code soon after the war.[29]

The second follow-up to legal realism was the emergence of the legal process school by the mid-20th century.[30] This movement, pays attention to legal institutions, legal reasoning, and neutral principles.[31] Koh also contends that the legal process school focuses on Ronald Dahl's school of political science, where a pluralistic political process is instrumental in making a rational but orderly policy change.[32]

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[24] *Id.* at 192.
[25] *Id.* at 187.
[26] CHRISTOPHER COLUMBUS LANGDELL, SELECTION OF CASES ON THE LAW OF CONTRACTS (1871).
[27] Koh, *supra* note 10 at 187.
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] *Id.* at 187.; HENRY MELVIN HART ET AL., THE LEGAL PROCESS: BASIC PROBLEMS IN THE MAKING AND APPLICATION OF LAW (1994). The manuscript was written by Henry Hart and Alberts Sacks in late 1950s and remained as a palimpsest until William Eskridge Jr. and Phillip Frickey published it in 1994.
[32] Koh, *supra* note 10 at 187.

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Later in the 1960s, there were three developments of the American legal process school. First, *Miranda v. Arizona* and *Goldberg v. Kelly* marked the rise of due process, while *Brown v. Board of Education* marked the equal protection revolution.[33] The second development was poverty law, which marked the prominence of clinical studies, poverty, and entitlements law.[34] The third development was the "law and" movement, which dragged economists, sociologists, anthropologists, psychiatrists, doctors, and others on to American law faculties.[35]

The continuation of these movements has led to the emergence of the "new scientism."[36] According to George Priest, the new scientism has led to "the emergence of rational choice and organizational theory, and new critical schools of thought and methodology—critical feminist, race, and legal studies, law and literature, and postmodernism."[37] Koh also observes the emergence of a generation of public law scholars known as the "new public law movement."[38] This movement, preserving the legal process school, views lawmaking as "not merely the rubberstamping of a pluralistic political process, but as a process of value-creation in which courts, agencies, and the people engage in a process of democratic dialogue."[39] They strive to strengthen the normativity of process with interdisciplinary consciousness regarding written lawmaking, including on legislation, statutory interpretation, and civic republicanism.[40]

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[33] *Id.* at 187; Miranda v. Arizona, 384 U.S. 436 (1966); Goldberg v. Kelly, 397 U.S. 254 (1970); Brown v. Board of Educ., 347 U.S. 483 (1954).
[34] Koh, *supra* note 10 at 187; Charles A. Reich, *The New Property*, 73 YALE L. J. 733 (1964).
[35] Koh, *supra* note 10 at 187.
[36] *Id.* at 188.
[37] *Id.* at 188; George Priest, *The New Scientism in Legal Scholarship: A Comment on Clark and Posner*, 90 YALE L. J. 1284 (1981).
[38] Koh, *supra* note 10 at 188.
[39] *Id.* at 188.; William N. Eskridge (Jr.) & Gary Peller, *The New Public Law Movement: Moderation as a Postmodern Cultural Form*, 89 MICHIGAN L. REV. 707, 707 (1991).
[40] Koh, *supra* note 10 at 188.

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As a prime judicial exemplar of the new public law movement, William Eskridge Jr. and Gary Peller enacted the landmark opinion of Judge Julia Cooper Mack in *Gay Rights Coalition of Georgetown University v. Georgetown University*.[41] The opinion illustrates the features of: (1) Its explicit invocation of background norms in doing statutory interpretation; (2) Its critical evaluative stance toward the legislative materials; and (3) Its careful treatment of colliding norms.[42]

As a comparison, Koh explicates the parallel evolution of international legal process scholarship as reminiscent of the United States domestic evolution. He observes that the works of organizations such as the Hague Academy of International Law display a form of formalism: the classical study of international law.[43] As in the American domestic evolution, the international realists addressed this formalism.[44] Identical to what has happened in the evolution of the United States domestic legal process school, there was an international codification movement as one of the responses to this realism.[45] For example, there were the Harvard Research on International Law, the International Law Commission, and the American Law Institute's Restatements of Foreign Relations Law.[46]

In the 1960s and 1970s, this period of international evolution also staged a further development of legal process theory. The rights movement was represented globally by the

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[41] Eskridge (Jr.) and Peller, *supra* note 39 at 752.; Gay Rights Coal. of Georgetown Univ. Law Ctr. v. Georgetown Univ., 536 A.2d 1, 5 (D.C. 1987).
[42] Eskridge (Jr.) and Peller, *supra* note 39 at 752.
[43] Koh, *supra* note 10 at 189; HAROLD D. LASSWELL & MYRES S. MCDOUGAL, JURISPRUDENCE FOR A FREE SOCIETY: STUDIES IN LAW, SCIENCE, AND POLICY (1991).
[44] Koh, *supra* note 10 at 189; ABRAM CHAYES, INTERNATIONAL LEGAL PROCESS (1968).
[45] Koh, *supra* note 10 at 189.
[46] *Id.*

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emergence of the international human rights movement.[47] The poverty law movement, as the second reaction, appeared internationally in the form of the emerging subject of law and development.[48]

At this point, Koh has construed that there have been analogous and connected theoretical schools tying together the domestic and international legal scholarship. One of the corresponding facts is the emergence of the international human rights movement.[49] The post-war international development mechanism has been proven to have been crafted by lawyers, those who had faith in the rule of law rather than power.[50] Not only did they believe in the rule of law, but they also had confidence in states' cooperation "within [an] international institutional and constitutional framework."[51] In accordance with this observation, international lawyers' work is typically threefold: (1) Describing the law through analysis of customary law and treaties; (2) Evaluating the application of the law; and (3) Identifying growth areas and prescribing what the rule of law should be.[52] These types of work can be sharply contrasted with the work of international relations theorists, who seek to find value-free causal explanations and predictions. Like early legal realists, theorists of international relations work as scientists who engage in "value-free, non-prescriptive inquiry into causal explanation."[53]

The transnational legal process school therefore operates in the growing interdependence of norms, as exemplified by international human rights and environmental law, where there is a

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[47] *Id.* at 189; David M. Trubek, *Toward a Social Theory of Law: An Essay on the Study of Law and Development*, 82 YALE L. J., 1 (1972).
[48] Trubek, *supra* note 47 at 1.
[49] Koh, *supra* note 10 at 190.
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*

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persistence of interstate cooperation which at the same time allows the development of formal and informal, public and nonpublic mechanisms to produce the norms to maintain such cooperation.[54] This cooperation involves a wide variety of structures that include ranges of fora, subjects, levels, jurisdictions, and processes.

> The law may be underenforced, it may be imperfectly enforced, but it is enforced, not by a simple domestic process of legislation, adjudication, and executive action, but by a process of complex enforcement that transpires in a variety of public and private fora, under a variety of domestic and international laws, triggered by a variety of governmental and nongovernmental actors. In short, international law is enforced by a transnational legal process, which is triggered not just by the United States and Russia, but also by the Security Council, the GATT, Exxon, Greenpeace, the Paris Club, Amnesty International, and the Lowenstein International Human Rights Clinic at Yale Law School.[55]

Koh's multifaceted description of transnational legal process portrays that the norms do not vary wildly from one place to another; rather, there are growing work process norms. This complex process involves the explanation of self-interest and norm internalization. While at some times this complex process does involve transnational litigation, the global internalization process shows that international legal norms are also enmeshed in domestic political processes, which makes the "normativity of [the] transnational legal process" part of national conduct.[56]

The transnational legal process school therefore allows one to explore the deep reasons for states' compliance with international norms and its predictive capacity emerges when transnational legal processes are "aggressively triggered by other transnational actors in a way that forces interaction in forums capable of generating norms, followed by norm-

[54] *Id.* at 193.
[55] *Id.* at 194.
[56] *Id.* at 199.

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internalization."[57] This process also allows lawyers to understand the power of norms in civil society and thus "design public policies against a backdrop of law."[58] That also means that nongovernmental organizations influence the process and determine the outcomes.[59] In Koh's words, transnational legal process allows public lawyers to focus on the "normativity of process, sensitive to practice, and alive to interdisciplinary theory."[60]

In his article *Bringing International Law Home*, Koh argues that whether a state is a liberal democracy is not a factor for norm internalization.[61] In other words, norm internalization is not dependent on the state's type of legal system.[62] Instead, it is influenced mainly by the type of norm that a state is trying to internalize.[63] Koh suggests that internalization of international law norms appears in three forms:

> (1) Social internalization occurs when a norm acquires so much public legitimacy that there is widespread general adherence to it.
> (2) Political internalization occurs when the political elites accept an international norm and advocate its adoption as a matter of government policy.
> (3) Legal internalization occurs when an international norm is incorporated into the domestic legal system and becomes domestic law through executive action, legislative action, judicial interpretation, or some combination of the three.[64]

Embellishing on the national internalization process, Koh describes the involvement of several internalization agents. He explicitly specifies that most thriving internalization work is begun by

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[57] *Id.* at 206.
[58] *Id.*
[59] *Id.*
[60] *Id.*
[61] Harold Hongju Koh, *1998 Frankel Lecture: Bringing International Law Home*, 35 HOUS. L. REV. 623, 673 (1998).
[62] *Id.*
[63] *Id.*
[64] *Id.* at 642.

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"transnational norm entrepreneurs." Koh asserts that these norm entrepreneurs are either transnational nongovernmental organizations or individuals who (1) "mobilize popular opinion and political support both within their host country and abroad"; (2) "stimulate and assist in the creation of like-minded organizations in other countries"; (3) "play a significant role in elevating their objective beyond its identification with the national interests of their government"; and (4) often direct their efforts "toward persuading foreign audiences . . . [about] the universal moral sense, rather than the particular moral code of one society."[65]

Further, Koh mentions governmental norm sponsors as national agents of internalization.[66] They are government officials engaged by norm entrepreneurs to take proactive positions within the state authorities.[67] When norm entrepreneurs run concomitantly with governmental norm sponsors, they develop transnational issue networks or "epistemic communities."[68] Kathryn Sikkink defines epistemic communities as "networks of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area."[69]

Interaction arises when these transnational issue networks have both public and private scaffolds.[70] These scaffolds act as either governmental or nongovernmental to submit both "general norms of international law (e.g., treaties) and specific interpretation of these norms in

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[65] *Id.* at 647.; Ethan A. Nadelmann, *Global Prohibition Regimes: The Evolution of Norms in International Society*, 44 INT'L ORG. 479–526, 482 (1990).
[66] Koh, *supra* note 61 at 649.
[67] *Id.* at 648.
[68] *Id.* at 649.
[69] Kathryn Sikkink, *Human Rights, Principled Issue-Networks, and Sovereignty in Latin America*, 47 INT'L ORG. 411–441, 411 (1993).
[70] Koh, *supra* note 61 at 649.

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particular circumstances (e.g., ICJ ruling)."[71] Koh labels these stages as "interpretive communities and law-declaring fora."[72]

Furthermore, Koh explicitly mentions that these fora include "treaty regimes; domestic, regional, and international courts; ad hoc tribunals; domestic and regional legislatures; executive entities; commissions of international publicists; and nongovernmental organizations."[73] Koh's list of these interpretive communities is notably inclusive of fora that have a comparable characteristic: They can point at "a nation's international conduct, then defining, elaborating, and testing the definition of particular norms and opining about their violation."[74] Robert Cover describes this as a "jurisgenerative process," where interpretive communities "create law and give meaning to the law through their narratives and precepts."[75]

After the interpretive communities have created international norms, we move to the next stage, which comprises an effort to answer the question, "how will national governments internalize those community interpretations into their own domestic bureaucratic and political structures?"[76] Koh labels this stage as the "bureaucratic compliance procedures," which are identical to the practice of corporate lawyers in developing a corporate compliance program. In reacting to the constructions made by law-declaring fora, "domestic governmental institutions adopt symbolic structures, standard operating procedures, and other internal mechanisms to help maintain their habitual compliance with internalized international norms."[77]

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[71] *Id.*
[72] *Id.*
[73] *Id.* at 650.
[74] *Id.*
[75] Robert M. Cover, *Foreword: Nomos and Narrative*, 97 HARV. L. REV. 4–68, 40 (1983).
[76] Koh, *supra* note 61 at 651.
[77] *Id.* at 652.

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As for this compliance area, Koh posits that within governments and international organizations, there are people such as in-house legal advisers who ensure that government policies adhere to the international norms internalized in domestic law.[78] Koh uses Robert Keohane's phrase, where "domestic decision-making is enmeshed with international legal norms because institutional arrangements for the making and maintenance of an international norm become entrenched in domestic legal and political processes."[79]

As the final stage of internalization, Koh states that "issue linkages" represent full internalization. This is the stage when "strong process linkages exist across issue areas."[80] It is a state when the internalization of an international norm in one area affects another area. He provides an example of when the United States internalized the twelve-mile ocean law, and this norm also affected the area of American refugee law. When such linkage exists, a violation or non-compliance in one area would also tend to lead to a violation or non-compliance in another area. In this regard, Koh suggests that the move from external coercion to internalized obedience is a repeated cycle of the transnational legal process.[81]

In summary, Koh's national internalization of global legal norms happens in six stages. These stages are the critical components of internalization that will guide the further analysis of this dissertation:

(1) Norm emergence via norm entrepreneurs;

(2) The enlisting of governmental norm sponsors;

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[78] *Id.*
[79] *Id.* at 653; Robert O. Keohane, *Compliance with International Commitments: Politics Within a Framework of Law*, *in* THE AMERICAN SOCIETY OF INTERNATIONAL LAW: PROCEEDINGS OF THE 86TH ANNUAL MEETING 176, 179 (1992).
[80] Koh, *supra* note 61 at 653.
[81] *Id.*

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(3) The formation of epistemic communities;

(4) The staging of interpretive communities and law-declaring fora;

(5) The formation of bureaucratic compliance procedures; and

(6) The existence of issue linkages.

Koh abbreviates the six stages above as the distinctive features of transnational legal process: (1) Non-traditional; (2) Non-statist; (3) Dynamic, as opposed to static; and (4) Normative.[82] Nontraditional means that the transnational legal process tears down the dichotomies of domestic-and-international, and public-and-private.[83] In the 21st century discourse of transnational legal process, these traditional dichotomies are less relevant.[84] With non-statist, Koh means that the actors involved in transnational legal process are not only states, but also non-states.[85] Koh observes that non-state actors are playing increasingly decisive roles in international norm making fora.[86] The third feature, dynamic, suggests that transnational law continuously grows and moves in multiple directions.[87] It is perpetually changing and travels between public and private, across the levels of domestic and international.[88] That is why Koh also asserts that transnational legal process involves not only the traditional international norms, but also the far-reaching term of global norms.[89] The fourth feature, normative, suggests that the product of the interaction resembles a new rule of law that is becoming the object of

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[82] Koh, *supra* note 10 at 184; Eskridge (Jr.) and Peller, *supra* note 39; WILLIAM N. ESKRIDGE, DYNAMIC STATUTORY INTERPRETATION (1994).
[83] Koh, *supra* note 10 at 184.
[84] *Id*.
[85] *Id*.
[86] *Id*.
[87] *Id*.
[88] *Id*.
[89] *Id*. at 184; Harold Hongju Koh, *Why Do Nations Obey International Law*, 106 YALE L. J. 2599, 2602 (1997).

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interpretation, internalization, and application.[90] With that in mind, transnational legal process encompasses normativity, and goes beyond a description of process.

2.3. Practices of Transnational Legal Process

One of the earliest works on transnational legal process is Koh's work entitled *Transnational Public Law Litigation.*[91] In this work, Koh introduces transnational public law as a merger between traditional domestic litigation and traditional international litigation.[92] Understanding the elements of transnational public law litigation is helpful in justifying the transnational nature of a domestic legal process.

In a traditional sense, domestic litigation is where "private individuals bring private claims against one another."[93] In this form of litigation, the litigation takes place in a competent domestic court.[94] The court, in turn, decides the case by enunciating norms or damage relief based on domestic law.[95] This private American law rendition of traditional domestic litigation is based on Lon Fuller's work regarding private law, *The Forms and Limits of Adjudication*.[96] Here, Fuller, as a scholar of the legal process school, asserts a broader understanding on adjudication. He states that adjudication should be understood as a "form of social ordering."[97] By this, Fuller means that adjudication is a way in which the relations between private entities

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[90] Koh, *supra* note 10 at 184; See for example Judge Mack's opinion in *Gay Rights Coalition of Georgetown University v. Georgetown University, supra* note 41 at 536.
[91] Harold Hongju Koh, *Transnational Public Law Litigation*, 100 YALE L. J. 2347, 2348 (1991).
[92] *Id.*
[93] *Id.*
[94] *Id.*
[95] *Id.*
[96] *Id.* at 2348; Lon Fuller, *The Forms and Limits of Adjudication*, 92 HARV. L. REV. 353, 354 (1978).
[97] Fuller, *supra* note 96 at 354.

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are "governed and regulated."[98] Meanwhile, Koh renders public law litigation as per Abram Chayes's christening of public rights vindication through judicial remedies in his 1976 work, *The Role of the Judge in Public Law Litigation*.[99]

On the other hand, Koh discerns the meaning of traditional international litigation as a type of litigation involving nation-states as the parties.[100] In particular, Koh observes the characteristics of the International Court of Justice.[101] This form of litigation seeks the enunciation of a public international norm that will produce a form of a negotiated political settlement.[102] Traditional international litigation is done before international tribunals of limited competence that base their judgments on treaties and customary international law.[103]

By merging these types of traditional litigation, Koh notes that transnational public law litigation involves all types of subjects—individuals, private entities, and nation-states—that are suing one another.[104] Albeit predominantly in domestic courts, these subjects claim their rights before different types of judicial fora.[105] Koh states that the basis of these claims is not limited to domestic or international law; rather, it relies on the growing body of transnational law, in which the two types of law have been merged.[106]

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[98] *Id.*
[99] Koh, *supra* note 91 at 2348; Abram Chayes, *The Role of the Judge in Public Law Litigation*, 89 HARV. L. REV., 1284 (1976); DUNCAN KENNEDY, A CRITIQUE OF ADJUDICATION: FIN DE SIÈCLE 1 (1997).
[100] Koh, *supra* note 91 at 2348.
[101] *Id.*
[102] *Id.*
[103] *Id.*
[104] *Id.*
[105] *Id.*
[106] *Id.* at 2349.

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Koh subscribes to Philip Jessup's rendition of transnational law.[107] Jessup acknowledges the pattern that "the only force in the sovereign state is its own law."[108] In this pattern, national law determines the applicability of rules from outside its jurisdiction as part of its law.[109] However, this does not prevent the use of foreign law as a fact.[110] Koh also observes that claims are usually related to rights that exist in the body of transnational law.[111] Accordingly, transnational public law litigation often results in both retrospective damages and prospective injunctive relief in the frame of transnational norms.[112]

The discourse on transnational public law litigation, as Koh elaborates further, opens the door to discussion of the transnational legal process. He probes at least three concerns attached to the role of adjudication in this regard: comity, separation of powers, and judicial incompetence.[113] The notion of comity has evolved since Ulrich Huber's formulation when he stated the rules of *de conflictu legum diversarum in diversis imperiis*—the conflict of laws maxim:

> Sovereigns will so act by way of comity that rights acquired within the limits of a government retain their force everywhere so far as they do not cause prejudice to the powers or rights of such government or of their subjects.[114]

Similarly, in the United States, comity as a judicial factor was established in *Hilton v. Guyot*, where Justice Gray states the following:

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[107] *Id.* at 2348.; PHILIP J. JESSUP, TRANSNATIONAL LAW 3 (1956).
[108] Koh, *supra* note 91 at 2348; JESSUP, *supra* note 107 at 3.
[109] Koh, *supra* note 91 at 2348; JESSUP, *supra* note 107 at 3; Arthur Nussbaum, *Proving the Law of Foreign Countries*, 3 AM. J. COMP. L. 60, 60 (1954).
[110] Koh, *supra* note 91 at 2348; JESSUP, *supra* note 107 at 3; Nussbaum, *supra* note 109 at 60.
[111] Koh, *supra* note 91 at 2348.
[112] *Id.* at 2349.
[113] *Id.* at 2356.
[114] Ernest G. Lorenzen, *Huber's De Conflictu Legum*, 13 ILL. L. REV. 375, 376 (1919).

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> 'Comity,' in the legal sense, is neither a matter of absolute obligation, on the one hand, nor of mere courtesy and good will, upon the other. But it is the recognition which one nation allows within its territory to the legislative, executive or judicial acts of another nation, having due regard both to international duty and convenience, and to the rights of its own citizens, or of other persons who are under the protection of its laws.[115]

The second factor is the separation of powers. Koh views this factor when a court defers to the executive branch in relation to foreign affairs expertise. In reviewing *United States v. Curtiss-Wright Export Corp*, *United States v. Pink*, *United States v. Belmont*, and *Chicago & S. Air Lines, Inc. v. Waterman Steamship Co.*, Koh sees that given the close relationship between these cases and the judicial application of international law, "foreign policy" is not a separate category.[116] The court in these cases allows the executive branch to bind the parties with its foreign policy decision as a "one voice" manifestation of external affairs. The operation of this separation of powers has resulted in the third factor: judicial incompetence. The practice of such deference determines the court's familiarity and experience with international jurisprudence and hence its competency level.[117]

These three factors, according to Koh, are involved in litigation that has five characteristics: (1) Transnational party structure; (2) Transnational claim structure; (3) prospective focus; (4) Transportability of those norms; and (5) Institutional dialogue.[118] The party structure suggests that the involved parties could be both state and non-state actors.[119] As exemplified by *Filartiga v. Pena-Irala,* an alien enjoys legal standing and hence makes further

[115] Hilton v. Guyot, 159 U.S. 113, 163–64, 16 S. Ct. 139, 143, 40 L. Ed. 95 (1895)
[116] Koh, *supra* note 91 at 2357. *See, e.g.*, United States v. Curtiss-Wright Export Corp., 299 U.S. 304 (1936); United States v. Pink, 315 U.S. 203 (1942); United States v. Belmont, 301 U.S. 324 (1937); Chicago & S. Air Lines, Inc. v. Waterman Steamship Co., 333 U.S. 103 (1948).
[117] Koh, *supra* note 91 at 2358.
[118] *Id.* at 2371.
[119] *Id.*

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elaboration possible.[120] The second structure suggests that there is an alleged single action that violates domestic and international, private and public law.[121] Right claims could arise either directly from a treaty or from implementing a domestic statute. When an implementing statute does not exist, a court should ask whether the claim can be derived from the treaty directly or whether the litigant is a member of a class protected by the treaty or upon whom the treaty bestow rights.[122] This characteristic suggests whether there is a "cause of action" and an "implied" private right of action under customary international law.[123]

Third, transnational public law litigation has a balanced interest in obtaining both judicial declaration of international norms and retrospective dispute settlements.[124] The fourth characteristic points to the litigants' awareness that the norms have an extent of usability in judicial interpretation or political bargaining in other domestic and international fora.[125] The transportability of norms also runs along both substantive and procedural pathways. *Filartiga* is an example where the substance of a transnational norm (torture) was domesticated into a domestic legal process (court). And through common law, this practice of domestication itself became a part of the procedural law.[126] The fifth characteristic, which is also related to comity and the separation of powers factors, suggests that there is an implication for the subsequent process of institutional dialogue in "various domestic and international, judicial and political fora to achieve ultimate settlement."[127]

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[120] Filartiga v. Pena-Irala, 630 F.2d 876 (2d Cir. 1980).
[121] Koh, *supra* note 91 at 2371.
[122] *Id.* at 2384.; Stefan A. Riesenfeld, *The Doctrine of Self-Executing Treaties and U.S. v. Postal: Win at Any Price?* 74 AM. J. INT'L L. 892, 892 (1980).
[123] Koh, *supra* note 91 at 2383.
[124] *Id.* at 2371.
[125] *Id.*
[126] *Id.* at 2368.
[127] *Id.* at 2371.

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2.4. Transnational Legal Process in the Emergence of Global Health Jurisprudence

In order to see the global jurisprudence national internalization process, this dissertation explores the abovementioned transnational elements. In that sense, along the way, this dissertation will expose the transnationality of HIV health jurisprudence, its norms, and especially how its national internalization works. This section, particularly, applying transnational legal process theory to global health jurisprudence starting a discourse in which HIV prevention norms are a significant part.

Scholars have been using the transnational legal process to study the growing body of international law further. Eugene Lim, for example, in his dissertation, claims that "domestic norm internalization plays an essential role in the management of state compliance with multilateral intellectual property standards."[128] Lim's dissertation applies Koh's transnational legal process theory, a theory in which national internalization is a significant element in a series involving interaction and interpretation. In arriving at this claim, Lim explicates the historical developments leading up to the 1995 Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement. Lim demonstrates that probing historical development is one robust way to learn the internalization process of international laws or standards in a more ubiquitous sense.

As for the present dissertation, the facts of HIV disruption in Indonesia have led to an objective observation that it is clear that HIV holds a position as both a pandemic and an epidemic. This fact warrants further investigation of the national internalization of global norms addressing the HIV response in Indonesia as a democratic state. While presenting Indonesia's

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[128] Eugene Lim, *Transnational Legal Process and the TRIPS Agreement: Intellectual Property Rights, International Law and the Compliance Conundrum*, 2008.

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HIV situation alone could be adequate, this innovative dissertation is also based theoretically on an emerging area of scholarship: global health governance.

In addressing global health problems, such as the Acquired Immune Deficiency Syndrome (AIDS) crisis, multiple actors have been involved in an ecosystem to produce norms and institutions.[129] Notably, civil society organizations, through non-governmental organizations (NGOs), have taken an increasingly important place in global health governance. Kelley Lee & Adam Kamradt-Scott describe the ontology of global health governance in three notions. The first is that of global health governance as "globalization and health governance," referring to the international actors, arrangements, and policymaking processes that govern health issues in the era of globalization.[130]

The second notion is that of global health governance as "global governance and health," which encompasses how global governance institutions outside of the health sector have influenced the broad social determinants of health.[131] The third notion is of global health governance as "governance for global health," which refers to the governance arrangements needed to further agreed global health goals.[132]

This study uses the third notion of global health governance because it is suitable for the focus on global health as an established area of interest. The two other descriptions of global health governance do not accurately take "global health" as an established subject of governance. The description of global health governance as the governance of global health will enable this study to operationalize the focus on the substantive legal rules, strategies, institutions, and

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[129] Global health disruptors: AIDS, THE BMJ (2018).
[130] Kelley Lee & Adam Kamradt-Scott, *The Multiple Meanings of Global Health Governance: A Call for Conceptual Clarity*, 10 GLOBAL HEALTH 28 (2014).
[131] *Id.* at 6.
[132] *Id.*

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procedures that support public health at the local, national, and international levels. The choice of this definition also enables the exploration of the interdependence between national and international law, and between national legal systems (recognizing structural realities in international relations), adhering to Koh's governing transnational legal process theory.

Commentators have been discussing the interrelationships between international and domestic law since the establishment of the World Health Organization (WHO). Lawrence Gostin argues that it is clear that despite the extreme distinctions between international and domestic law, each side informs the other.[133] In order to witness the impact of international law regimes, it is necessary to assess how their norms infuse domestic law and policy.[134] Similarly, the presence or absence of national health regulation can either reinforce or undermine the aims of international law.[135]

The interplay between international and domestic law occurs globally. As Gostin suggests, the inclusion of global norms in the domestic sphere could help overcome the dull compliance and ineffectiveness ingrained in international law.[136] Furthermore, both the international regime and the domestic legal system determine the incorporation of international law.[137] International law depends substantially on effective implementation at the domestic level.

In ensuring the expected outcome (compliance), the process requires governments to have both the political will and the operational capacity. It is also evident that more health-related international instruments have different expectations for different actors. State parties are expected to provide an increase in implementation capacities. The international community is

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[133] LAWRENCE O. GOSTIN, GLOBAL HEALTH LAW 70 (2014).
[134] *Id.*
[135] *Id.*
[136] *Id.*
[137] *Id.*

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expected to provide technical and financial assistance. This distributed labor has been the fundamental governing principle in multiple health-related instruments since the adoption of the WHO's International Health Regulation (IHR).

The governance of global health, especially in the area of HIV/AIDS, involves the continuous growth of norms within and between jurisdictions. As a response to the governance of global health, David Fidler introduces the notion of "global health jurisprudence" as a way to extend the use of the law in public health endeavors within and between countries to the continuation of the increased use of law in public health.[138] With the idea of global health jurisprudence, there is an implicit principle that national and international public health activities should, wherever possible, be subject to the rule of law.[139] Nonetheless, in the era of global health governance, in which the globalization of public health has taken place, and the increased demand for international action, the analysis should abandon the traditional rule of law focus on governance within unitary states. At the same time, applying the philosophy of governance analysis to the current decentralized structure and dynamic of international law would be unrealistic.

Therefore, this present innovative study uses the lens of jurisprudence to examine the transforming 21st century relationship between law and public health. The first definition of "jurisprudence" suggests the ability to examine whether practical uses of law to address real-life problems reflect the purposes, patterns, principles, and interdependencies that form a systematic framework or strategy.[140] The term "jurisprudence" also safeguards the analysis from the diverse

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138 Fidler, *supra* note 9 at 379.
139 *Id.*
140 *Id.* at 395.

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and inconsistent ways in which the term "global health law" is otherwise used.[141] Moreover, the principal difficulty of using the term "global health law" arises from the fact that there is no rigid structure of global health law as distinct from international and national public health laws.[142]

The second definition of jurisprudence is "knowledge of or skill in law."[143] The pivotal position of knowledge of and skill in law has grown in the early 21st century in efforts to address cross-border public health problems.[144] Such knowledge and skill represent the dimension of jurisprudence where law serves practical functions in governance efforts to address policy challenges.[145] Jurisprudence also has a third definition concerning the philosophy of law,[146] which asks the questions, "What is law?" and "What is the relationship between law and morality?"[147] These philosophical inquiries provide a robust beginning from which to discuss public health purposes.[148] This aspect of jurisprudence is well justified given that the transformation of the role of law in national and international public health stimulates considerations about more in-depth conceptual discussions about the foundational relationship between law and public health.[149]

Mapping the transnational nature of global health jurisprudence is a worthy addition to the cartography of transnational legal process scholarship. However, without a particular examination of a national case, that effort would be less grounded. This study attempts to take

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141 *Id.* at 379.
142 *Id.* at 395.
143 THE NEW SHORTER OXFORD ENGLISH DICTIONARY ON HISTORICAL PRINCIPLES (Lesley Brown & William Little eds., Thumb Index ed. 1993).
144 Fidler, *supra* note 9 at 395.
145 *Id.*
146 THE NEW SHORTER OXFORD ENGLISH DICTIONARY ON HISTORICAL PRINCIPLES, *supra* note 143.
147 Fidler, *supra* note 9 at 395.
148 *Id.*
149 *Id.*

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the HIV pandemic—an epidemic in Indonesia—to enrich our understanding of the applicability of the transnational legal theory.

The interplay between international and domestic law is not subject to a single explanation. These complex processes involve the question of whether the mere incorporation of global norms into the domestic legal sphere would, as transnational legal process theory suggests, necessarily result in compliance. There is also the rival possibility of the inherent ineffectiveness of international law.

While this study focuses specifically on legal norms' national internalization, grounding Koh's transnational legal process in the particular area of global health means two things: (1) Looking at the transfer of international HIV norms into the Indonesian domestic legal process; and (2) Evaluating such transfer process as a norm itself. As raised by Adriaan Bedner previously, the Indonesian legal process does not rely too much on adjudication.[150] Instead, while there is room for judges to be creative, the extent thereof is limited to what is permitted by legislation.[151] In terms of jurisprudence, that is to say, Indonesia's legal system lies between legal formalism and legal realism.

Legal realism is the attempt to correct legal formalism, given that legal formalism is a method where judges blindly obey the text of the law.[152] As the antithesis to legal formalism, legal realism tends to see "real-world" situations as primary to statutory law. As a follow-up, the legal process invites us to reconcile the two strongholds by looking at the bigger picture. It

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[150] Bedner, *supra* note 15 at 27.
[151] Andy Omara, *Protecting Economic and Social Rights in a Constitutionally Strong Form of Judicial Review: The Case of Constitutional Review by the Indonesian Constitutional Court*, 2017; Hugh Spitzer, *Court Rulemaking in Washington*, 6 SEATTLE U. L. REV. 31 (1982).
[152] Walter J. Walsh, *Redefining Radicalism: A Historical Perspective*, 59 GEO. WASH. L. REV. 636, 648 (1991).

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primarily consists of the questions of why and from which institution a law originated. This idea provides an opportunity for scholars to be more inclusive in discussing the use of laws. With such greater flexibility, this dissertation will include perspectives and experiences beyond legal texts or court decisions.

The development of HIV jurisprudence can be seen in the 2006 collaboration between the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the Canadian HIV/AIDS Legal Network (CHALN.) This interaction, which is also a form of transnational legal process, has produced a body of domestic HIV litigation best practices. In the preface to the collaboration, the UNAIDS Executive Director Dr. Peter Piot states that these best practices have shown that civil society can change the domestic context of HIV through the litigation of human rights related to HIV.[153] The collaboration found that domestic litigation is primarily centered on the themes of HIV discrimination, access to treatment, and HIV prevention and care in prison.[154]

The UNAIDS/CHALN collaboration indicates that the legal arguments used in such litigation are derived from international human rights law. Some of those cases sought courts' interpretations on recognizing HIV treatment as a form of domestic constitutional right, however, a considerable number used international norms directly in their claims. The prominent human rights norms used include Article 26 of the International Covenant on Civil and Political Rights (ICCPR.)

> All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race,

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[153] RICHARD ELLIOTT, CANADIAN HIV/AIDS LEGAL NETWORK & JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, COURTING RIGHTS: CASE STUDIES IN LITIGATING THE HUMAN RIGHTS OF PEOPLE LIVING WITH HIV 5 (2006).
[154] *Id.* at 8.

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> color, sex, language, religion, political or other opinion, national or social origin, property, birth or *other status*.[155]

According to the United Nations Commission on Human Rights, the "other status" in international human rights treaties is to be interpreted as including health status, including HIV/AIDS.[156] This interpretation provides the basis for advocating against HIV-related discrimination through domestic fora. The interpretation of antidiscrimination human rights treaties as being HIV-inclusive also relates to the interpretation of the International Covenant on Economic, Social and Cultural Rights (ICESCR) on the right to health. The denial of health benefits, such as through forms of discrimination, violates Article 12 of the ICESCR, which ensures that access to health benefits "shall include those necessary for...the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[157] Further, in 2000, the ICESCR Committee issued General Comment No. 14 on The Right to the Highest Attainable Standard of Physical and Mental Health.[158]

The development of these interpretations was also moderated by the adoption of the International Guidelines on HIV/AIDS and Human Rights by the Second International Consultation on HIV/AIDS and Human Rights in 1996, led by the Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS. After the adoption of General Comment No. 14, the Third International Consultation on HIV/AIDS and Human Rights adopted

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[155] International Covenant on Economic, Social and Cultural Rights art. 26, Dec. 16, 1966, 993 U.N.T.S. 3; S. Exec. Doc. D, 95-2 (1978); S. Treaty Doc. No. 95-19; 6 I.L.M. 360 (1967).
[156] United Nations Commission on Human Rights, Res. 44 (1995); United Nations Commission on Human Rights, Res. 43 (1996).
[157] *See supra* note 155 art. 12(d).
[158] The United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 14 on The Right to the Highest Attainable Standard of Physical and Mental Health (2000).

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the newest version of the International Guidelines, which was later consolidated in 2006. The International Guidelines provide a number of domestic obligations.

> Government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.[159]

The International Guidelines also stipulate positive obligations regarding domestic legislations where "public health legislation . . . [should] ensure, whenever possible, that pre- and post-test counselling be provided in all cases."[160] Regarding this stipulation, the CHLN and UNAIDS collaboration states "counselling ensures the voluntary nature of HIV testing and contributes to the effectiveness of subsequent care or HIV prevention."[161]

The International Guidelines themselves are a product of an earlier transnational legal process. The International Consultation on Health Legislation and Ethics in the Fields of HIV/AIDS took place in Oslo in 1988. In the same year, the World Health Assembly adopted resolution WHA 41.24 that urged member states to avoid discriminatory actions toward HIV-positive citizens. In 1989, the WHO and the Global Programme on AIDS conducted the First International Consultation on HIV/AIDS and Human Rights. In 1990, these norms on HIV, ethics, and human right were brought to regional workshops in Seoul, Brazzaville, and New Delhi. Similar regional consultations were conducted in Europe (Prague Statement) and Central

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[159] INTERNATIONAL GUIDELINES ON HIV/AIDS AND HUMAN RIGHTS 2006, CONSOLIDATED VERSION par. 18 (Joint United Nations Programme on HIV/AIDS & United Nations eds., 2006).
[160] *Id.* par. 28(c).
[161] ELLIOTT, CANADIAN HIV/AIDS LEGAL NETWORK, AND JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, *supra* note 153 at 17.

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Asia. These consultations established the prospective legal measures to be used by other countries around the globe, which was then included in the International Guidelines.[162]

In 1994, 42 states at the Paris AIDS Summit adopted the Paris Declaration on Greater Involvement of People Living with HIV/AIDS. Known as the GIPA Principles, it determined the norm that ensuring meaningful participation of HIV positive people at all level of policymaking is a process required to ensure the domestic ability to address HIV/AIDS human rights obligations. Between 1993-1995, there were also consultations conducted in Cebu, Dakar, Colombo, Beijing, and Nadi.[163]

The Second Consultation International Consultation on HIV/AIDS and Human Rights in 1996 displays the application of the GIPA Principles by allowing non-state actors to sit equally at the table. The international consultation considered the background papers presented by a number of NGOs: Alternative Law Research and Development Center (ALTERLAW) (Philippines); Network of African People Living with HIV/AIDS (NAP+) (Zambia); Colectivo Sol (Mexico); International Community of Women Living with HIV/AIDS (ICW+) (global) and Global Network of People Living with HIV/AIDS (GNP+) (global).[164] The consultation agreed on certain rules of play that involved non-state actors, particularly NGOs. With this consensus, the international consultation has produced a new rule of process that transcends traditional international law. States are not the sole norm-maker because there is a recognition of the role of non-state actors, NGOs in particular, in influencing branches of power. Similarly, the International Guidelines also recognize contributions from various academics and research

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[162] *See supra* note 159.
[163] *Id.* at 106.
[164] Secretary-General of the United Nations, *Report on Second International Consultation on HIV/AIDS and Human Rights* (1996).

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centers such as the Swiss Institute of Comparative Law, the Danish Center on Human Rights, Harvard School of Public Health, the International Federation of Red Cross and Red Crescent Societies, the Georgetown/Johns Hopkins University Program in Law and Public Health.[165]

During the 1990s, more countries were observed to have reformed their laws to accommodate international human rights law through the works of legal advocates, practitioners and activists at governmental and community levels, such as in the United States, the United Kingdom, Australia, New Zealand, Hong Kong, and Canada.[166]

In 2001, the 106th Inter-Parliamentary Conference in Ouagadougou, Burkina Faso, determined that parliamentarians of its member states should create supportive legislation to address HIV in their countries.

> [T]o step up their national efforts to establish effective national and international AIDS policies and programmes . . . including the use of condoms, measures to counter discrimination and the provision of care to affected persons, including orphans.[167]

This mandate is strategic because the Inter-Parliamentary Union is an international organization whose mission is to be the main focal point for worldwide parliamentary dialogue. While it embodies its own legal personality, it shares the United Nations' objectives. In 1999, UNAIDS

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[165] *See supra* note 159 at 108; INTERNATIONAL FEDERATION OF THE RED CROSS AND RED CRESCENT SOCIETIES, AIDS, HEALTH AND HUMAN RIGHTS: AN EXPLANATORY MANUAL (1995); DANISH CENTRE ON HUMAN RIGHTS, AIDS AND HUMAN RIGHTS (1988); SWISS INSTITUTE OF COMPARATIVE LAW & COUNCIL OF EUROPE, *Comparative Study on Discrimination against Persons with HIV/AIDS: Study by the Swiss Institute of Comparative Law, Lausanne, under the Auspices of the Council of Europe* (1993); LAWRENCE O. GOSTIN & ZITA LAZZARINI, PUBLIC HEALTH AND HUMAN RIGHTS IN THE HIV PANDEMIC (1997).

[166] *See supra* note 159 at 107; Ryan White Comprehensive AIDS Resources Emergency Act (Ryan White CARE Act), Pub. L. 101–381, 104 Stat. 576 (1990).

[167] INTER-PARLIAMENTARY UNION, *106th Inter-Parliamentary Conference: Urgent action to combat HIV/AIDS and other pandemics which seriously endanger public health, and economic, social and political development and even threaten the survival of many nations,* Ougadougou (2001).

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worked with the Inter-Parliamentary Union to provide a "handbook" for legislators to help them in examining HIV laws in their respective countries.[168]

The legislator's handbook includes a number of processes that have been seen as norms with legal implications. First, regarding the need for a national framework, it proposes the creation of an inter-ministerial committee on HIV/AIDS. An inter-ministerial committee can "ensure integrated development and high-level coordination of individual ministerial national action plans, and monitor and implement further HIV/AIDS strategies."[169] Inter-ministerial committees have been founded in multiple jurisdictions. In Thailand, the Thai National AIDS Prevention and Control Committee was founded in 1991. It includes the Thai NGO Coalition on AIDS as a member.[170] Similar committees have been founded in South Africa, France, United Kingdom, Malawi, Zambia and Indonesia. The inter-ministerial committee does not have to be specifically related to AIDS and can be adjusted according to each country's budgetary and health system.

The other process norm is the creation of parliamentary committees on HIV/AIDS. As also mandated by the 1998 Inter-Parliamentary Union Resolution, the creation of a parliamentary committee on HIV/AIDS "can provide an ongoing forum for parliamentarians to deepen their understanding of the epidemic through regular briefings and policy discussion and can serve as a vehicle for law reform."[171] A committee is an ideal place for both major and minor party to develop nonpartisan support for HIV/AIDS laws, policies, and programs.[172] Such a committee

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[168] HELEN WATCHIRS, HANDBOOK FOR LEGISLATORS ON HIV/AIDS, LAW AND HUMAN RIGHTS: ACTION TO COMBAT HIV/AIDS IN VIEW OF ITS DEVASTATING HUMAN, ECONOMIC AND SOCIAL IMPACT (1999).
[169] *Id.* at 31.
[170] *Id.*
[171] *Id.*
[172] *Id.* at 32.

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has been established in the United Kingdom and Australia.[173] In the United Kingdom, the committee is called the All-Party Parliamentary Group on AIDS (APPGA) and has multiple activities, including: (1) meetings with scientists and other relevant experts; (2) collaborating with other All-Party Parliamentary Groups; (3) participating in parliamentary hearings with constituents; (4) preparing parliamentary briefings on specific HIV programs; (5) influencing legislation and policies; (6) lobbying members of Parliament; and (7) arranging visits to AIDS service organizations to ensure that members are updated on frontline activities.[174] Recently, the APPGA issued its publication entitled *No One Left Behind: Towards a Sustainable HIV Response for Key Populations and Women and Girls.*[175]

Other than the inter-ministerial committee on HIV/AIDS and the parliamentary committee on HIV/AIDS, multisectoral advisory on HIV/AIDS is also a process norm that appears in multiple jurisdictions.[176] Typically, a multisectoral advisory body is comprised of professional and community representation.[177] They address legal and ethical issues of laws and policies. This body can be governmental, such as the Australian Legal Working Party of the Intergovernmental Committee of AIDS,[178] and can also be nongovernmental, such as the South African AIDS Law Project and the Project on Legal and Ethical Issues Raised by HIV/AIDS of the CHLN and Canadian AIDS Society.[179] There is also the Malaysian AIDS Council, an umbrella for 27 other groups, that has its legal and ethical subcommittee.[180] In Kyrgyzstan, there

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[173] *Id.*
[174] *Id.*
[175] ALL-PARTY PARLIAMENTARY GROUP ON HIV AND AIDS, *No One Left Behind: Towards a sustainable HIV response for key populations and women and girls* (2017).
[176] WATCHIRS, *supra* note 168 at 33.
[177] *Id.*
[178] *Id.*
[179] *Id.*
[180] *Id.*

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is the Technical Advisory Group on Policy and Legislation established by the Kyrgyzstan Multisectoral Co-ordination Committee on HIV/AIDS/STDs Prevention.[181] This advisory group led the National AIDS Law in 1997.[182] Other advisory groups also exist in other places such as the United States, the United Kingdom, Canada, Germany, Kenya, Malawi, and the Philippines.[183]

In accordance with the Paris Declaration, process norms are also dependent on active engagement between the government, at risk communities, and affected communities.[184] Communities, such as the networks of PLHIV, have an irreplaceable position of trust, knowledge, and experience of how and why infection happened.[185] Community-based organizations have the advantage to better reach into risk communities.[186] Therefore, it is a norm to include the participation of the most-affected communities in the ministerial, parliamentary and advisory forums, through formal attendance as well as through written submissions.[187] Some of the earliest examples of this approach happened in Uganda, Thailand, and the Philippines.[188]

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[181] *Id.*
[182] *Id.*
[183] *Id.*
[184] *Id.* at 34.
[185] *Id.*
[186] *Id.*
[187] *Id.*
[188] *Id.* at 35. "In Uganda, The AIDS Support Organization (TASO) was established as a small self-help group in 1987 and has now grown to having 150 staff and almost 2,000 volunteers.50 Thailand also has some very successful grassroots support organizations, such as the Wednesday Friends' Club run by the Red Cross, the Duang Prateep Foundation in Bangkok and the New Life Friends in Chiang Mai. In Northern Thailand a District Model has been used in villages by CARE. It provides comprehensive community care and focuses on strengthening community partnership and ownership with integrated programming, including the development of clear antidiscrimination policies in training. The Philippine National AIDS Council was formed in 1992 as a multisectoral body to advise the President on policy development and coordinate implementation of a National Strategy. It has 13 government and 7 NGO representatives, including the President of the people living with HIV and AIDS (PLWHA) organization. The Council formulated a National AIDS Prevention Strategy, using a national consultative process,

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Nonetheless, a 1997 study by the United Nations Development Programme (UNDP) reports that PLHIV engagement in Asia faces a "general inability to comprehend, lack of serious consideration and disinterest on the part of senior bureaucrats and medical professionals regarding the benefit of PLHIV's involvement."[189] In many other countries, there has been no involvement of PLHIV, other than being service recipients.[190]

As a matter of process, the above-mentioned community engagement and the creation of various committees have to be connected with law reform and review processes. Based on worldwide experience, the Inter-Parliamentary Union and UNAIDS also have concluded a norm on this process.

> States should review and reform public health legislation to ensure that they adequately address the public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.[191]

This process norm has been conducted in various places since the 1990s. Mexico experienced this back in 1995 when the country passed the Law for the Prevention and Control of Infection by HIV.[192] The law was the product of a collaboration between 17 governmental agencies and 19

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which was respectful of human rights. A key achievement of the Strategy is the mainstreaming of AIDS information and education in government departments responsible for education and the interior. The Olongapo City AIDS Foundation established in 1992 at local level has a successful community-based approach in its massive information campaigns, and care and support programmes. The Inter-Agency HIV/AIDS Network was formed in 1995 in the province of Palawan where there have been no reported case of HIV/AIDS."

[189] *Id.* at 36.; BILL O'LOUGHLIN & SUZANA MURNI, *Report on a Consultancy on the Involvement of People Living with HIV/AIDS in Policy and Programme Development in the Response to the HIV Epidemic in Asia and the Pacific* (1997).

[190] WATCHIRS, *supra* note 168 at 36.

[191] *Id.* at 36.

[192] *Id.* at 37.

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NGOs.[193] As a national law, the law is incorporated in the Constitution and is superior over local laws.[194] The 1995 law covers issues of confidentiality, the prohibition of mandatory testing, and the prohibition of discrimination in various areas including marriage, employment, education, medical treatment, accommodation, and immigration.[195]

Argentina is also an example of this process when it passed its HIV law in 1990. At that time, the law was passed as a reaction to the adoption of coercive laws at the local level. The national law comprises issues of "discrimination, confidentiality (subject to exceptions, such as treatment and care purposes, criminal, family law, or adoption cases) and informed consent to testing (subject to exceptions, such as blood donation and immigration.)"[196]

In Canada, CHALN and the Canadian AIDS Society initiated a joint project mentioned earlier, Project on Legal and Ethical Issues Raised by HIV/AIDS in 1995.[197] The project conducted workshops to engage with the broader community.[198] It also publishes "literature reviews a regular newsletter, discussion papers and reports on various topics: prisons; discrimination; criminal law; testing and confidentiality; gay and lesbian legal issues; and aboriginal communities (discrimination, testing and confidentiality)."[199] While in India, domestic advocates pushed for the principles and strategies stipulated by the International Guidelines for HIV/AIDS and Human Rights to be linked with the mainstream control of other communicable diseases.[200]

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193 *Id.*
194 *Id.*
195 *Id.*
196 *Id.*
197 *Id.* at 38.
198 *Id.*
199 *Id.* at 39.
200 *Id.* at 40.

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In 2001, Kenya also showed a form of participatory process when the Honorable Amos Wako, Attorney-General of Kenya (and former member of the United Nations Human Rights Committee) worked with the Legal Task Force on Issues Relating to HIV/AIDS to submit a proposal to the government on a legal framework for to address the epidemic in Kenya.[201] The task force rolled out public consultations nationally. After a year, the Attorney-General promised that new legislation would be in place.[202]

In general, there are multiple ways of ensuring domestic laws are in line with the need for human rights promotion in addressing HIV/AIDS as a pandemic. Other than the legislator guidelines and the International Guidelines, throughout the period of 1988-1996 there were numerous interactor fora that led to the shaping of global HIV norms.[203]

(1) London Declaration on AIDS Prevention, World Summit of Ministers of Health, 28 January 1988;

(2) Paris Declaration on Women, Children and AIDS, 30 March 1989;

(3) Recommendation on the Ethical Issues of HIV Infection in the Health Care and Social Settings, Committee of Ministers of the Council of Europe, Strasbourg, October 1989 (Rec. 89/14);

(4) Council of Europe, Committee of Ministers, Recommendation R(87) 25 to member States concerning a common European public health policy to fight AIDS, Strasbourg, 1987;

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[201] David Patterson & Leslie London, *International law, human rights and HIV/AIDS*, 80 BULLETIN OF THE WORLD HEALTH ORGANIZATION 964–969 (2002).
[202] *Id.*
[203] *See supra* note 159 at 109.

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(5) European Union, European Parliament and Council Decisions on "Europe Against AIDS" programme (including dec. 91/317/EEC and dec. 1279/95/EC);

(6) Declaration of Basic Rights of Persons with HIV/AIDS, Organizing Committee of the Latin American Network of Community-Based Non-Governmental Organizations Fighting AIDS, November 1989;

(7) Declaration of the Rights of the People with HIV and AIDS, United Kingdom, 1991;

(8) Australian Declaration of the Rights of People with HIV/ AIDS, National Association of People Living with HIV/ AIDS, 1991;

(9) Prague Statement, Pan-European Consultation on HIV/ AIDS in the Context of Public Health and Human Rights, November 1991;

(10) Rights and Humanity Declaration and Charter on HIV and AIDS, United Nations Commission on Human Rights, 1992;71 South African AIDS Consortium Charter of Rights on AIDS and HIV, 1 December 1992;

(11) Cebu Statement of Belief, UNDP Inter-Country Consultations on Ethics, Law and HIV, the Philippines, May 1993;

(12) Dakar Declaration, UNDP Inter-Country Consultations on Ethics, Law and HIV, Senegal, July 1994;

(13) Phnom Penh Declaration on Women and Human Rights and the Challenge of HIV/AIDS, Cambodia, November 1994;

(14) Paris Declaration,World AIDS Summit, Paris, 1 December 1994;

(15) Malaysian AIDS Charter: Shared Rights, Shared Responsibilities, 1995;

(16) Chiang Mai Proposal on Human Rights and Policy for People with HIV/AIDS, submitted to the Royal Thai Government, September 1995;

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(17) Asia-Pacific Council of AIDS Service Organization's Compact on Human Rights, September 1995;

(18) Montréal Manifesto of the Universal Rights and Needs of People Living with HIV Disease;

(19) Copenhagen Declaration on Social Development and Programme of Action of the World Summit for Social Development, March 1995; and

(20) New Delhi Declaration and Action Plan on HIV/AIDS, Interdisciplinary International Conference: AIDS, Law and Humanity, December 1995.

The prominence of HIV on various global political stages is paralleled by the increase in domestic litigation around the world where global HIV norms are being relied upon. The body of litigation collected by CHALN and UNAIDS shows that most of this litigation happened following the adoption of the International Guidelines in 1996.

For example, in the Indian case of *MX v. ZY,* the plaintiff sought a remedy for his employer's discriminatory policies related to his HIV status.[204] The court awarded him compensation for lost income.[205] The court did not refer to any international human rights instruments, however, it referred to several policy statements from non-Indian jurisdiction, such as the WHO's resolutions, ILO's, and the South African Code on HIV/AIDS and Employment.[206] Internally, the court referred to the 1995 National HIV Testing Policy adopted by the National AIDS Control Organization.[207]

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[204] ELLIOTT, CANADIAN HIV/AIDS LEGAL NETWORK, AND JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, *supra* note 153 at 20; MX v. ZY, AIR 1997 Bom 406 (High Court of Judicature, 1997).

[205] MX v. ZY, AIR 1997 Bom 406 (High Court of Judicature, 1997).

[206] *Id.*

[207] *Id.*

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Nonetheless, the use of international human rights law can also develop into divergent unintended legal consequences in a case. In the case of *Mr. X v. Hospital Z* before the Indian Supreme Court, the appellant sought a remedy for an alleged confidentiality breach by Hospital Z.[208] He claimed that the breach had led to the cancellation of his marriage and his ostracism from his community. The court denied the claim, and instead invoked Indian Penal Code sections 269–270 that impose criminal penalties for a "negligent act likely to spread infection of disease dangerous to life" and "malignant act likely to spread infection of disease dangerous to life."[209] In its judgment, the Supreme Court extended the interpretation of the Penal Code provisions by imposing a positive legal duty on a person with HIV not to marry on the ground of the protection of their future spouse from the risk of HIV.[210]

Subsequently, in the case of *A, C & Others v. Union of India & Others*, the petitioners relied on the Universal Declaration of Human Rights and the ICCPR along with the Indian Constitution and other judgments of the Indian Supreme Court to support their argument that the right to marry is a basic human right,[211] and that such criminalization would drive people away from HIV testing services and will instead worsen the epidemic.[212] They stressed the availability of other prevention measures such as safer sex practices and the prevention of vertical HIV transmission.[213] On the other hand, the respondent argued that such a prohibition was necessary

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[208] Mr. X v. Hospital Z, (1998) 8 SCC 296, varied 2002 SCCL.COM 701 (Civil Appeal No. 4641 of 1998), Supreme Court of India (1998 & 2002).
[209] *Id.*
[210] *Id.*
[211] A, C & Others v. Union of India & Others, High Court of Judicature at Bombay [Mumbai], Writ Petition No. 1322 of 1999.
[212] *Id.*
[213] *Id.*

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due to the social context of India, where women are disproportionately pressured to give consent to a sexual relationship, hence, the criminalization is necessary for the sake of women's rights protection.[214] The High Court dismissed the petition and the case was referred to the Supreme Court which upheld its original position.[215]

In that case, two of the four petitioners were HIV-positive and were represented by the Lawyers Collective HIV/AIDS Unit. Lawyers Collective is an Indian legal aid service aimed at helping and empowering marginalized groups in India through the law. One of the members of the Board of Trustees is Anand Grover, who was the United Nations Special Rapporteur on the Right to Health from August 2008 to July 2014. Currently, Grover is an acting member of the Global Commission on Drug Policy. This strong transnational relationship exemplifies how global HIV norms are continuously being advocated through domestic state and non-state players.

While the case of *A, C & Others v. Union of India & Others* did not result in success for the petitioners, the 1998 Venezuelan case of *J. R. B. v. Ministry of Defense* before the Supreme Court of Justice of Venezuela had a mixed result. In this case, the petitioners were four members of the armed forces who were diagnosed HIV positive and forced to go on medical leave.[216] They sought to strike down the Ministry of Defense's directive requiring the compulsory removal of HIV-positive personnel from military active duty.[217] They also sought their reinstatement to military service.[218] They argued that the implementation of the directive violated

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[214] *Id.*
[215] *Id.*
[216] J. R. B. *et al.* v. Ministry of Defence, Case No. 14000, Supreme Court of Justice of Venezuela (Political-Administrative Bench) (1998).
[217] *Id.*
[218] *Id.*

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their dignity and personal integrity; their right to privacy; right to work; right to health; and their freedom from discrimination and equality before the law.[219] The petitioners based their arguments on the Universal Declaration of Human Rights; the American Declaration on the Rights and Duties of Man; the American Convention on Human Rights; the ICCPR; the ICESCR; and the Constitution of the Republic of Venezuela.[220]

The Court found that there was a violation of the right to privacy when the petitioners' commander disclosed their HIV status.[221] The Court recognized the presence of HIV-related stigma as a reality in Venezuelan society.[222] Regarding the right to health, the Court found that the Ministry infringed their need for medical attention. The Court referred to the Constitution, the Universal Declaration of Human Rights and the American Declaration of the Rights and Duties of Man. In spite of this, the Court rejected the right to work claim by stating that medical leave is appropriate to protect the armed forces from potential HIV risk. The Court also rejected their claims relating to the rights to dignity, non-discrimination, and equality before the law as the Court could not find a sufficient causative nexus between the claim and the Minister, in order to establish liability.

In 2001, Jorge Odir Miranda Cortez and 26 other people living with HIV (PLHIV) submitted a petition to the Inter-American Commission on Human Rights, known as *Jorge Odir Miranda Cortez et al. v. El Salvador*.[223] Cortez was the president of Atlacatl, an association of PLHIV in El Salvador. In this case, they were supported by the Agua Buena Human Rights

[219] *Id.*
[220] *Id.*
[221] *Id.*
[222] *Id.*
[223] Jorge Odir Miranda Cortez *et al.* v. El Salvador, Inter-Am. Comm'n on H.R., Report No. 29/01, Case 12.249 (2001).

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Association of Costa Rica and the Foundation for Studies for the Application of Law.[224] They sought "precautionary measures" in the form of an interim order from the Inter-American Commission on Human Rights requiring the Government of El Salvador provide antiretroviral therapy to prevent deaths while the Commission investigated the underlying merits of the claim. In 1999, they had previously filed a case before the Salvadorian Supreme Court of Justice demanding the inclusion of antiretrovirals in the Salvadorian Social Security Institute on the basis of international human rights arguments, but the Court did not make a judgment. In two years, 10 of the 36 applicants have died while waiting for the decision.[225]

The Commission admitted the petition.[226] Shortly after, the Supreme Court of Justice released its decision and the Commission declared the petition moot without hearing the merits.[227] Following this, lawmakers passed the national HIV law.[228] The Salvadorian Law on the Prevention and Control of the Infection caused by the Human Immunodeficiency Virus stipulates the rights of every PLHIV to "health care, medical, surgical and psychological treatment", as well as counselling and "preventive measures to impede the progress of the infection."[229] This case provides a precedent on HIV treatment as a rights-based precautionary measure.[230] It also provides a new norm of process where advocacy to an international body could help to speed up the domestic lawmaking process in the judicial, legislative, and executive branches.[231]

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[224] *Id.*
[225] *Id.*
[226] *Id.*
[227] *Id.*
[228] *Id.*
[229] *Id.*
[230] ELLIOTT, CANADIAN HIV/AIDS LEGAL NETWORK, AND JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, *supra* note 153 at 71.
[231] *Id.* at 71.

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In 2002, the Constitutional Court of South Africa decided the case of *Minister of Health and Others v. Treatment Action Campaign and Others.*[232] Its original applicants, acting as respondents before the Constitutional Court were the Treatment Action Campaign, the Children's Rights Centre, and Dr. Haroon Saloojee who is a physician.[233] In this case, the government rolled out research to evaluate the effectiveness of nevirapine as a HIV antiretroviral l to reduce the risk of mother-to-child HIV transmission. The evaluation study was conducted in two sites.[234] The original applicants sought for an order that nevirapine be administered to other areas that were not under study.[235] They claimed that by limiting access to only two sites, the Government of South Africa has violated the right to access healthcare services and children's right to basic healthcare services protected by the international human rights law.[236] The High Court ruled in favor of the applicant.[237] Nonetheless, the Ministry of Health appealed claiming concerns regarding the efficacy of when nevirapine is not administered as a "full package", outside the pilot sites.[238] However, the Supreme Court determined the issue differently.

> [F]rom the evidence that the provision of nevirapine will save the lives of a significant number of infants even if it is administered without the full package and support services that are available at the research and training sites.[239]

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[232] Minister of Health and others v. Treatment Action Campaign and others, Constitutional Court of South Africa, CCT 8/02 (2002).
[233] *Id.*
[234] *Id.*
[235] *Id.*
[236] *Id.*
[237] *Id.*
[238] *Id.*
[239] *Id.*

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The State appellant claimed that rolling out nevirapine outside the pilot sites would result in drug resistance, however, the Court established that such a risk was worth taking compared to the alternative where patients would suffer and die without treatment efforts.[240] The Supreme Court eventually rejected the appeal and ordered that the government remove all restrictions that prevented nevirapine access in health facilities outside the pilot sites.[241] Decided just before the opening of the XIV International AIDS Conference in Barcelona, this case has become one of the world's leading decisions on the justiciability of HIV treatment within the right to health.[242]

In 2004, the case of *Edgar Mauricio Carpio Castro et al. v. Programa Nacional del SIDA-VIH-ITS & Ministerio de Salud Publica* before the Constitutional Tribunal of Ecuador established that antiretroviral treatment was a part of the human right to health.[243] The case was first brought before the court of first instance by four people living with HIV who needed antiretroviral treatment.[244] Earlier, in 2002, 153 PLHIVs including four applicants in this case submitted a petition before the Inter-American Commission of Human Rights seeking continued antiretroviral treatment as a "precautionary measure" due to the failure or refusal of the State in ensuring antiretroviral access in general.[245] Following the 2001 case of *Jorge Odir Miranda*

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[240] *Id.*
[241] *Id.*
[242] ELLIOTT, CANADIAN HIV/AIDS LEGAL NETWORK, AND JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, *supra* note 153 at 85.
[243] Edgar Mauricio Carpio Castro *et al.* v. Programa Nacional del SIDA-VIH-ITS & Ministerio de Salud Pública, Constitutional Tribunal (Third Chamber), Decision No. 0749-2003-RA (2004).
[244] *Id.*
[245] Jorge Odir Miranda Cortez *et al.* v. El Salvador, Inter-Am. Comm'n on H.R., Report No. 29/01, Case 12.249, *supra* note 223.

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Cortez et al. v. El Salvador, the Commission ordered these precautionary measures, however, it suspended one of the drugs and only dispensed one type of antiretroviral.[246]

On the basis of their constitutional rights, the four applicants sought the immediate reinstatement of antiretroviral provisions according to the required dosage as prescribed by physicians, including the provision of viral load testing, CD4/CD8 testing, and genotype and phenotype testing, as means for effective HIV treatment.[247] The court of first instance granted the application, but the Attorney-General and the Minister of Health appealed to the Constitutional Tribunal.[248] The Tribunal ruled in favor of the applicant by upholding the decision of the court of instance.[249]

Here, the applicants alleged that the unavailability of decent HIV treatment amounted to the infringement of the right to life; the right to health as protected by the Constitution; and the right to free HIV/AIDS treatment as set out by Article 6b of the Law on HIV/ AIDS Prevention and Comprehensive Care (*Ley para la Prevención y Asistencia Integral del VIH/SIDA*) and the Article 3 of the Regulation on Care for People Living with HIV/AIDS (*Reglamento para la Atención a las personas que viven con el VIH-SIDA*.)[250] The Tribunal granted the applications sought and ordered the Ministry of Health to provide uninterrupted HIV treatment.[251] The Tribunal expressly noted Ecuador's adoption of the 2001 Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly Special Session.[252] By having this

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[246] Edgar Mauricio Carpio Castro *et al.* v. Programa Nacional del SIDA-VIH-ITS & Ministerio de Salud Pública, Constitutional Tribunal (Third Chamber), Decision No. 0749-2003-RA (2004), *supra* note 243.
[247] *Id.*
[248] *Id.*
[249] *Id.*
[250] *Id.*
[251] *Id.*
[252] *Id.*

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in the case, the ruling stands out as a landmark where a court has invoked a non-binding resolution such as the Declaration of Commitment on HIV/AIDS to support its argument.[253] The CHLN and UNAIDS recognize that such a declaration could provide an advantage in domestic advocacy by the civil society in other parts of the world.

2.5. The Uncharted Area of HIV and the Law in Indonesia

While the study of HIV and the law in Indonesia is quite underdeveloped, there is an attempt to evaluate this area by Simplexius Asa in 2011. Asa discusses the appropriateness of risk behavior criminalization from the perspective of Douglas Husak's criminalization principles.[254] Asa's study is an adequate starting point for further assessment of local HIV laws.

From 2006 to 2011, Asa observes that there was a complete absence of local HIV law violations that led to prosecution. He concludes that the criminalization of risk behaviors under the laws ignores the capacity of legal enforcers.[255] Therefore, Asa concludes that the criminalization of HIV risk behaviors is an overreaction. He argues that worry about the HIV outbreak should not be the reason for overcriminalization because it disregards the function of criminal law as the "ultimate remedy."[256] Asa's conclusion exactly resembles realists' concern about the law's inaccuracy in addressing real-world problems like HIV.[257]

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[253] ELLIOTT, CANADIAN HIV/AIDS LEGAL NETWORK, AND JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, *supra* note 153 at 97.
[254] Simplexius Asa, *Suatu Tinjauan Hukum Pidana terhadap Kriminalisasi Perilaku Beresiko dalam Peraturan Daerah tentang Penanggulangan HIV dan AIDS di Indonesia (En. Criminal Law Review on Risk Behavior Criminalization in Local Laws on HIV in Indonesia)*, 2011.
[255] *Id.* at 143.
[256] *Id.*
[257] Robert F. Blomquist, *The Good American Legislator: Some Legal Process Perspectives and Possibilities General*, 38 AKRON L. REV. 895, 899 (2005).

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Asa finds that the law is a part of the national HIV strategy.[258] The strategy states that law is a form of structural intervention to increase the efficiency of the national HIV response. Asa states that this inclusion of criminalization that he scrutinizes is part and parcel of that objective. However, the national strategy document does not mention the logic of attaching criminal sanctions to risk behavior as a more efficient means of HIV prevention.

Asa's focus on HIV criminalization furthers the multidisciplinary approach.[259] Earlier, David Patterson also concludes that since the HIV epidemic appears in multiple ways, it is best to build a response based on a multidisciplinary approach.[260] This kind of approach requires an *a priori* enthusiasm to move beyond one's silo and be attentive to different points of view and contributions.[261]

Asa's study promises to encourage legal scholars' greater attention to HIV, which seems to be dominated previously by experts coming from medical and public health backgrounds. While Asa posits his argument from the perspective of criminal law, this present dissertation will supplement a divergent perspective by focusing on the appropriateness of criminalization among other HIV programs. This present study tries to enhance the conversation among international law, public health, jurisprudence, and international relations scholarship. This approach is a subtle attempt to stretch the frontiers of knowledge across diverse dimensions of HIV.

Asa also leaves ample room for further study on Indonesian HIV law beyond domestic borders. It is this gap that this present dissertation tries to explore. By applying transnational

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[258] Asa, *supra* note 254 at 3.
[259] David Patterson, *HIV: Public Health, Criminal Law and the Process of Policy Development*, 1995.
[260] *Id.* at 144.
[261] *Id.*

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legal process theory, this dissertation intends to contribute to the developing academic scrutiny of Indonesian HIV law that was already pioneered by Asa.

While Asa provides a precedent of domestic examination of local HIV laws, Daniel Grace's dissertation presents an exemplary study of transnational transfer of norms, specifically in the area of HIV and AIDS. He problematizes the United States Agency for International Development-Action for West Africa Region (USAID/AWARE HIV) Model Law program in Central and West Africa.[262] Grace addresses both the content and the transnational work process of creating and challenging the omnibus Model Law.[263]

He reveals that transnational interaction between transnational actors occurred when the Canadian HIV/AIDS Legal Network (CHALN) challenged the USAID/AWARE Model Law by creating an alternative model law.[264] In support of this argument, Richard Pearshouse finds that the ability of the domestic legal system to objectively check and balance the model law has been minimal, especially in terms of addressing stigma and discrimination.[265] Grace observes that an informant finds that there is a gap between people with legal backgrounds and laypeople.[266]

Grace also raises the notion of "therapeutic" sovereignty that has been exhibited by AIDS exceptionalism.[267] This phenomenon of exceptionalism refers to the framing of the AIDS response as a humanitarian response.[268] The intrusion of transnational AIDS norms into a state

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[262] Daniel Grace, *This is not a Law: The Transnational Politics and Protest of Legislating an Epidemic*, 2012.
[263] *Id.* at 12.
[264] *Id.* at 263.
[265] Richard Pearshouse, *Legislation Contagion: The Spread of Problematic New HIV Laws in Western Africa*, 12 HIV/AIDS POL'Y & L. REV. 5, 9 (2007).
[266] Grace, *supra* note 262 at 222.
[267] *Id.* at 275.
[268] *Id.* at 276.

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overrides the state's sovereignty because the response frames it as a life-or-death situation.[269] This thesis enriches the idea about the roles of asymmetric power within the cycle of the transnational legal process.

Eugene Lim also raises this asymmetric in his study. He argues that external pressures exerted by international networks, as well as foreign governments in different fora, are significant in initiating a series of cognitive shifts nudging states to change their behavior.[270] In the area of global health jurisprudence, David Fidler states categorically that the post–World War II rise of the medical-technical approach has led to the development of science-backed transnational rules.[271] Fidler argues that this medical-technical ethos explains the decrease of the WHO's legitimacy[272]; however, since most HIV-related norms are post-war norms, this present dissertation could modify the argument.

In his dissertation, Grace submits a couple of questions for future inquiries to which this present dissertation can relate. One of them is, "Are people most affected by an issue allowed to participate in the process of legislative reform meaningfully?"[273] This question inspires this present dissertation to gather perspectives from HIV-positive peer groups as the most affected group.

Asa and Grace's studies show that transnational norms on HIV do occur and are observable. Therefore, given the dynamic situation of HIV law in Indonesia, this present

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[269] *Id.*
[270] Lim, *supra* note 128 at 134.
[271] David P. Fidler, *The Future of the World Health Organization: What Role for International Law*, 31 VAND. J. TRANSNAT'L L. 1080–1126, 1101 (1998).
[272] *Id.*
[273] Grace, *supra* note 262 at 277.

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dissertation tries to meet the need for a legal study utilizing Koh's transnational legal process—focusing primarily on state–society dynamics—in the presence of global health jurisprudence.

2.6. Understanding the Landscape: The Indonesian Legal System

In post-colonial settings like Indonesia, some colonial legal concepts are still partially preserved.[274] Post-colonial governments partially accept colonizers' laws—with modification—to control an independent society.[275] This practice was inevitable due to the heat of the moment of independence, when a decent lawmaking process was impossible.[276]

Indonesian society had established its own tribal/customary legal concepts well before the colonizers came with their laws.[277] There have been legal concepts on property law, family law, criminal law, and tort law in different tribal communities.[278] However, the urge for a unified post-colonial law modified these concepts.[279] The attempt to unify the law required legal and institutional dynamics. In some decisions, such as those on family law, the court combines tribal law and state-sanctioned Islamic law.[280]

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[274] Daniel S. Lev, *Judicial Unification in Post-Colonial Indonesia*, 16 INDONESIA 1, 3 (1973); Walter J. Walsh, *The First Free Exercise Case*, 73 GEO. WASH. L. REV. 1 (2004); Walter J. Walsh, *The Priest-Penitent Privilege: An Hibernocentric Essay in Postcolonial Jurisprudence*, 80 IND. L. J. 1037 (2005).
[275] Lev, *supra* note 274 at 13; DAVID E. APTER, THE POLITICS OF MODERNIZATION 271 (1969).
[276] Lev, *supra* note 274 at 13.
[277] Mark Cammack, *Changing Indonesia's Constitution: A Review Essay*, 81 INDONESIA 151–163, 153 (2006); PETER BURNS, THE LEIDEN LEGACY: CONCEPTS OF LAW IN INDONESIA 48 (2004). "[T]he Indies was not, van Vollenhoven wrote, 'constitutionally barren and empty' prior to Dutch contact; the region was brimful with institutions of government and authority."
[278] Lev, *supra* note 274 at 22–23.
[279] *Id.*
[280] Bedner, *supra* note 15 at 23.

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Following its declaration of independence in 1945, Indonesia retained a portion of its colonial judicial structures, concepts, and procedures.

> The constitution of 1945 was reminiscent of the institutions of colonial Indonesia. All laws in force at the time of the Proclamation of Independence were retained. Japanese criminal provisions were rescinded in favor of the older criminal code, to which a few minor amendments were made. But occupation innovations in judicial organization were kept.[281]

Hans Kelsen's theory is appropriate to explain this Indonesian legislative structure, which resembles most European legal traditions. The theory suggests that higher-level norms are the root of lower-level norms, hence the hierarchy.[282] The highest forms of norms are: (1) The Constitution; (2) The People's Consultative Assembly Decree; (3) Laws or Government Regulation in Place of Laws; (4) Government Regulation; (5) Presidential Regulation; (6) Provincial Regulation; and (7) Regency Regulation.[283] Oher forms of law are also enlisted, including laws issued by ministries and the Constitutional Court.[284]

The lawmaking process in Indonesia is associated with the making of statutory law as the primary source of law. The making of a statutory law involves the executive (the President) and legislative (the Parliament) branches.[285] Both branches must endorse a bill before it becomes a law.[286] Both the President (executive) and the Parliament (legislative) can propose a bill.[287]

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[281] Lev, *supra* note 274 at 13.
[282] HANS KELSEN, PURE THEORY OF LAW 206 (1967).
[283] Law No. 12 on Legislations art. 7 (2011).
[284] *Id.* art. 8.
[285] *Id.* art. 72.
[286] *Id.*
[287] *Id.* art. 43.

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The Parliament's general assembly must internally approve a bill before submission to the Executive.[288] The Executive can propose a bill based on the needs expressed by the ministries.[289] All bills must include an accompanying academic paper, except in certain areas like annual budgeting.[290] Typically, the Executive and the Parliament prepare both long- and short-term national legislation programs.[291]

If a bill becomes a law, then it becomes a primary source of law. However, typically, an interventional statutory law would not be workable without a Governmental Regulation issued by the Executive as the operational guideline.[292]

The judiciary is not directly involved in the making of statutory law.[293] However, this does not mean that the judiciary is not a part of the legal process. The judiciary has intricate functions both to enforce the law and to uphold justice.[294]

The judiciary's role in lawmaking is associated with the precedents of the Constitutional Court and the Supreme Court.[295] The decision of a judicial review by the Constitutional Court becomes generally applicable when it decides that a law is unconstitutional or not.[296] This is the only point where the Judiciary intervenes in the decisions of the Legislature and the Executive: through the invalidation of their products (statutory laws). However, this power only works when

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[288] *Id.* art. 46.
[289] *Id.* art. 47.
[290] *Id.* art. 43(3).
[291] *Id.* art. 20.
[292] *Id.* art. 25.
[293] Law No. 48 on Judiciary Power art. 2 (2009).
[294] *Id.* art. 2.
[295] *Id.* art. 20.
[296] Law No. 8 on Constitutional Court art. 10(1) (2011).

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someone files a case before the Constitutional Court.[297] The Judiciary cannot initiate the power of a constitutionality test arbitrarily.

Through his comparative historical study, Choky Ramadhan concludes that Indonesia is a melting pot between civil law and common law traditions.[298] HIV-related laws are made mostly through the political process in and between the Legislature and the Executive. At the same time, the judiciary maintains its role as *negative legislator*.[299]

In Indonesia, a judicial review by the constitutional court is the only avenue whereby the judicial branch can "check and balance" the legislative branch. Since a judicial review can be triggered only when there is a citizen complaint, the "presumption of constitutionality" is one governing canon of construction.[300] Legislation is therefore in force so long there is no judicial review that invalidates such legislation.[301]

This presumption of constitutionality means the constitutionality test relies on the citizens' initiative to bring constitutional cases to the court. Therefore, an enabling political environment is necessary to ensure that citizens have equal access to the legal and political process. While judicial review is a normal process for the country, people's awareness of

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[297] Law No. 24 on Constitutional Court art. 29 (2003).

[298] Choky Ramadhan, *Konvergensi Civil Law dan Common Law di Indonesia dalam Penemuan dan Pembentukan Hukum (En. The Convergence of Civil Law and Common Law in Indonesian Legislation and Legal Interpretation)*, 30 MIMBAR HUKUM—FAKULTAS HUKUM UNIVERSITAS GADJAH MADA 213, 226 (2018).

[299] MOH. MAHFUD M.D., KONSTITUSI DAN HUKUM DALAM KONTROVERSI ISU (EN. THE CONSTITUTION AND THE LAW IN ISSUE CONTROVERSIES) 10 (2009). Mahfud defines a *negative* legislator as a body with the authority to cancel a law.

[300] Marbury v. Madison, 5 U.S. 137 (1803); ALEXANDER HAMILTON, FEDERALIST PAPER NO. 78 (1788).

[301] Pan M. Faiz, *Perubahan Politik Hukum Pengujian Peraturan Daerah Pasca Putusan Mahkamah Konstitusi (En. The Change of Legilsation Review Policy in the Aftermath of Constitutional Court Decision)*, *in* PEMERINTAH DAN PEMERINTAHAN DAERAH-REFLEKSI PADA ERA REFORMASI, 96 (2013).

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bringing a constitutional case varies over time. The court's capacity to handle cases also determines the success of a judicial review application.

In the Indonesian legal hierarchy, constitutional review is only applicable to laws made by the President and the national Parliament. Since 2004, Indonesia has transitioned into a decentralized polity by granting more lawmaking autonomy to local politics in adopting local laws, however, a citizen could only submit a judicial review regarding a local law to the Supreme Court; not the Constitutional Court.[302] A judicial review tests a local law against a national law; not against the Constitution directly.[303] An applicant could request that the court test a law as a whole or partially, including any provision within the local law.[304] Contrasted to the lower court application of law, this procedure allows the lawmaking process through court interpretation as a part of legal process.

2.7. Conclusion

Based on the preceding literature review, transnational legal process is a robust theory to be used in analyzing the work of global health jurisprudence. In particular, transnational legal process allows the analysis to see the interaction, interpretation, and internalization of global HIV norms in Indonesia. From the emergence of global HIV norms, the literature review finds that the national internalization of global norms occurs through the intertwined works between state and non-state actors, in both domestic and international fora. The process norms, as the

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[302] Law No. 48 on Judiciary Power, *supra* note 293 art. 20; Law No. 3 on Supreme Court art. 31A (2009); Law No. 33 on Local Autonomy (2004). By decentralizing its political power, it does not mean that Indonesia is not adopting the federal system, rather, it is a unitary state where the local political power is originated from the central government; not *vice versa*.
[303] Law No. 3 on Supreme Court, *supra* note 302 art. 31A.
[304] *Id.*

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literature review shows, include: (1) The creation of an inter-ministerial committee on HIV/AIDS; (2) The creation of a parliamentary committee on HIV/AIDS; (3) The creation of multisectoral advisory bodies; (4) Community engagement; (5) Participatory process in lawmaking, reform, and review; (6) Identification of domestic and international basis for human rights claims through public and private litigation; and (7) Identification of prospective international law-declaring fora to influence domestic legal process.

This literature review also justifies the use of Indonesia as our case study. Indonesia has a relatively stable political situation, so this study has the potential to draw more accurate inferences about the lawmaking processes in question. Bringing the abovementioned schools of thought to examine the uncharted areas of HIV and the law in Indonesia is a provocative academic endeavor.

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3. The Transnational Legal Process of Global HIV Norms in the Indonesian Context

3.1. Introduction

Continuing from the previous overview of the HIV situation and the Indonesian legal system, this chapter describes the development of the HIV legal environment in Indonesia explicitly. As an addition to library research, personal correspondence with informants is essential for finding these legal documents from various institutions and individuals. The macro-historical examination justifies that the proliferation of Indonesian local HIV laws is worth studying.

This chapter divides the findings into two parts: (1) The macro-historical examination; and (2) In-depth historical examination. The macro-historical examination provides a broad overview of the legal environment. This procedure is the basis of the second part's focus. The study finds that there is a spiking uptrend in HIV local laws after the UNGASS Declaration on HIV/AIDS in 2001. In the second part, this chapter presents a hyperlocal elaboration of local laws. The elaboration divides the timeline into three periods from 2001 to 2017.

3.2. Macro-Historical Examination

The early reaction to HIV can be traced back to July 3, 1981, when the New York Times published the first news story on the spike of Kaposi's sarcoma's incidence among a specific

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population in New York City and the San Francisco Bay area.[305] The news story did not mention the term "AIDS"; instead, it described that the researchers found severe defects in victims' immunological systems. The news also described a hypothesis that there was no apparent danger to non-homosexuals from contagion.[306] However, it reported that while cancer is not contagious, particular viruses or environmental factors might precipitate it.

The engagement of Indonesian actors in the formalities of global norms began in the early 1990s. At that time, civil society and the Ministry of Health, backed by the UN Global Programme on AIDS, began the responses to the epidemic.[307] In 1991, Indonesia had the first International AIDS Candlelight Memorial in Surabya, East Java.[308] The memorial was organized by Nusantara Lesbian and Gay Workgroup (Gaya Nusantara) and Surabaya City Transgender Association (Perwakos).[309] It was held to remember those who passed away due to the virus. At the same time, the annual event was meant as a sign that HIV problem is real. The memorial was also an event to "recharge" the motivation of those who were working in the field. The first International Candlelight memorial was followed by a National Seminar and Workshop in Denpasar, Bali. This workshop discussed the plan to develop a national AIDS Response Strategy.

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[305] Lawrence K. Altman, *Rare Cancer Seen in 41 Homosexuals*, N.Y. TIMES, July 3, 1981, https://www.nytimes.com/1981/07/03/us/rare-cancer-seen-in-41-homosexuals.html (last visited Sep 27, 2018); RANDY SHILTS, AND THE BAND PLAYED ON: POLITICS, PEOPLE, AND THE AIDS EPIDEMIC (20th anniversary edition ed. 2007).
[306] Altman, *supra* note 305.
[307] Jane S. Wilson, *HIV/AIDS in Indonesia*, *in* AIDS IN ASIA 91–98, 92 (Yichen Lu, Max Essex, & Ellen Stiefvater eds., 2004).
[308] Spiritia Foundation, Sejarah HIV di Indonesia (En. The History of HIV in Indonesia) (2009).
[309] *Id.*

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In 1994, the Yogyakarta Institute for Publishing Education (LP3Y) and the Yogyakarta Family Planning Association (Lentera-PKBI-DIY) worked with the Ford Foundation to conduct a journalist workshop on "Writing AIDS." The period of 1989-1995 is the awakening times at the global level when various organizations were involved in multiple regional consultation meetings in the preparation of the International Guidelines on HIV/AIDS and Human Rights. In 1994, President Soeharto's administration adopted the National AIDS Strategy through a Presidential Decree.[310] The same decree also set up the National AIDS Control Commission at the national, provincial, and district levels.[311] In this period, most of the efforts were to find out that the epidemic did exist. By the end of 1994, there were 275 cases of HIV infection, however, the new National AIDS Commission estimated that there would be 1,990,000 cases of HIV infection by 2005.[312]

In 1995, Yayasan Pelita Ilmu, one of the earliest NGOs working in the field of HIV/AIDS in Indonesia launched three programs. In January, it published "Support" monthly magazine as the first civil society-based HIV/AIDS awareness program through print media. It also opened "Sanggar Kerja" as a shelter for HIV-positive people who were ill or being outcasted by their community. To support the shelter, Yayasan Pelita Ilmu also launched "buddies" program.[313]

One of the PLHIV at that time, Suzana Murni, established Spiritia as the first independent peer support group for HIV-positive people. In line with the 1994 Paris Declaration on the

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[310] Wilson, *supra* note 307 at 92.
[311] *Id.* at 93.
[312] Spiritia Foundation, *supra* note 308.
[313] *Id.*

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Greater Involvement of People Living with HIV/AIDS (GIPA Principles) that was just adopted the year before, the mission of the peer support group is to ensure psycho-social support for people living with HIV, especially in the absence of HIV treatment at that time and the sheer stigma and discrimination. One of the national newspapers wrote that the virus has been used to commit crimes.[314]

Similarly, the embroilment of global actors in national policymaking has been more evident since the Presidential Decree. During this stage, the United Nations Development Program (UNDP), the Australian Agency for International Development (AusAID), and USAID rendered decisive help to Indonesian actors.[315] At the same time, there have been bilateral assistance colloquies connecting Australian, American, and German agencies.[316]

In the beginning of 1995, twenty-five NGOs gathered in an HIV/AIDS workshop in Pacet, East Java.[317] The workshop declared the Pacet Declaration on Ethics and Human Rights Issues Related to the HIV/AIDS Epidemic and Prevention Efforts.[318] In anticipating the increase of HIV cases, the declaration calls for an ethical approach. It emphasizes the importance of ensuring the rights to privacy and self-determination in HIV testing, which was known as the voluntary counseling and testing (VCT).[319] The declaration also stipulates the commitment of the civil society to continuously advocate and scrutinize all stages of future HIV/AIDS programs.[320]

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[314] *Id. supra* note 308; PUTU OKA SUKANTA, SUZANA MURNI: LILIN MEMBAKAR DIRINYA (EN. SUZANA MURNI: THE CANDLE BURNED HER (2006); SUZANA MURNI, DUA SISI SATU SOSOK (EN. TWO SIDES ONE FIGURE) (Putu Oka Sukanta ed. 2006)
[315] Wilson, *supra* note 307 at 93.
[316] *Id.* at 93.
[317] NGO HIV/AIDS Workshop, Pacet Declaration on Ethics and Human Rights Issues Related to the HIV/AIDS Epidemic and Prevention Efforts (1995).
[318] *Id.*
[319] *Id.*
[320] *Id.*

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With the adoption of the Pacet Declaration, and the initial presence of international development agencies, this mid-1990s advancement represents the onset of a more methodical HIV/AIDS response in Indonesia. The country has been able to furnish the following foundational ingredients:

(1) The HIV/AIDS response's legal basis through a Presidential Decree;[321]
(2) The establishment of a National AIDS Control Commission;[322]
(3) The establishment of the commission's secretariat;[323]
(4) The establishment of a national AIDS strategy policy document;[324]
(5) The appointment of the Coordinating Ministry of People's Welfare as the leading coordinator;[325]
(6) The presence of bilateral donors in multiple provinces;[326] and
(7) The active roles played by several UN agencies.[327]

This 1990s progress signals the reaping of Indonesia's openness and involvement with outside actors. Although Indonesia has been acting mostly as a beneficiary of support, this is a form of active participation in the shaping of global AIDS policies.

The civil society movement surfaced when the NGOs, through the *Grup Koordinasi Nasional Mobilisasi AIDS Nusantara*/National AIDS Mobilization Coordinating Group

[321] Presidential Decree No. 36 on National AIDS Commission (1994).
[322] *Id.*
[323] *Id.*
[324] *Id.*
[325] *Id.*
[326] Wilson, *supra* note 307 at 93.
[327] *Id.*

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(GKNMAN), managed to coordinate the 1996 International Candlelight Memorial in 31 cities in Indonesia.[328] This event got the attention needed and then followed up with the First National HIV/AIDS Meeting in Jakarta.[329] The participants in the meeting formed three organizations: (1) *Perhimpunan Dokter Peduli AIDS Indonesia*/the Indonesian Physician Association for AIDS, (2) *Forum Komunikasi LSM/Organisasi Peduli AIDS*/the Communication Forum for AIDS Service NGOs (FKLOPA), and *Masyarakat Peduli AIDS Indonesia*/the Indonesian AIDS Care Society (MPAI).[330] Also in the same year, AIDS-INA was launched as the first mailing list on HIV/AIDS.[331] In the same year, Spiritia's founder Murni spoke at the Global Conference on HIV/AIDS. At the closing plenary, Murni spoke openly as an HIV positive person and addressed the ideals of access to HIV drugs.

> The possibility of making second rate drugs available for study in developing countries I found insulting. People with HIV and AIDS, people in developing countries are not guinea pigs. What's applied to the so-called developed world, should also be applied to the developing world.[332]

The conference concluded with a hope that the cooperation of scientists, policymakers, and activists would bring the "cure" closer.

Also in mid-1990, the United Nations instituted the Joint United Nations Programme on HIV and AIDS (UNAIDS) to serve hand in hand with the extant institutions: WHO, UNDP, and the United Nations Population Fund (UNFPA.)[333] These organizations are known to operate not

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[328] Spiritia Foundation, *supra* note 308.
[329] *Id.*
[330] *Id.*
[331] *Id.*
[332] Suzana Murni, *Closing Plenary Speech: The Global Conference on HIV/AIDS, July 11th, 1996, Vancouver, Canada* (1996).
[333] Wilson, *supra* note 307 at 93.

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only in Indonesia but in most UN member countries around the globe.[334] As an example, the World Bank rolled out a large-scale project in Jakarta and Riau provinces.[335]

This institutionalized movements to address HIV as an epidemic showed such demand that in 1997 Indonesia imported the first antiretroviral drugs (AZT, ddI, ddC, 3TC, saquinavir, and ritonavir), however, the prices were beyond the purchasing ability of HIV patients at that time.[336]

By the end of 1997, there were 619 cases of HIV and 153 of them were fighting AIDS.[337] This situation pushed Spiritia to extend the peer support work beyond its members. In 1998, Spiritia managed to conduct the first National PLHIV Meeting in Ubud, Bali.[338] The meeting was attended by 16 participants from different places in Indonesia.[339] The participants came from various social backgrounds. In the absence of affordable HIV treatment, the meeting was emphasized on peer social support by providing a safe environment for participants to share their experience of living with HIV. Through this meeting, Spiritia started to listen to experiences of stigma and discrimination. Also, in this year, Murni was elected as the Regional Coordinator of the Asia Pacific Network of People Living with HIV (APN+). In the following year, Murni secured a seat on the National AIDS Commission as the only civil society representative among the ministry officials. Her presence as an HIV positive person was itself a form of advocacy bringing the message that HIV is real and those infected are no equal.

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[334] *Id.*
[335] *Id.*
[336] Spiritia Foundation, *supra* note 308.
[337] *Id.*
[338] *Id.*
[339] *Id.*

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Following the adoption of the 1997 Narcotics Law and the 1997 Psychotropic Law, a number of drugs and HIV activists organized the National Workshop and Seminar on Drugs Use and Abuse.[340] This conference involved Indonesian policy makers from different sectors and also a number of speakers from Malaysia and Australia.[341] This conference introduced the concept of reducing the risk of HIV among drugs users that is also known as "harm reduction" program.[342] The attention to coordinate HIV and narcotics issue has arisen when in 2000 the Kerobokan narcotics prison in Bali found 56% HIV cases among its 67 inmates who were injecting drug users.[343]

In 2000, the Second National HIV/AIDS Meeting was conducted in Jakarta.[344] In the same year, Indonesia conducted the unprecedented documentation of human rights violations against PLHIV.[345] The research was an international collaborative project conducted by the Asia Pacific Network of People Living with HIV/AIDS (APN+). The project was funded by AusAID and had the UNAIDS Country Director as one of the National Advisory Board.[346] The research was conducted in four countries: Indonesia, India, Thailand, and the Philippines.[347] In Indonesia, the research was led by Spiritia Foundation members who had access to PLHIV respondents in four provinces.[348] The research concluded that most of HIV-related discrimination were taking place in healthcare settings, in the forms of breach of confidentiality and discriminatory

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[340] *Id.*
[341] *Id.*
[342] *Id.*
[343] *Id.*
[344] *Id.*
[345] Susan J. Paxton *et al.*, *AIDS-related discrimination in Asia*, 17 AIDS CARE 413–424 (2005).
[346] *Id.*
[347] *Id.*
[348] *Id.*

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conducts.[349] The research was used by the civil society as an advocacy tool through a national dissemination in 2001 targeting executive agencies, legislative members, and the judiciary.[350]

As HIV is a global health problem, multiple actors are involved in a significant number of agreed strategies and institutionalizations to address it. In 2000, the Millennium Development Goals included HIV as a specific goal.[351] In 2003, President Bush launched the President's Emergency Plan for AIDS Relief (PEPFAR) to assist the countries most-hit by HIV.[352] In the same year, the World Health Organization (WHO) adopted the 3 by 5 Initiative to ensure treatment of 3 million people by 2005.[353] Also, in 2003, Indonesia received its first grant from the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM).[354] In 2005, the WHO adopted the International Health Regulation (IHR) to address the link between public health and international traffic and trade. Indonesia has been working with various bilateral development agencies in responding to the HIV crisis.[355] In recent years, this partnership has been expanding to include philanthropy organizations.[356]

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[349] *Id.*
[350] *Id.*
[351] WHO | MDG 6: Combat HIV/AIDS, Malaria and Other Diseases, WHO, http://www.who.int/topics/millennium_development_goals/diseases/en/ (last visited Jan 19, 2018).
[352] About PEPFAR, https://2006–2009.pepfar.gov/about/index.htm (last visited Jan 19, 2018).
[353] WHO | About the 3 by 5 Initiative, WHO, http://www.who.int/3by5/about/initiative/en/ (last visited Jan 19, 2018).
[354] Country: Indonesia, THE GLOBAL FUND, https://www.theglobalfund.org/en/portfolio/country/?loc=IDN&k=d0e17d32-68e3-481a-9ca5-bac4e685c119 (last visited Jan 19, 2018).
[355] INTERNATIONAL HEALTH REGULATIONS (2005, World Health Organization ed., 3d ed. 2016). *See also* WHO Official Records, No. 176, 1969, Res. WHA22.46 and Annex I; WHO Official Records, No. 209, 1973, Res. WHA26.55. WHA34/1981/REC/1 Res. WHA34.13; WHO Official Records, No. 217, 1974, Res. WHA27.45, and Res. EB67.R13; Amendment of the International Health Regulations (1969) Res. WHA48.7, Res. WHA56.29, Res. WHA56.28, and Res. WHA58.3 (2005).
[356] Tahir Foundation & Gates Foundation Partner, BILL & MELINDA GATES FOUNDATION, https://www.gatesfoundation.org/Media-Center/Press-Releases/2013/10/Tahir-Foundation-and-

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In the context of bilateral assistance, the parties appeared as equals. This means that bilateral initiatives regard the outputs and outcomes as politically worthwhile for both Indonesia and the benefactor country.[357]

As an example, in the 2008–2015 Australian-Indonesia Partnership for HIV, it is explicit that the partnership's advantages were two-way.[358] The partnership advanced Australia's national interests in assisting global economic growth.[359] Notably, Australia recognized the shift of global economic power to the Indo-Pacific region.

Table 1. Indonesia's Interaction with Other Nation-States within the United Nations

Global Health Institution	Forms of Norms	Indonesia's Interaction
WHO	• The WHO Constitution • The Declaration of Alma-Ata 1978 • Global Program on AIDS 1986 • 3 by 5 Initiative 2003 • International Health Regulation 2005	Indonesia is a part of the World Health Assembly (WHA), the WHO's principal decision-making body. Indonesia is a State Party to the IHR 2005, which entered into force in June 2007 to strengthen health security at the national level, without reservations.[360]
WTO	Doha Declaration allows developing countries to produce generic ARVs.[361]	Indonesia is a WTO member state under the group of countries with the pharmaceutical industry level of Reproductive Capabilities on Active Ingredients and Finished Products.[362]

Gates-Foundation-Partner (last visited Jan 19, 2018). In 2013, Tahir Foundation announced it would invest $65 million in GFATM. The Gates Foundation matched their commitment to GFATM.

[357] Australia-Indonesia Partnership for HIV 2008–2015 Including the HIV Cooperation Program for Indonesia: Program Design, 1 (2007).

[358] *Id.* at 1.

[359] *Id.*

[360] INTERNATIONAL HEALTH REGULATIONS (2005), *supra* note 355.

[361] World Trade Organization Ministerial Conference, *Declaration on the TRIPS Agreement and Public Health,* WT/MIN(01)/DEC/2 (November 20, 2001).

[362] PROMOTING ACCESS TO MEDICAL TECHNOLOGIES AND INNOVATION: INTERSECTIONS BETWEEN PUBLIC HEALTH, INTELLECTUAL PROPERTY, AND TRADE, 165 (Hans G. Bartels et al. eds., 2013).

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In the era of global health governance, Indonesia also mixes with non-state actors like the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI). Unlike its treaty-based interaction under the United Nations, in these interactions with non-state actors, the norms were created through contracts for specific interests.

Table 2. Indonesia's Interaction with Non-State Actors

Global Health Institution	Forms of Norms	Indonesia's Interaction
GFATM	Grant contracts (Round 01 to Round 09). GFATM's strategic objective in 2008–2016 rounds cover human rights promotion.[363]	Indonesia has been a recipient of the fund since 2003, covering the areas of prevention, targeted intervention, program management, health system strengthening, care, support, and treatment.[364]

[363] Restated Contract No. IDN-404-G05-H: Indonesian HIV/AIDS Comprehensive Care (Principal Recipient: Indonesian Ministry of Health/Directorate General of Disease Control and Environmental Sanitation) (2008).
[364] Contract No. IDN-102-G03-H-00: Prevention and Alleviation of HIV Impact (Principal Recipient: Indonesian Ministry of Health/Directorate General of Disease Control and Environmental Sanitation) (2003); Contract No. IDN-404-G04-H: Indonesian HIV/AIDS Comprehensive Care (Principal Recipient: Indonesian Ministry of Health/Directorate General of Disease Control and Environmental Sanitation) (2005); Contract No. IDN-809-G07-H: Indonesia Response to Government and Civil Society Partnership in 12 Provinces (Ministry of Health/Directorate General of Disease Control and Environmental Sanitation) (2009); Contract No. IDN-809-G07-H: Indonesia Response to Government and Civil Society Partnership in 12 Provinces (Principal Recipient: Indonesian Planned Parenthood Association) (2009); Contract No. IDN-809-G07-H: Indonesia Response to Government and Civil Society Partnership in 12 Provinces (Principal Recipient: National AIDS Commission) (2009); Contract No. IDN-910-G15-H: Indonesia Response to HIV Government and Civil Society Partnership in 21 Provinces (Principal Recipient: Nahdlatul Ulama) (2010); Contract No. IDN-H-IPPA: Indonesia Response to HIV Government and Civil Society Partnership in 12 Province (Principal Recipient: Indonesian Planned Parenthood Association) (2013); Contract No. IDN-H-MOH-949: Indonesia HIV Response: Accelerating the Achievement of the Three Zeros (Principal Recipient: Ministry of Health/Directorate General of Disease Control and Environmental Sanitation) (2016); Contract No. IDN-H-NAC-946: Indonesia HIV Response: Accelerating the Achievement of the Three Zeros (Principal Recipient: National AIDS Commission) (2016); Contract No. IDN-H-

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The Global Alliance for Vaccines and Immunization (GAVI)	Grant contracts	Indonesia has been the recipient of GAVI funding in many areas, including the health system strengthening in 2008, 2012, 2013, and 2014 under the performance-based model.[365]

In 2001, HIV gained its political prominence at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, when 189 countries recognized HIV as a national and international development issue.[366] Based on the Second International Consultation on HIV/AIDS and Human Rights 1996 and the Third International Consultation on HIV/AIDS and Human Rights 2002, the Office of the United Nations High Commissioner for Human Rights (OHCHR) and UNAIDS adopted the 2006 International Guidelines on HIV/AIDS and Human Rights.[367] In 2012, the Global Commission on HIV and the Law suggested that laws and practices should encompass human rights to effectively address discrimination, promote public health, and protect the right to health.[368]

Indonesia was one of eleven countries in Asia and the Pacific where the HIV epidemic is on the rise.[369] To update the 1994 projection, in 2014, the Indonesian Ministry of Health

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NU: Indonesia Response to HIV Government and Civil Society Partnership in 21 Provinces (Principal Recipient: Nahdlatul Ulama) (2013); Contract No. IDN-H-SPIRITI-954: Indonesia HIV Response: Accelerating the Achievement of the Three Zeros (Principal Recipient: Spiritia Foundation) (2015); Contract No. IDN-S10-G16-H: Indonesia Response to HIV Government and Civil Society Partnership in 33 Provinces (Principal Recipient: National AIDS Commission) (2010); Contract No. IDN-S10-G17-H: Indonesia Response to HIV Government and Civil Society Partnership in 33 Provinces (Principal Recipient: Ministry of Health/Directorate General of Disease Control and Environmental Sanitation) (2010).

[365] GAVI The Vaccine Alliance, *Indonesia*.

[366] KEEPING THE PROMISE: SUMMARY OF THE DECLARATION OF COMMITMENT ON HIV/AIDS: UNITED NATIONS GENERAL ASSEMBLY, SPECIAL SESSION ON HIV/AIDS 25–27 JUNE 2001, NEW YORK (Joint United Nations Programme on HIV/AIDS ed., 2002).

[367] *See supra* note 159.

[368] Global Commission on HIV and the Law: Risk, Rights, Health (2012).

[369] JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, GETTING TO ZERO: HIV IN ASIA AND THE PACIFIC at 485 (2011).

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estimated that the number of people living with HIV in 2016 would be 812,798.[370] For the same year of 2016, the estimated number of adult people living with HIV (PLHIV) on antiretroviral therapy (ART) was 44,594. A report from 2014 shows that ART adherence was as low as 67%.[371] The Ministry of Health's estimation also forecasted that the number of new HIV infections in 2016 would be approximately 10% of the total estimated HIV-positive population, reaching 96,480 people.[372] This disparity between the number of new HIV infections and the total estimated number of people living with HIV indicates the considerable demand to encourage more people to get tested and therefore treated.

Regarding HIV/AIDS in Indonesia, four arguments can support the claim that Indonesia had a diagonal HIV program in 2010–2015, when the HIV program was not fully integrated. First, in terms of financing, Indonesia separated the HIV program from the mainstream health program. The inclusion of the Global Fund in the HIV program was clear evidence of non-integrated financing in the Indonesian health system. Moreover, international funds also came from the governments of the United States of America, Australia, and the Netherlands.[373]

The National AIDS Spending Assessment 2011–2012 also indicates that the Global Fund had disbursed its funds to four primary recipients: the Ministry of Health, National AIDS Commission, Nahdlatul Ulama (an Islamic nongovernmental organization), and PKBI (the Indonesian Planned Parenthood Association).[374] Each primary recipient was responsible for

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[370] Ministry of Health of the Republic of Indonesia, Estimasi dan Proyeksi HIV/AIDS di Indonesia 2015–2020 (En. HIV/AIDS Estimation and Projection in Indonesia 2015–2020), 22 (2017).
[371] AUDIT REPORT: GLOBAL FUND GRANTS TO THE REPUBLIC OF INDONESIA, 4 (2015).
[372] *See supra* note 370 at 22.
[373] Nadjib Mardiati *et al.*, *National AIDS Spending Assessment 2011–2012* 23 (2013).
[374] *Id.* at 23.

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delivering its own HIV program at the local level. This configuration indicates that the international funds did not become exclusively part of the Ministry of Health.[375]

Secondly, the National HIV and AIDS Strategy and Action Plan 2010–2014 is the basis for Indonesia's partial integration of HIV programs to the mainstream health interventions. It covers the areas of governance organization, planning, service delivery, monitoring, and evaluation.[376] This policy document is a response to the existing challenges related to the health system, including (1) inadequate program coverage and effectiveness to assure achievement of universal access, (2) uncertainty related to program sustainability, (3) weak health and community service systems, (4) the need to improve governance in all sectors, and (5) the need to establish more a conducive environment for effective implementation of the full range of HIV and AIDS programs and services.[377] The actions planned by this document indicate the diagonal nature of the approach:

(1) Expand and scale up the coverage of all prevention efforts;
(2) Expand and scale up availability of care, support, and treatment services, as well as impact mitigation;
(3) Strengthen partnerships as well as health service and community systems;
(4) Increase coordination among stakeholders and effective use of resources at all levels; and
(5) Improve and expand utilization of structural interventions; implement evidence-informed program planning, priority setting, and implementation.[378]

This action plan shows that there was a clear division between the health service system and the overall HIV and AIDS program.

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[375] *Id.*
[376] Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS Tahun 2010-2014 (En. National HIV and AIDS Strategy and Action Plan 2010–2014) (2010).
[377] *Id.*
[378] *Id.*

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Thirdly, Desai et al. reported the nature of the Global Fund's integration into the Indonesian health system. The design of their analysis used the conceptual framework of integration developed by Atun et al. in 2010. The conceptual framework analyzes the compatibility between the problem (the nature of the HIV epidemic), the intervention (the complexity of the vertical program), the adoption system (intervention acceptance), health system characteristics (health system functions), and the social context.[379]

In general, the report claims that the Global Fund's portfolio had been fully integrated into Indonesia's HIV intervention, while the HIV intervention itself had mainly been vertical.[380] In terms of governance and organization, this report suggests that there was generally more integration of all functions, particularly planning and service delivery, at local levels, but they were less integrated at the central or national level.[381]

Fourthly, the Center for Health Policy and Management Universitas Gadjah Mada (CHPM) provided a report from nine provinces in Indonesia in terms of HIV program integration using an adapted version of Atun's conceptual framework.[382] The 2016 study shows that there is a certain level of integration on regulatory and policy functions in the health system.[383] Nonetheless, the accountability and responsiveness dimensions are still lacking because of the inability of local government to accommodate full engagement of key populations in planning, implementation, monitoring, and evaluation.[384]

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[379] Rifat Atun *et al.*, *Integration of Targeted Health Interventions into Health Systems: A Conceptual Framework for Analysis*, 25 HEALTH POL'Y PLAN 104–111, 106 (2010).
[380] Monica Desai *et al.*, *Critical Interactions Between Global Fund-Supported Programmes and Health Systems: A Case Study in Indonesia*, 25 HEALTH POL'Y PLAN i43–i47 (2010).
[381] *Id.* at i44.
[382] CHPM, *The Integration of HIV and AIDS Response into the Health System: Landscaping from Nine Provinces in Indonesia* 18 (2016).
[383] *Id.* at 12.
[384] *Id.*

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The area of service delivery, which includes prevention, care, support, treatment, and impact mitigation, has been better integrated because the service provider works by following the mechanisms of the global health system.[385] However, the integration does not take place in the functions of financing, healthcare resources, strategic information, and community participation. The dependency on vertical, centrally governed HIV programs is also affected by the critical factor of the lack of understanding regarding the local HIV epidemic.[386]

Overall, the following table illustrates the general verdict on Indonesia's diagonal HIV program:

Table 3. Indonesian Health System Functions and HIV Program Integration Level

Health System Functions[387]	Integration Level[388]
Governance	Partially integrated
Financing	Not integrated
Planning	Partially integrated
Service delivery	Partially integrated
Monitoring and evaluation	Not integrated
Demand generation	Partially integrated

The effort to reverse the HIV epidemic in Indonesia through prevention and treatment strategies is facing a complicated relationship of factors. The stigma associated with HIV inhibits the at-

[385] *Id.*
[386] *Id.*
[387] Atun et al., *supra* note 379.
[388] Desai et al., *supra* note 380. Partially integrated means that a function is integrated in some but not all cases, meaning that a health system function is managed and controlled both by the general healthcare system and a specific program-related structure. Not, or only to a very limited extent, integrated into the health system as a whole means that a health system function is (quasi-) exclusively under the management and control of a specific program-related structure which is distinct from the general healthcare system. Fully, or predominantly, integrated into the health system means that a health system function is (quasi-) exclusively under the management and control of the general healthcare system.

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risk population from getting tested for HIV.[389] Limited access to correct information about HIV leads to ignorance and disempowers people from taking preventative measures. When an HIV-positive person is on antiretroviral therapy, there are issues of adherence, procurement, opportunistic infection, double infection, and socioeconomic impact. These challenges occur in a legal environment that has contradictions between the laws and the HIV program.[390] Such contradictions both directly and indirectly affect the course of the epidemic.[391]

This dissertation study starts its in-depth historical examination by gathering data about the trend of HIV lawmaking since 1945. HIV was not present in the country until the late 1980s; however, 1945 was the year when Indonesia founded its Constitution. The Constitution requires all legislation to comply with its human rights mandates.[392] It is particularly interesting that the Constitution acknowledges human rights about three years *before* the adoption of the 1948 Universal Declaration of Human Rights. The historical data on HIV-related laws continue to 2019, the year of the latest Provincial Regulation identified by this study.

This historical mapping of HIV-related laws is needed before this study can perform the transnational legal process analysis. Without a comprehensive understanding of the existing laws, this study would not be able to see the substantive pattern of norms between laws throughout the timeline, across the country.

This study collected its data from April 2018 until July 2019. In that period of twelve months, this study ran through distinct approaches. As the first approach, this study used the internet to explore available legal documents online. At the same time, this study also used

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[389] NATIONAL CONSULTATION ON LEGAL AND POLICY BARRIERS TO HIV IN INDONESIA, *supra* note 2.
[390] *Id.*
[391] *Id.*
[392] The Constitution of the Republic of Indonesia art. 28 (1945).

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individual correspondence with various parties to find documents that are not available on the internet.

When researching the legal documents, this study used three inclusion criteria. These criteria are substitutive. First, the legal document should contain HIV-specific provisions. If not, the document should go through the second criterion, that it must have provisions regulating HIV risk factors. The third criterion is that a legal document must cover human rights.

The last criterion provides the way for this study to justify the notion of human rights obligations as the interpretative bridge between domestic and international norms. It is also the reason the study includes the Indonesian Constitution. In other words, the recognition of human rights in the Constitution could explicate the right to health as a constitutional right, which is also recognized by international human rights law.

Until July 2019, this study collected 258 records of HIV-related legal documents. This collection consists of twenty-one different legal document categories from the global to the city level.

Table 4. Legal Document Categories

Grouping	Type of Legal Document
Local nonpolitical	Regent Regulation Mayor Regulation Governor Regulation Governor Instruction
Local This present dissertation focuses on this group.	City Regulation Regency Regulation Provincial Regulation
National	Constitution Law Presidential Decree Presidential Regulation Government Regulation Ministerial Decree Ministerial Regulation Circular Letter

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Global	Convention Global Health Policies Bilateral Organizational Policy International Organizational Policy International Agreement (Contract) International Regulation

This study intends to see the presence of global HIV norms in the domestic legal process, and it is of the utmost priority to employ a bottom-up strategy. With this strategy, the study focuses primarily on the local-level group of laws, which includes Provincial, City, and Regency Regulations. These local types of law are distinguished by the characteristic of their geographical scope and the involved political process. A Provincial Regulation shall be made by a Governor together with the provincial parliament body. At the regency level, a Regent and a regency-level parliamentary body are the two bodies that could pass a Regency Regulation. Similarly, a Mayor and a city-level parliamentary body make City Regulations.

This study does not extensively embellish on the remaining nonpolitical local laws (Regent Regulation, Mayor Regulation, Governor Regulation, Governor Instruction) because of their single-branch nature. This means that the process does not involve other political bodies. Hence, this study would not be able to draw inferences on the relationship between actors.

As a start, this study can report the frequency of these legal documents. While a frequency report has its limitations, it can provide a basic understanding of which agency has the most interest in responding to HIV nationally.

Table 5. Frequency (Total: 258), 1945–2017

No.	Law Type	Frequency	Grouping
1.	Ministerial Decree	38	National
2.	Ministerial Regulation	33	National
3.	Regency Regulation	32	Local

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4.	Law	25	National
5.	Provincial Regulation	23	Local
6.	International Agreement (Contract)	18	Global
7.	City Regulation	17	Local
8.	Bilateral Organization Policy	11	Global
9.	International Organization Policy	11	Global
10.	Circular Letter	8	National
11.	Government Regulation	8	National
12.	Global Health Policies	7	Global
13.	Mayor Regulation	6	Other
14.	Presidential Regulation	6	National
15.	Governor Regulation	5	Other
16.	Presidential Decree	3	National
17.	Regent Regulation	3	Other
18.	Constitution	1	National
19.	Convention	1	Global
20.	Governor Instruction	1	Other
21.	International Regulation	1	Global

This frequency table suggests that the top types of laws regulating HIV responses are Ministerial Decrees, Ministerial Regulations, Regency Regulations, Laws, and Provincial Regulations. Both Ministerial Decrees and Ministerial Regulations are types of laws that are typically created by a ministry that is under the executive branch. The relatively high frequency of these legal documents suggests that the government has been an active player in the national HIV response. Through the ministerial authorities, the government has been utilizing public resources to a certain extent to deal with the HIV challenges in the country.

The next-highest-frequency laws are Regency Regulations, Laws, and Provincial Regulations. These laws are identical that their legal process involves the interplay between the executive and the legislative body. This feature is appealing because the involvement of the legislative body opens up entry to examine public participation in politics.

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There are twenty-three HIV-specific Provincial Regulations in the thirty-four provinces in Indonesia. This means that HIV has been one of the provincial priority programs of 67.6% of provinces. This fact suggests that the legal process has been occurring in most provinces in Indonesia. This fact recommends further analysis of these provincial-level legal processes.

On the other hand, Regency Regulation, regardless of its high frequency, has a low presence relative to the number of regencies in Indonesia. The 416 total regencies in Indonesia dwarf the thirty-eight HIV-specific Regency Regulations, even when adding seventeen City Regulations. It is, however, not easy to infer anything about priority at the regency or city level without looking at the real rationale behind the presence of a regency-level law. With 67.6% Provincial Regulation coverage, nonetheless, it is safe to suggest that a Provincial Regulation can cover multiple regencies with smaller political cost. As an example, a single Regency Regulation could cost up to an equivalent of $21,478, while competing with other bills.[393]

Laws, on the other hand, have a different situation. Currently, Indonesia does not have an HIV-specific national law. As the nationwide multibranch type of law, the existing related laws comprise population-specific laws, health-related laws, and the blanket of the national Penal Code. Indonesia has the National AIDS Strategy and Action Plan as the national reference for local HIV laws. A local law would be beneficial to accommodate specific local needs.[394] However, local laws cannot be directly tested against the national plan—through a legislative review before the Supreme Court—because the national plan is not a law made through agreement between the President and the national Parliament.

[393] Andi Nur Aminah, *Satu Perda Habiskan Biaya Rp. 300 juta di Biak (En. A Single Law Requires IDR 300 Million in Biak)*, REPUBLIKA, January 13, 2017.
[394] Law No. 12 on Local Government art 13 (2008).

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3.2.1. Timeline

After collecting legal documents, this study could start to see them chronologically. This study uses a histogram chart to capture the trend of HIV lawmaking between 1945 and 2017. This pixelated histogram below (Chart 1) shows the distribution of the 258 legal documents reviewed in this study according to the year of their adoption. One of the most noticeable messages from this histogram is that the increase in HIV laws started in 2001. This is the year when the United Nations General Assembly held a Special Session on HIV/AIDS (UNGASS). In that session, the General Assembly adopted the UNGASS Declaration as the highest political stage for HIV prevention.[395]

The histogram shows that from 2001 to 2005, there was an ongoing increase in HIV-related laws, marked by the increase in ministerial-level laws. In that period, there was only one local law, the 2003 Jayapura Regency Regulation in Papua. It is also in this period that Indonesia got its first GFATM grant agreement. Regarding the role of the government, the timeline shows ample adoption of Ministerial Decrees on HIV/AIDS in this period.

As mentioned earlier, in 1994, the government adopted a 1994 Presidential Decree that formed the National AIDS Commission.[396] Nonetheless, the 1998 financial crisis meddled with Indonesia's HIV response.[397] According to the 2001 Indonesian Human Development Report, the financial crisis harshly disrupted the social structure, which contributed to poverty.[398] The

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[395] United Nations General Assembly Special Session, *Declaration of Commitment on HIV/AIDS*, Res. 55/13 (June 26, 2001).
[396] Presidential Decree No. 36 on National AIDS Commission, *supra* note 321.
[397] Wilson, *supra* note 307 at 93. Wilson describes that unemployment and poverty increased sharply, and some observers linked increased risk and vulnerability to HIV infection to these factors, although definitive analysis is not yet available.
[398] TOWARDS A NEW CONSENSUS: DEMOCRACY AND HUMAN DEVELOPMENT IN INDONESIA: INDONESIA HUMAN DEVELOPMENT REPORT 2, 2001 (BPS-Statistics Indonesia, Bappenas and UNDP Indonesia).

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effort to tame the financial crisis meant the government had to dissolve the Ministry of People's Welfare, the preeminent sector of HIV prevention at that time.[399] After the post-crisis election, President Megawati Soekarnoputri revived the Ministry of People's Welfare, which was a meaningful improvement to the Indonesian HIV program.[400]

During President Megawati's term (2001–2004), Indonesia took advantage of the staging of the UNGASS. The Minister of Health, Achmad Sujudi, led the Indonesian mission at the General Assembly.[401] According to Wilson's report, the official Indonesian mission consisted of nine entities: the Ministries of Health, Women's Empowerment, and Family Planning and Reproductive Health; the National AIDS Commission; the Parliament; the Ministry of Foreign Affairs; and Suzana Murni, Aty Uleng, and Dr. Nasser, who were stewarding the NGOs.[402]

At the pre-UNGASS consultations in New York, the delegations had a tangled colloquy regarding the Declaration of Commitment. The delegates were trying to reach unison on a broad spectrum of contentious HIV subjects for the first time.[403] In the same year, there was a report that officials were experimenting with harm reduction methods as the beginning of harm reduction's embodiment as a government policy.[404]

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[399] Wilson, *supra* note 307 at 93.
[400] *Id.*
[401] *Id.*
[402] *Id.*
[403] *Id.*
[404] *Id.*

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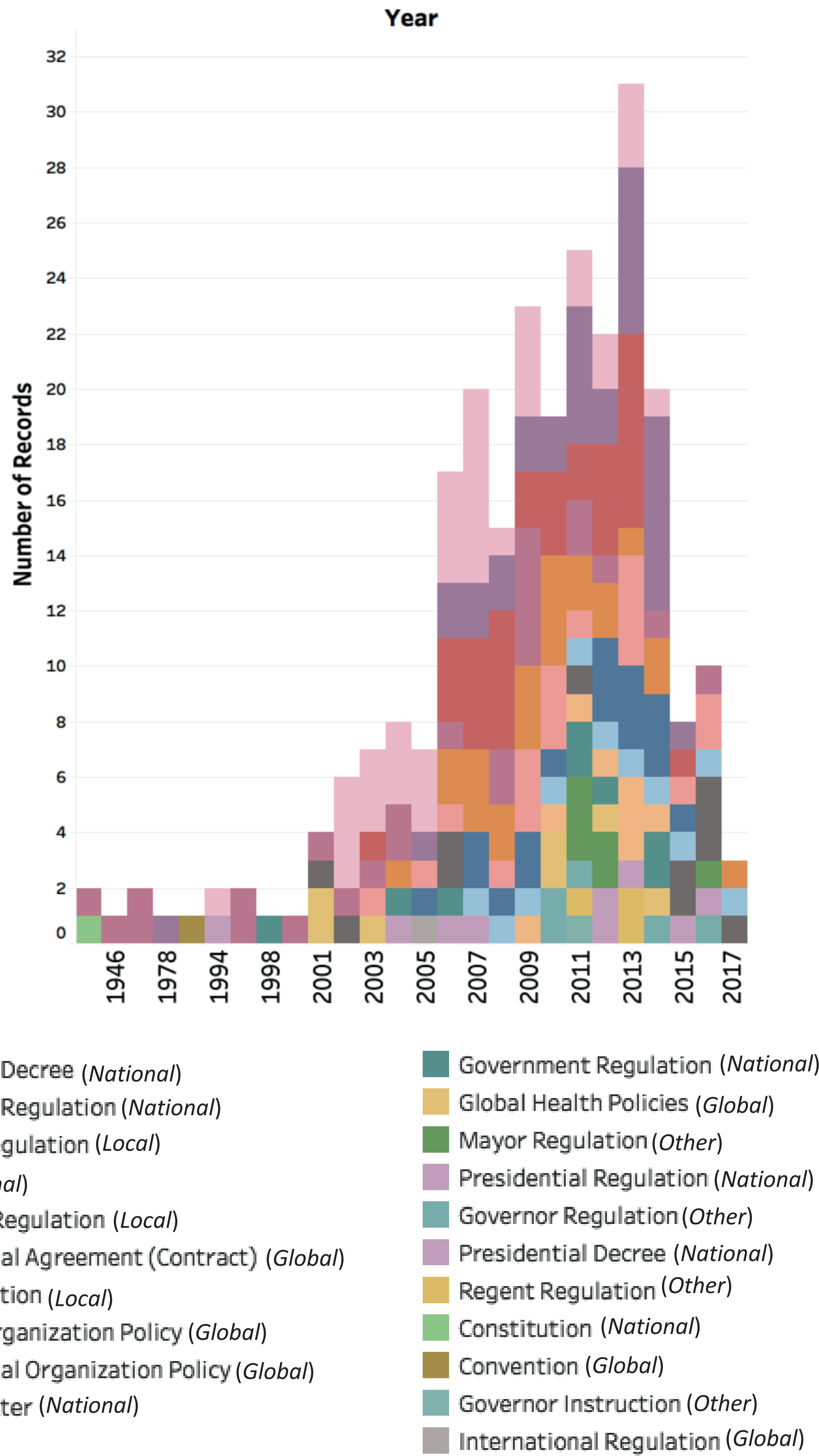
Chart 1. HIV Law Timeline



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Further on, the timeline histogram (Chart 1) shows a significant uptrend in the period of 2006–2013. Beginning in 2006, there is a milestone in the adoption of the 2006 Presidential Regulation on the National AIDS Commission. At the global level, the United Nations adopted the Guideline Title

International Guidelines on HIV/AIDS and Human Rights (Consolidated 1996–2002).[405]

In that period, there was constant growth in both local and ministries' laws. There were sixty-one local laws (Provincial, Regency, and City Regulations) adopted just in that period. This portion comprises 84.7% of the seventy-two total local laws in the categories across the chart.

Similarly, mostly in the executive branch, sixty-two laws were passed from 2006 to 2013, comprising Presidential Decrees, Presidential Regulations, Government Regulations, Ministerial Decrees, Ministerial Regulations, and Circular Letters. This trend comprises 64.6% of the 96 identified laws in that category during the whole period covered in the study.

Moreover, in the same period, the timeline histogram shows the proliferation of laws other than those mentioned earlier. The laws in the remaining categories counted forty-six in 2006–2013 out of eighty-two laws in the period 1945–2017 (56%).

[405] *See supra* note 159.

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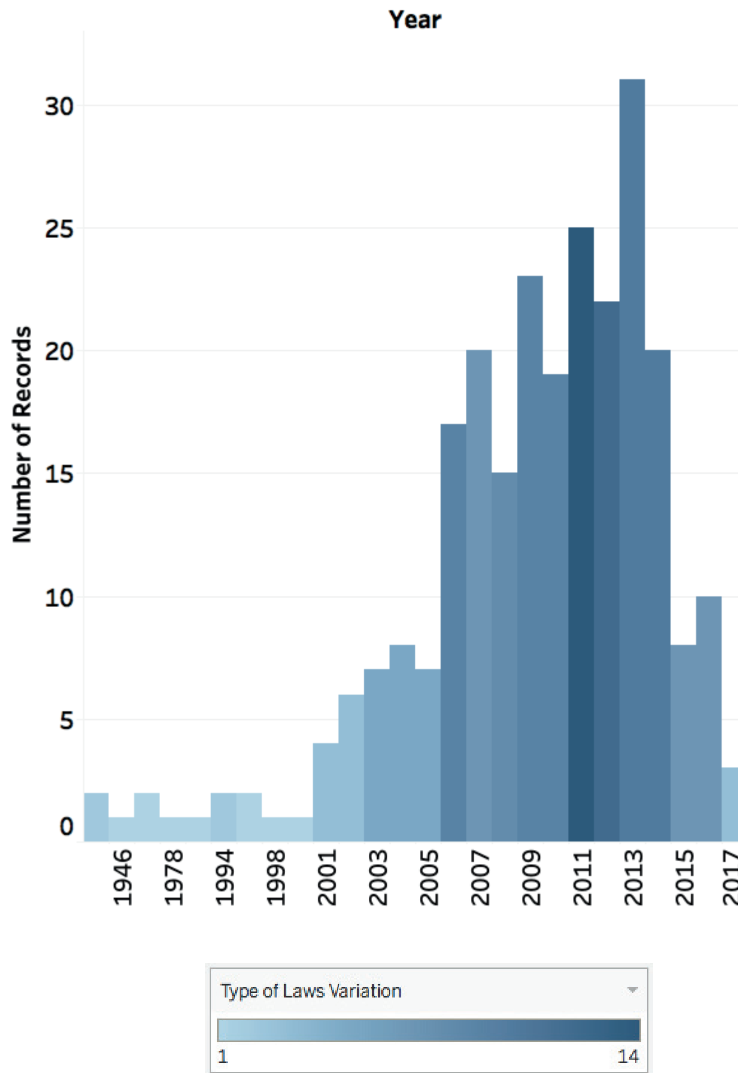
Chart 2. Variation in Distinct Legal Types



Within this period, Chart 2 also tells the reader about each year's variation in terms of law type. The darkness of the columns indicates the heterogeneity of law type. A darker column means that the law type is more heterogenous in that particular year. This heterogeneity suggests the level of attention to HIV/AIDS paid by different agencies and levels. Chart 2 shows that the years of 2011, 2012, and 2013 have the most law type variation relative to other years across the timeline.

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3.2.2. HIVLaw.ID

As a companion, this dissertation has produced an online legal database called HIVLaw.ID (http://hivlaw.ID). The database project aims to build and grow an open-source annotated database of laws and policies related to the HIV program in Indonesia. Since the beginning of the HIV epidemic in Indonesia, it has been a tricky job to understand the notion of "HIV Law" in Indonesia. This dissertation found legal documents in various places through both institutions and individuals.

Moreover, population health norms have been flowing boundlessly between jurisdictions globally. This dissertation is built on the collection of legal documents; therefore, with HIVLaw.ID in place, HIV program stakeholders could get broader and more in-depth insights into their decision-making processes. For example, an advocacy group could discover hidden policy gaps, loopholes, or contradictions through the platform so they could set their agenda with better accuracy.

HIVLaw.ID offers ample room for annotations. While other agencies might have developed a legal directory, HIVLaw.ID strives to give more substantial insights through ongoing interaction with stakeholders in gathering inputs. The annotations therefore will not be mere static sentences; rather, they will be changing in response to updates.

The first version of HIVLaw.ID is a natural mixture of English and Indonesian language. Nonetheless, in Phase 2, the platform shall be fully equipped with a bilingual interface. While the platform will not promise to have 100% bilingual downloadable documents, the bilingual annotations will be of help to reach both Indonesian- and English-reading audiences.

In further detail, the platform shall adhere to the following blueprint:

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Phase 1 (July–December 2019)

(1) Search engine deployed;

(2) Domain activated;

(3) Core data in place and searchable;

(4) 75% initial annotations;

(5) Beta version launch; and

(6) Fundraisers.

Phase 2 (January and ongoing)

(1) Additional data included;

(2) 100% initial annotation;

(3) First quarterly annotation update published;

(4) Full version; and

(5) Fundraisers.

As this dissertation finds, the current count of records between 1945 and 2017 is 258. Through ongoing research and supported by users' contributions, it will grow larger over time. The current legal documents were indexed into fourteen categories and 244 sub-categories, producing 91,427 entries.

The study starts the categorization through a combination of preset codes and new codes generated by the aggregate data:

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(1) Cited Laws;

(2) Screening;

(3) Prevention;

(4) Surveillance and Reporting;

(5) HIV Testing and Confidentiality;

(6) Non–Health Sector Programs;

(7) Care, Support, and Treatment;

(8) Governance and Funding;

(9) Obligations and Prohibitions Specific to People Living with HIV/AIDS;

(10) Obligations and Prohibitions for Other Specific Groups;

(11) Obligations and Prohibitions in General;

(12) Criminalization;

(13) Criminal Sanctions; and

(14) Other Sanctions.

The platform of HIVLaw.ID allows us to pull up a query based on different conditions. HIVLaw.ID uses the versatile Caspio (www.caspio.com) online database's Free Plan. The database development is structured to be very simple, where a user can find a specific annotated legal document within three steps: Search, display result, and detail page.

The Search section comprises four dropdown selections based on Law Category, Year, Location, and Jurisdiction. The Law Category dropdown menu allows a user to select one of the twenty-one law types. The Year dropdown menu offers the year selection from 1945 to 2017. The Location dropdown menu displays the geographical location of the lawmaking process, but

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does not necessarily determine its jurisdiction. Subsequently, jurisdiction selection will be offered under the Jurisdiction dropdown menu. The Location menu is the parent menu of the Jurisdiction. For example, if a user selects Bali as the location, then the Jurisdiction dropdown menu will be limited to jurisdictions within Bali as a province. In this case, the Jurisdiction menu will display some regencies and cities in Bali only.

In addition to the dropdown searches, HIVLaw.ID also allows a user to narrow the search by providing checkbox filters. In its first version, HIVLaw.ID provides four filters: (1) Breach of confidentiality is a crime; (2) Discrimination against HIV-positive people is a crime; (3) The law mandates HIV prevention among injecting drug users through harm reduction programs; and (4) People living with HIV could be criminally liable for HIV transmission.

The search engine of HIVLaw.ID will display the results based on the configured criteria. With this "AND" rule, the platform can narrow the search based on a user's preferred search restrictions.

The platform will display a list of all legal documents that match the search conditions. Furthermore, a user can click on the Details link, which will take the user to a new page containing further details about that particular law.

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Image 1. HIVLaw.ID Search Page

HIVLaw.ID

The Annotated Indonesian HIV Laws Lookup

Law Category -Any-

Year -Any-

Location -Any-

Jurisdiction -Any-

You could also add more conditions to your query by using the checkboxes below. If you have a suggestion for a specific search condition that is not listed here, please let us know through the Contact Form.

Breach of confidentiality is a crime.

Discrimination against HIV positive people is a crime.

The law mandates HIV prevention among injecting drug users through harm reduction program.

HIV positive people could be criminally liable for HIV transmission.

SEARCH

On the Details page, HIVLaw.ID displays an extended list of information, including the link to download the legal document's file, a brief feature about the law, the annotation, and the list of laws cited by the law.

The first version of HIVLaw.ID, however, has the limitation that it does not include all 244 indexes or sub-categories in the query. This project tried to include them at first; however, it appeared that it did not provide a practical user experience. There were too many filters, which made it difficult for a user to explore the Search page itself. Instead, this project will be focusing

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on the quality of the annotation. In the long run, the project will continue its engagement with multiple stakeholders to provide information that can be curated and included in the annotation section. With this approach, the platform can maintain its qualitative characteristics while growing quantitatively as a database.

Image 2. HIVLaw.ID Details Page

Details

Search Again

Law Maker	Regent
Law Category	Regency Regulation
Law Number	20
Year	2003
Title	Jayapura Regency Regulation No. 20 on HIVI-AIDS and STDs Prevention and Response
Location	Papua
Jurisdiction	Jayapura Regency
File	Download File
Breach of confidentiality is a crime.	yes
Discrimination against HIV positive people in health setting is a crime.	yes
HIV positive people could be liable for HIV transmission.	yes
Note	Contains HIV-specific provisions

Do you have more information about this specific document? We are striving to grow this annotated database to be a useful information platform. Help us enrich this database by sending us your knowledge about this specific document. We need to know more field experiences, advocacy works, related cases, corrections, or other suggestions. Please submit them through this simple Contact Form.

Create a Free Online Database

Disclaimer: This is a Caspio free app. Do not submit passwords or other sensitive data. Report Abuse

Related laws

Laws related to this document will be listed here.

1981 Criminal Procedural Law (KUHAP)	cited
1992 Health Law (UU Kesehatan)	cited
1992 MoH Decree on HIV Screening on Donated Blood (Keputusan Men	cited

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3.3. In-Depth Historical Examination

The previous section shows a significant increase in national and local HIV laws. This section explores the development of national and local HIV laws from 2001 to 2017. The latest political declaration on HIV and AIDS shows the commitment of the UN Member States to end the AIDS epidemic by 2030.[406] Since the deadline is coming in twelve years, these seventeen years of development are helpful to see the compatibility of the Indonesian legal environment with that goal.

3.3.1. Period of 2001–2005

As mentioned earlier, the year 2001 marks the point when HIV/AIDS gained global prominence. In its Special Session on HIV/AIDS held on 25–27 June 2001, the United Nations General Assembly adopted the Declaration of Commitment on HIV/AIDS. The assembly was mandated by United Nations Resolution 55/13 of 3 November 2000, which reflected the urgency for the United Nations to start addressing the problem of HIV/AIDS in all its aspects. This Declaration was a culmination of various preceding commitments on HIV/AIDS:

(1) The United Nations Millennium Declaration of 8 September 2000;
(2) The political declaration and further actions and initiatives to implement the commitments made at the World Summit for Social Development of 1 July 2000;
(3) The political declaration and further action and initiatives to implement the Beijing Declaration and Platform for Action of 10 June 2000;

[406] Resolution Adopted by the General Assembly on 8 June 2016: Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030 (2016).

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(4) Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development of 2 July 1999;

(5) The regional call for action to fight HIV/AIDS in Asia and the Pacific of 25 April 2001;

(6) The Abuja Declaration and Framework for Action for the fight against HIV/AIDS, tuberculosis, and other related infectious diseases in Africa, of 27 April 2001;

(7) The Declaration of the Tenth Ibero-American Summit of Heads of State, of 18 November 2000;

(8) The Pan-Caribbean Partnership against HIV/AIDS of 14 February 2001;

(9) The European Union Programme for Action: Accelerated action on HIV/AIDS, malaria and tuberculosis in the context of poverty reduction, of 14 May 2001;

(10) The Baltic Sea Declaration on HIV/AIDS Prevention of 4 May 2000; and

(11) The Central Asian Declaration on HIV/AIDS of 18 May 2001.[407]

The 2001 UNGASS Declaration also had the momentum because by the end of 2000, HIV/AIDS had infected an estimated 36 million people worldwide and claimed 22 million lives.[408] Ninety percent of this epidemic happened in developing countries and 75% in sub-Saharan Africa.[409] This situation led heads of state and governments not only to support the Declaration with political commitments but also to endorse the establishment of the Global AIDS and Health Fund.[410] The Fund had acquired many benefactions and promises from governments,

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407 Declaration of Commitment on HIV/AIDS, *supra* note 395.
408 *Id.* at 1.
409 *Id.* at 6.
410 *Id.* at 2.

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foundations, businesses, and private citizens.[411] This collective resource mobilization was the beginning of non-state actors' participation in the governance of the HIV/AIDS response. After the Declaration was concluded, the Indonesian delegates conducted a press conference to inform the civil society, NGOs, sectoral ministries, and donor agencies. The delegates sent the message about Indonesian position and commitments

In mid 2001, Spiritia Foundation worked with AusAID to scale up the HIV peer support program. The cooperation was able to conduct the Second National PLHIV Meeting attended by 36 participants. This meeting declared The Principles of HIV/AIDS Response. It is the first Indonesian political declaration made by the community of PLHIV.

In October 2001, Murni delivered the Keynote Speech, entitled "Breaking Down Barriers", at the Sixth International Congress on AIDS in Asia and the Pacific in Melbourne (ICAAP).

> Advocacy must continue to make drugs more accessible and affordable. I believe important drugs like HIV drugs should be available as a choice and not a luxury. Research for better drugs that are less toxic must also continue and always be supported. Side effects have reduced the quality of life and productivity of quite a few HIV positive people even though their viral load becomes low or even undetectable. If people are healthy, children are taken care of. If people are healthy, there is possibility we gain more than what we lose. We must put people's lives before profit.[412]

The messages from the ICAAP gave an extent of traction at the global-level treatment advocacy. On 9–14 November 2001, the World Trade Organization (WTO) adopted the declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health,

[411] *Id.*
[412] Suzana Murni, *Breaking Down Barriers: Keynote Speech at the Sixth International Congress on AIDS in Asia and the Pacific,* 2001.

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known as the Doha Declaration.[413] Through the Doha Declaration, the World Trade Organization (WTO) acknowledged HIV as a global public health predicament touching many developing and least-developed countries.[414] Furthermore, the Doha Declaration recognized that, while necessary to enhance the development of new medicines, intellectual property rights protection as set out in the TRIPS Agreement could hinder members from taking measures to protect public health. The purpose of the Doha Declaration was to provide flexibility. In the area of law, the Declaration explicitly recognizes that domestic industries must be consistent with international law.[415] At the same time, the Declaration acknowledges the need to evaluate the impact of international trade agreements on access to local manufacturing of essential drugs. Hence, the Declaration perpetuates the norm of a global, cross-sectoral, and multi-stakeholder HIV/AIDS response.

In August 2001, three months before the Doha Declaration, Indonesian lawmakers passed Law No. 14 Year 2001 on Patent.[416] The Patent Law 2001 explicitly mentions the Agreement Establishing the World Trade Organization in the opening.[417] Article 99 of the Patent Law 2001 gave the Indonesian government the "government use" flexibility,[418] whereby the government could decide to exploit a patent in circumstances of extreme urgency. With this fresh law in mind, the Indonesian delegation could not disagree when the Doha Declaration included HIV/AIDS as a representation of such circumstances:

> Each Member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS,

[413] Declaration on TRIPS Agreement and Public Health, *supra* note 361.
[414] *Id.*
[415] Declaration of Commitment on HIV/AIDS, *supra* note 395 at 12.
[416] Law No. 14 on Patent (2001).
[417] *Id.* at Preamble.
[418] *Id.* art. 99.

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> tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.[419]

Since 2001, the first-line regimen of ARV has continued to decline in cost from US$10,000 per person per year to US$130 per person per year.[420] The use application of TRIPS flexibility explains that drop. Indian pharmaceutical companies took advantage of this flexibility to provide 90% of the generic ARV market in the developing world.[421] This price dropping began in 2001, the same year the Doha Declaration pushed implementation of the TRIPS Agreement to comply with public health interests. The treatment advocacy from both domestic and international has resulted in the importation of these Indian generic antiretrovirals by the Indonesian government.[422]

In Southeast Asia, the ASEAN Task Force on HIV and AIDS (ATFOA) was established in 1993 as a coordinating body to address the epidemic in this emerging economy. It is essential to acknowledge that at least 1.5 million people are living with HIV in ASEAN states. On 5–6 November 2001—less than a week before the WTO Ministerial Conference in Doha—ASEAN adopted the ASEAN Declaration on HIV/AIDS, signed at the Seventh ASEAN Summit in Brunei Darussalam in 2001.[423] The primary purpose of the Declaration was to leverage the potential of the relationships among ASEAN member states to increase access to better HIV care and prevention. As such, HIV and AIDS had been claimed as a potential interest among ASEAN

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[419] Declaration on TRIPS Agreement and Public Health, *supra* note 361.
[420] Chan Park, *Taking the Fight to Their Realm: The Role of Patent Oppositions in the Struggle for Access to Medicines*, 11 HIV/AIDS POL'Y L. REV. 84–85, 3 (2006).
[421] *Id.* at 3.
[422] Spiritia Foundation, *supra* note 308.
[423] Seventh Asean Summit, Bandar Seri Begawan 5–6 November 2001, *ASEAN | One Vision One Identity One Community*, https://asean.org/?static_post=seventh-asean-summit-bandar-seri-begawan-5-6-november-2001-2 (last visited Sep 29, 2018).

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member states. In a specific political understanding, this meant they were obliged to share the required resources to respond to HIV in the region.

As announced in the ASEAN Declaration on HIV/AIDS during the Seventh ASEAN Summit, ASEAN member governments pledged to "[l]ead and guide the national responses to the HIV and AIDS epidemic as a national priority to prevent the spread of HIV infection and reduce the impact of the epidemic by integrating HIV and AIDS prevention, care, treatment, and support and impact mitigation priorities into the mainstream of national development planning, including poverty eradication strategies and sectoral development plans."[424]

The year 2001 was a prominent milestone in using treatment as a key strategy in reversing HIV/AIDS as a global health problem. The UNGASS Declaration, the Indonesian Patent Law, and the Doha Declaration created a sufficient legal environment to allow broader coverage of ART.

In 2002, Spiritia Foundation started its work with Ford Foundation to scale-up its program. The organization has made various empowerment trainings to encourage the development of peer support groups at the local level. In this year, Spiritia teams had managed to organize advocacy visits to 36 cities in 20 provinces.[425] These visits have been able to initiate communications and support systems between local NGOs, local health offices, local parliament, and healthcare providers. However, in the rise of its activities, Spiritia lost Murni when she died in July 2002 in Jakarta. She passed away partly due to the limited access to the antiretrovirals. She was planned to attend the Fourteenth International AIDS Conference in Barcelona, Spain.

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[424] *Id.*
[425] Wilson, *supra* note 307 at 93.

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The Barcelona conference was mainly about to increase the access to treatment. An Indonesian leading HIV physician, dr. Samsuridjal Djauzi, then started *Gerakan Nasional Meningkatkan Akses Terapi HIV/AIDS*/the National Movement to Enhance the Access to HIV/AIDS Therapy (GN-MATHA).[426] The movement was intended to ensure the access of antiretrovirals to 10,000 PLHIVs by 2005.[427] Subsequently, the Ministry of Health decided to include the first line antiretrovirals (AZT, 3TC, and nevirapine) in the Schedule of Essential Medicines which to be available at major hospitals across the country.[428]

In the same year, the Ministry of Health adopted three decrees on HIV/AIDS. Ministerial Decree No. 137 provides the legal basis for the health sector's technical team and its secretariat. This decree refers to the earlier presidential decree in 1994 on the National AIDS Commission. Based on this ministerial decree, the health sector's technical team is to conduct public health assessments, specifically on populations vulnerable to HIV transmission.[429] This technical team is also to formulate recommendations for subsequent AIDS policies.[430] The ministerial decree, in particular, enables the health sector to distribute AIDS-specific epidemiological duties.

This ministerial decree also explicitly states that the Directorate General of Disease Control and Environmental Sanitation shall fund the works of the technical team. The money will come from both the Directorate General's budget and foreign aid disbursed through the Ministry of Health.[431] The adoption of this funding mechanism indicates the government's anticipation of receiving foreign aid.

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[426] Spiritia Foundation, *supra* note 308.
[427] *Id.*
[428] *Id.*
[429] Health Ministerial Decree No. 137 on Technical Team and the Secretariat of the Health Sector AIDS Response (2002).
[430] *Id.*
[431] *Id.*

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With this ministerial decree, too, the health sector took the leading role in Indonesian HIV prevention. The government believes that HIV is a health problem, and therefore it is best to respond through the health sector's approach.[432]

In August 2002, the Ministry of Health adopted a decree on the Guidelines for Rehabilitation Service Delivery for Narcotics, Psychotropics, and other Addictive Substances Abuse and Addiction.[433] Through this decree, the government regulates addiction rehabilitation services under the leadership of the Ministry of Health. This decree also recognizes that drug addicts are patients that need medico-psycho-social therapies.[434]

It is particularly interesting to note that this decree refers to Law No. 22 Year 1997 on Narcotics (the 1997 Narcotics Law).[435] The 1997 Narcotics Law affirms the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988.[436] As a response to drug trafficking as a transnational organized crime, this convention explicitly criminalizes the unauthorized possession of narcotics and psychotropic drugs.[437]

The current 2009 Narcotics Law obliges drug addicts to get treatment, including by enrolling in an addiction rehabilitation service as mandated by the decree.[438] This is where the Ministry of Health decree plays its role. However, the law provides that the decision to go to the rehabilitation center lies in judges' hands.[439] This means that the suspect would be in a detention

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432 *Id.*
433 Health Ministerial Decree No. 996 on the Guidelines for Rehabilitation Service Delivery for Narcotics, Psychotropics, and other Addictive Substances Abuse and Addiction (2002).
434 *Id.* art. 2.
435 *Id.* at Preamble.
436 Law No. 22 on Narcotics at Preamble (1997).
437 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances art. 3(2) (1988).
438 Law No. 35 on Narcotics art. 4 (2009).
439 *Id.* art. 103.

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center—instead of a rehabilitation center—until his case is in trial. When the case is in trial, the order for rehabilitation is for the judge to decide. This discretionary room conflicts with the obligation to rehabilitate under the same law. Moreover, it is unclear whether the order for rehabilitation replaces prison because the order for rehabilitation is exclusive from the case decision.

Later, in September 2002, the Ministry of Health adopted a decree on the formation of the coordinating committee for AIDS, tuberculosis, and malaria for the GFATM.[440] Even though the GFATM claims to be a funding organization without programmatic interference, the decree includes individuals from international actors as members of the committee.[441]

This decree eases Indonesia's grant application to the GFATM. This committee functions as the GFATM's Country Coordinating Mechanism (CCM).[442] The primary function of the committee is to prepare a collective national proposal to the GFATM.[443] The joint proposal contains smaller proposals submitted by various entities in their respective interests. The committee has the authority to shortlist the proposals before they become collective national proposals—the committee reports to both the GFATM Secretariat and the Indonesian Health Minister.

The GFATM requires a single proposal for all three diseases. This requirement has forced institutionalized coordination between the stakeholders of AIDS, tuberculosis, and malaria to

[440] Health Ministerial Decree No. 1211 on the Formation of the Coordinating Committee for AIDS, Tuberculosis, and Malaria Response (2002).
[441] *Id.* The decree includes Greg Petersen (WHO Representative for Indonesia) and Jane Wilson (Country Director Adviser of UNAIDS) as committee members.
[442] *Id.*
[443] *Id.*

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meet and talk about priorities and feasible interventions.[444] Being a GFATM grantee is a considerable chance to fill in the response gap, especially in the field of HIV/AIDS.

The third ministerial decree on AIDS, adopted in October 2002, is the one that set out the Guidelines for HIV/AIDS and Sexually Transmitted Diseases Response.[445] This decree explicitly legitimizes global health norms. In Section V, it provides that the national HIV response must include the following activities:

(1) Cooperating with the Association of Southeast Asian Nations (ASEAN);
(2) Regular consultation meetings with international institutions;
(3) Promoting collaborative global research on HIV/AIDS;
(4) Implementing international initiatives to reduce HIV vulnerability among women, youth, and children;
(5) Strengthening both national and international mechanisms regarding human rights and ethics toward people living with HIV; and
(6) Regular meetings with the representatives of ally countries.[446]

At this point, the decree explicitly shows the government's position toward global health norms on HIV/AIDS. Indonesia recognizes global health initiatives, is willing to take part in global HIV responses by preparing a GFATM proposal, and appoints the health sector to lead the national

[444] *Id.* The committee includes individuals from the parliament, the National AIDS Commission, the Narcotics Commission, epidemiology experts, the Ministry of Finance, the Ministry of Interior Affairs, the National Development and Planning Agency, NGOs, PLHAs network, TB activists, the Hospital Association, universities, and international organizations.
[445] Health Ministerial Decree No. 1285 on the Guidelines for HIV/AIDS and Sexually Transmitted Diseases Response (2002).
[446] *Id.* § V(13).

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response. The response, however, has to anticipate the divergence of the narcotics criminal law policies. Drug use was known as a risk factor for HIV around the world at that time. While the Ministry of Health's decree on addiction rehabilitation tries to assist the implementation of the 1997 Narcotics Law, the law itself does not represent goals other than to punish. The law intends to deter and retribute drug trafficking as a transnational organized crime.

The first point of Section V suggests the inclusion of the domestic HIV/AIDS response in ASEAN's works.[447] ASEAN has the 2002–2005 Work Programme on HIV/AIDS II to support the implementation of the Seventh ASEAN Summit Declaration on HIV/AIDS of the Brunei Darussalam ASEAN Summit in November 2001.[448] The Work Programme sets out the ideals for regional HIV responses. It highlights the importance of a multi-sectoral approach, the involvement of civil society, and seamless networking among researchers, as well as the hope for affordable treatments.[449]

Relevant to the situation in Indonesia, Section G(3) of the Work Programme describes HIV prevention, treatment, and care among drug users.[450] This section states its awareness about the dominant policies on supply reduction, the illegal status of drug users, stigmatization and discriminatory attitudes toward users, and inadequate skills of personnel involved with the issue of drug use.[451] The section clearly implies that such a situation makes it more difficult for drug users to access treatment and HIV prevention information.

Therefore, we can see that the health sector stands between two constraining ideas, especially in looking at drug users. On one side, it leans toward global health ideas about the

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[447] *Id.*
[448] ASEAN WORK PROGRAMME ON HIV/AIDS II, 2002–2005 (ASEAN & ASEAN eds., 2002).
[449] *Id.* § C(4).
[450] *Id.* § G(3).
[451] *Id.* §

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right to treatment for drug users. On the other side, it has to work with the draconian 1997 Narcotics Law as the umbrella law.

In 2003, the Third National PHIV Meeting adopted the Cikopo Statement as the updated voice of the most-affected groups.[452] As another way of advocacy, a group of PLHIV organized a photo exhibition inside the Parliament building.[453] The exhibition was done in collaboration with USAID and Family Health International.[454] It was intended to share the human face of PLHIV to the legislative members. Subsequent to the event, the Ministry of Health decided to subsidize generic antiretrovirals.

In February 2003, the Ministry of Health adopted an amendment decree to update the membership of the GFATM's CCM.[455] There was no change in the number of people on the committee. It has twenty-four members, a chair, a vice-chair, and a secretary.[456] The committee consists of various people from various areas, including some from outside the ministry. As this is a ministerial decree, the direct appointment of members bypasses the issue of representativeness.

The new committee still includes people from international organizations, such as the WHO Representative to Indonesia and the UNAIDS Country Director. This continuous inclusion represents the openness of leading national HIV stakeholders toward inputs from the WHO and UNAIDS as prominent advocates of global health norms. Moreover, the UNAIDS Country Director strategically sits as one of the proposal reviewers for the AIDS component.

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452 Spiritia Foundation, *supra* note 308.
453 *Id.*
454 *Id.*
455 Health Ministerial Decree No. 199 on the Formation of the Coordinating Committee for AIDS, Tuberculosis, and Malaria Response (2003).
456 *Id.*

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In this first contract, the Principal Recipient that signed the contract was the Directorate General of Disease Control and Environmental Sanitation (Ministry of Health) and planned to give antiretrovirals to 100 PHIVs in five provinces.[457] The function of the Principal Recipient is to disburse the money to Sub-Recipients, who will disburse further to Sub-Sub-Recipients.[458] The Sub-Sub-Recipients then disburse the money to Implementing Units.[459]

The relationship between the GFATM and a Principal Recipient does not reflect a relationship of principal and agent, of partnership in law, or of a joint venture. The contract limits the GFATM's liability solely to the funding aspect, without any attachment to the program's success. The contract states in Article 25 that

> The Principal Recipient undertakes the Program on its own behalf and not on behalf of the Global Fund. This Agreement and the Grant shall in no way be construed as creating the relationship of principal and agent, of partnership in law or of joint venture as between the Global Fund and the Principal Recipient or any other person involved in the Program. The Global Fund assumes no liability for any loss or damage to any person or property arising from the Program.[460]

The binding area of the contract, therefore, lies mainly in the funding administration between the Principal Recipient and its lower recipients. The contract involves an independent auditor known as a Local Fund Agent (LFA).[461] In this contract, the appointed LFA is PricewaterhouseCoopers.

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[457] Contract No. IDN-102-G03-H-00: Prevention and Alleviation of HIV Impact (Principal Recipient: Indonesian Ministry of Health/Directorate General of Disease Control and Environmental Sanitation), *supra* note 364.
[458] *Id.*
[459] *Id.*
[460] *Id.* art. 25.
[461] Contract No. IDN-102-G03-H-00: Prevention and Alleviation of HIV Impact (Principal Recipient: Indonesian Ministry of Health/Directorate General of Disease Control and Environmental Sanitation), *supra* note 364.

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The role of the LFA is to ensure the implementation of the promised programs, as far as overseeing Principal Recipients' books and records.

The contract between the GFATM and the Principal Recipient falls under the jurisdiction of the United Nations Commission on International Trade Law (UNCITRAL). Article 26 of the Program Agreement states that:

> Any dispute between the Global Fund and the Principal Recipient arising out of or relating to this Agreement that is not settled amicably shall be submitted to arbitration at the request of either the Global Fund or the Principal Recipient. The arbitration shall be conducted in accordance with UNCITRAL Arbitration Rules as at present in force. The Global Fund and the Principal Recipient agree to be bound by the arbitration award rendered in accordance with such arbitration, as the final adjudication of any such dispute, controversy, or claim. The place of arbitration shall be Geneva, Switzerland.[462]

Based on these contractual features, the contract does not bind Indonesia to fulfill its right to health obligations. The program's success relies on the ability of Indonesian HIV programmers to develop a proposal that is accurate and ideal, yet administratively feasible in the eyes of the GFATM. This means that an excellent audit report does not necessarily reflect a successful HIV program. It could only reflect excellent administrative performance. Therefore, audit reports cannot be the only way to evaluate the success of the funding.

In August 2003, the Ministry of Health adopted a decree on the Guidelines for Health Epidemiology Surveillance System.[463] The decree uses the WHO's definition of surveillance.[464] This decree was adopted to provide the legal basis for an integrated and comprehensive epidemiological surveillance system. This system allows continuous surveillance not only

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[462] *Id.* art. 26.
[463] Health Ministerial Decree No. 1116 on the Guidelines for Health Epidemiology Surveillance System (2003).
[464] *Id.* § I(B).

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limited to outbreak situations.[465] With this decree, the government can gather and analyze data from the lowest technical implementor units (i.e., primary healthcare centers) across the country.[466] The communicable disease bracket includes HIV/AIDS together with tuberculosis, sexually transmitted diseases, and malaria.[467] The surveillance system also covers health problems, including reproductive health, geriatrics, narcotics use, and pharmaceutical product consumption.[468]

This decree also explicitly cites the International Health Regulation 1998 (IHR).[469] The IHR shows that global law acknowledges the national-level legal process. Article 44 of the IHR implies that the implementation of the IHR relies on the formulation of laws and other legal and administrative provisions. The decree also provides that the Ministry of Health partner with various entities, including international, regional, and bilateral bodies.[470] Through this decree, the government expects strict evidence-based public health policies, including on HIV/AIDS. By actualizing IHR's reliance on national laws, this decree shows that the health sector has well internalized global health law.

In continuation of the decree on the Epidemiology Surveillance System, the Ministry of Health adopted another decree that regulates the integrated epidemiology surveillance system explicitly for infectious and non-infectious diseases.[471] This decree also cites the IHR.[472]

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[465] *Id.* § III(B).
[466] *Id.* § I(B).
[467] *Id.* § I(A).
[468] *Id.* § III(D).
[469] *Id.* at Preamble.
[470] *Id.* § III(E).
[471] Health Ministerial Decree No. 1479 on the Guidelines for the Integrated Epidemiology Surveillance System of Infectious and Non-infectious Diseases (2003).
[472] *Id.* at Preamble.

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In terms of funding regulation, the general decree in the epidemiology surveillance system provides the legal basis that the national budget or other funding, including foreign aid, should fund the surveillance system. Similarly, the subsequent decree regulates that the funding source shall be based on each administrative level of governance:

(1) Surveillance by Regency/City Health Office shall receive funding from the regency/city budget and other funding resources;
(2) Surveillance by Provincial Health Office shall receive funding from the provincial government budget and other funding resources; and
(3) Surveillance by the Directorate General of Disease Control and Environmental Sanitation shall receive funding from the national government budget and other funding resources.[473]

This arrangement allows a working accountability system, especially given that the GFATM grant started in the same year, with the Directorate General of Disease Control and Environmental Sanitation as the Principal Recipient.[474] In practice, provincial and regency/city health offices are the Sub- and Sub-Sub-Recipients of the GFATM fund.[475] With this decree, the Ministry of Health established its institutional preparedness and authority.

The decree is strongly related to the Indonesian Round 01 GFATM Proposal, which includes the strengthening of the surveillance system in the list of proposed programs.[476] A

[473] *Id.* § C.
[474] Contract No. IDN-102-G03-H-00: Prevention and Alleviation of HIV Impact (Principal Recipient: Indonesian Ministry of Health/Directorate General of Disease Control and Environmental Sanitation), *supra* note 364.
[475] *Id.*
[476] *Id.* at Annex A. Program Implementation Abstract.

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working integrated surveillance system would be strategic in generating baseline data for future upscaling proposals.

In December 2003, the Regency of Jayapura in Papua Province adopted the first local HIV law.[477] The Provincial Regulation was created by the Regent and endorsed by the Regency People's Representative (parliament). Among other administrative laws, the law cites the 1992 Health Law, the 1997 Narcotics Law, the 1997 Psychotropics Law, the 1999 Human Rights Law, and the 2002 Child Protection Law.[478] The law also cites the 1994 National AIDS Strategy and the 1994 Presidential Decree on National AIDS Commission.[479]

The law mainly provides obligations to sex workers, pimps, and healthcare providers.[480] The law obliges healthcare providers to deliver services without discrimination against people living with HIV or their families.[481] Moreover, the law also obliges the health sector to ensure voluntary HIV counseling and testing, to provide condoms, to collect HIV-related data, and to report brothels that do not cooperate with HIV programs.[482]

The law obliges female sex workers to ensure that their customers use a condom.[483] Similarly, the law obliges male and transgender sex workers to use a condom at every sexual contact.[484] The law also obliges all sex workers to refuse all males who do not want to use a

[477] Jayapura Regency Regulation No. 20 on HIV-AIDS and STDs Prevention and Response (2003).
[478] *Id.* at Preamble.
[479] *Id.*
[480] *Id.* art. 7–11.
[481] *Id.* art. 11.
[482] *Id.*
[483] *Id.* art. 7(1).
[484] *Id.*

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condom.[485] Failure to perform this obligation attracts a five-day prohibition of work. Repeat violators get a six-month prison sentence or a $500-equivalent fine.[486]

For pimps, there are prohibitions against employing minors under the age of eighteen, forcing a sex worker to work, and charging room rent or other fees to sex workers who fail to ensure condom use. In the same law, we can also see the introduction of an institutionalized burden of HIV prevention on sex workers and those who live with HIV.[487] For those who are aware of their HIV-positive status, there is a legal obligation to take HIV prevention measures.[488]

If we look at the HIV situation in Papua, an early report by Leslie Butt in 2002 found a specific situation in Papua province.

> There are presently 20.4 cases per 100,000 people in Papua, a dramatic contrast to the rest of Indonesia, which has only 0.42 cases per 100,000 people. Approximately 40% of the HIV and AIDS cases in Indonesia are located in the province of Papua, even though that province has less than 1% of the country's population. If HIV is a problem elsewhere in Indonesia, in Papua it is rapidly becoming an epidemic.[489]

Butt et al. report that the sex work activity in Papua mostly occurred outside brothels.[490] About four thousand sex workers were working in brothels, another four thousand sex workers were on the street, and another four thousand were in more hidden sites in rural areas.[491] Interventions, as exhibited by the law, mainly target those who are working in brothels. Condom use in brothels

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[485] *Id.*
[486] *Id.* art. 13.
[487] *Id.* art. 8.
[488] *Id.* art. 7.
[489] Leslie Butt, Gerdha Numbery, and Jake Morin, *The Smokescreen of Culture: AIDS and the Indigenous in Papua, Indonesia*, 9 PAC. HEALTH DIALOG 283–289, 283 (2002).
[490] *Id.* at 283.
[491] Butt *et al.*, *supra* note 489 at 283.

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was over 70%.[492] Demographically, most sex workers in brothels were "Indonesians," while most on-street sex workers were "Papuans."[493] Butt et al. allege that Indonesian clients were usually wealthier.[494] They maintain that Indonesians were more likely to have the money needed to experience the services of a bar hostess or brothel resident who was, in turn, more apt to educate them about the use of condoms.[495] On the contrary, the team find that the only street worker intervention program found a less than 5% condom use rate in the same capital city.[496]

Therefore, the Jayapura law could help legitimize the use of brothels as public health intervention sites for HIV. However, more legal protection is needed to cover on-street interventions, taking into account the reported demographic situation. Interestingly, Butt et al. assert that there is an inclination among Indonesian officials and health managers to construct the failure to reach off-brothel workers as a cultural predicament among indigenous Papuans.[497] The Butt report finds that there were pretenses based on the narrative that the culture of sex orgies and "wife-swapping" drive HIV transmission among Papuans.[498] Butt et al. find that these pretenses are untrue. Instead, such pretense displays the culture of blaming the officials and health managers.[499]

After the Doha Declaration, Indonesia adopted a Presidential Decree on October 5th, 2004, to justify a "government use."[500] The Decree followed Article 5 of the Indonesian

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[492] *Id.* at 283; PKBI and Family Health International, *Laporan Kegiatan (En. Activity Report STI/HIV/AIDS Prevention for Sex Workers in Tanjung Elmo)* (2000).
[493] Butt *et al.*, *supra* note 489.
[494] *Id.*
[495] *Id.*
[496] *Id.*
[497] *Id.*
[498] *Id.*
[499] *Id.*
[500] SANGEETA SHASHIKANT, THE SUBSTANTIVE PATENT LAW TREATY: THE DANGERS OF GLOBAL PATENT POLICY HARMONIZATION 9 (2009).

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Government Regulation No. 27 of 2004, adopted on the same day, regarding the Mechanism of Patent Exploitation by the Government.[501] The decree states that there is an "urgent need of the community in the effort to control the HIV/AIDS epidemic."[502] This Presidential Decree No. 83 of 2004 Regarding Exploitation of Patent by the Government on Antiretroviral Drugs was mandated by the Minister of Health to appoint a pharmaceutical manufacturer as the patent exploiter on behalf of the Government.[503] The mandate took the recommendations from the Head of the National Drug and Food Authority into account. The two ARVs were Nevirapine (for seven years) and Lamivudine (for eight years), and the exploitation period covered the remaining patent protection term. The Decree also sets the "compensation fee" at 0.5% of the net selling value of the ARVs concerned to the patentholder.[504] The Indonesian pharmaceutical company, Kimia Farma marketed its generic antiretrovirals in August 2003.[505]

In September, Indonesia hosted the Jogjakarta Round Table Meeting that was attended by participants from 16 countries. The meeting was to evaluate the implementation of antiretrovirals in Indonesia. Given the amount of work has been done, President Megawati Soekarnoputri invited a group of PLHIV to have a discussion in the Palace.[506]

As a follow-up of the patent sector advocacy, on 19 October, the Ministry of Health adopted a decree on the Provision of Free Anti-tuberculosis and Antiretroviral Drugs.[507] With this decree, the government has been successful in integrating tuberculosis and HIV responses.

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501 *Id.*
502 *Id.*
503 *Id.*
504 *Id.* at 10.
505 Spiritia Foundation, *supra* note 308.
506 *Id.*
507 Health Ministerial Decree No. 1190 on the Provision of Free Antituberculosis and Antiretroviral Drugs (2004).

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The decree reflects an established procurement system where funding is readily available for those in need.

The procurement of tuberculosis drugs and antiretrovirals, however, is dependent on existing demand assessment. The government does not procure antiretrovirals for all Indonesians. Instead, it procures antiretrovirals for some people based on epidemiological estimation.[508]

The government administers these free drugs through several appointed hospitals. An earlier decree appointed these hospitals in July. The Ministry of Health appoints twenty-five hospitals in fifteen provinces as antiretroviral referral hospitals.[509] The functions of these hospitals include:

(1) Developing a Standard Operating Procedure;
(2) Handing out antiretrovirals procured directly by PT. Kimia Farma;
(3) Providing the required facilities;
(4) Procuring healthcare providers, including specialists, dentists, nurses, pharmacists, laboratory analysts, counselors, and case managers;
(5) Forming an integrated service team for special infections; and
(6) Submitting reports.[510]

Following up the meeting of a number of PLHIV activists with President Megawati Soekarnoputri, in January 2004, representatives from six provinces with the highest HIV burden

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508 *Id.*
509 Health Ministerial Decree No. 781 on the Appointment of Referral Hospital for People Living with HIV/AIDS (2004).
510 *Id.*

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gathered n Jayapura with the National AIDS Commission, the Parliament, and the head of one of the Parliament's commission.[511] The meeting ended with the declaration of *Komitmen Sentani*/Sentani Commitment.[512] One of the promises was that the Parliament to give antiretroviral treatment to at least 5,000 HIV-positive people in 2004.[513] The Commitment was a collective achievement after the waves of advocacy conducted in the previous three years. Backed by international donors, the Indonesian PLHIV civil society has made the steps to reach out to their peers, the parliament, the President, and also local politicians.

The year 2004 also marked the first provincial HIV-specific law, which the government of East Java Province adopted in August.[514] Similar to the Jayapura law, this law cites the 1992 Health Law, the 1997 Narcotics Law, the 1997 Psychotropics Law, the 1999 Human Rights Law, and the 2002 Child Protection Law. The law also cites the 1994 Presidential Decree on National AIDS Commission.[515] Early in February 2004, Spiritia conducted the Fourth National PLHIV Meeting in Tretes, also in East Java province as one of the six provinces with the highest HIV burden at that time. The Meeting, attended by 60 PLHIVs, adopted *Pernyataan Tretes/*the Tretes Declaration that strengthened what has already stipulated by politicians at the national level.[516] The following constitute the background of the East Java law as stipulated in the provincial law:

(1) East Java is one of the six provinces with the fastest-growing HIV infection rates in the country;

[511] Spiritia Foundation, *supra* note 308.
[512] *Id.*
[513] *Id.*
[514] East Java Provincial Regulation No. 5 on HIV/AIDS Prevention and Response in East Java (2004).
[515] *Id.* at Preamble.
[516] Spiritia Foundation, *supra* note 308.

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(2) There is a need for program integration and consolidation to build coordination and work mechanisms to respond to HIV locally; and

(3) HIV prevention policy needs to accommodate behavior change, accessible care, support, and treatment, as well as the protection of the individual rights of people living with HIV and their families, to mitigate the impact of the epidemic and to prevent discrimination.[517]

With this law in place, the provincial government of East Java can use the provincial budget to support national HIV policies as mandated by the Sentani Commitment and the Tretes Declaration. The law consists of an ample portion of the National AIDS Strategy, which also reflects global HIV norms:

(1) Information, education, and communication programs;

(2) Formal and informal life skills education;

(3) Condom 100%;

(4) Voluntary HIV counseling and testing;

(5) Affordable antiretrovirals and opportunistic infection treatments;

(6) Basic health services from public and private healthcare providers;

(7) Universal precaution to prevent HIV infection in healthcare facilities;

(8) Blood donation screening;

(9) Epidemiology and behavioral surveillance;

(10) Referral system for care, support, and treatment;

(11) Sterile injecting equipment among high-risk population;

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[517] East Java Provincial Regulation No. 5 on HIV/AIDS Prevention and Response in East Java (2004), *supra* note 514 at Annex.

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(12) Confidentiality;

(13) The right to care, support, and treatment for people living with HIV;

(14) Non-discrimination; and

(15) Respect of human dignity.[518]

However, this law introduces mandatory disclosure for people living with HIV. In Article 6, the law prohibits people diagnosed with HIV from having sexual intercourse unless they have disclosed their HIV status to the consenting sexual partner.[519] The article also prohibits people living with HIV from sharing needles or other medical equipment that attracts the risk of HIV transmission.[520] It also prohibits people living with HIV from donating their blood, semen, organs, or body tissue.[521] Furthermore, the article prohibits any action that has the risk of HIV transmission, either with persuasion or violence.[522]

If we compare Article 6 of this law with Jayapura's law, we can see that East Java's law reaches a broader group of people. Unlike Jayapura's law, which mainly targets sex workers, East Java's law places the burden of HIV prevention on all people living with HIV who already know their status. The law targets people living with HIV because it does not place any burden of HIV status disclosure on people living with HIV who never get tested, or those who are HIV-negative. The law imposes six months of prison time for a violation of Article 6.[523] This burden imbalance could raise questions about whether this kind of provision could lead to stronger

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[518] *Id.* art. 3–8.
[519] *Id.* art. 6(a).
[520] *Id.* art. 6(b).
[521] *Id.* art. 6(c).
[522] *Id.* art. 6(d).
[523] *Id.* art. 9.

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stigmatization against people living with HIV. An interview respondent stated that stigmatizing HIV law provisions also reflect the level of understanding and perceptions of the lawmakers.[524] It also may disincentivizing HIV testing.

In summary, 2004 was a turning point in HIV treatment in Indonesia. The government has been able to take advantage of the TRIPS' flexibility of "government use." It got money from the GFATM in 2003 to scale up the production and administration of ARVs. Subsequently, it prepared the referral hospitals in July 2004 to anticipate the government's use of patents for antiretrovirals in October. At the local level, several lawmakers adopted an HIV law that would enable the implementation of national HIV policies. However, the law includes criminalization of people living with HIV, which could induce stigma.

Following up the increasingly prepared HIV infrastructure, Spiritia initiated the "HIV Stops Here" to encourage the participation of PLHIV communities throughout the country in various HIV prevention program.[525] The upscaled HIV testing facilities due to the new policies implementation has helped the civil society to grow. To ensure the effectiveness of the new HIV policies, Spiritia conducted the first "Treatment Educator" training to increase the skills and knowledge of local peer support groups to take the active role in supporting their members who are taking antiretrovirals.[526] The training was including the topics of adherence, side effects, social aspects of taking antiretrovirals, and the basic medical knowledge on how the drugs work.[527]

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[524] Interview Respondent 1, *Interview on HIV and the Law in Indonesia* (2019).
[525] Spiritia Foundation, *supra* note 308.
[526] *Id.*
[527] *Id.*

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The growth of the civil society was marked by the fact that Spiritia has been able to inspire the development of 33 peer support groups existed in 24 cities in 20 provinces.[528] This massive increase has been strategically worked out to adopt a stronger civil society voice through *Pernyataan Bali*/the Bali Statement adopted by the national conference of peer support groups organized by Spiritia in November.[529]

In 2005, the HIV response was still under the coordination of the National AIDS Commission using the outline set out by the National AIDS Strategy 2003–2007.[530] In February 2005, the GFATM began a new funding round.[531] According to the program implementation plan, the Ministry of Health had determined three primary goals:

(1) Scaling up care, support, and treatment in seventeen target provinces with support from WHO's 3 by 5 Initiative;

(2) HIV prevention among the three target populations where the epidemic was most widespread: commercial sex workers, injecting drug users, and transgender people; and

(3) HIV prevention among vulnerable men through workplace programs in targeted industries.[532]

The first goal includes seven key services areas:

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[528] *Id.*
[529] *Id.*
[530] Rencana Aksi Nasional Penanggulangan HIV dan AIDS di Indonesia 2003–2007 (En. National Action Plan for HIV and AIDS Response in Indonesia 2003–2007) (2003).
[531] Contract No. IDN-404-G04-H: Indonesian HIV/AIDS Comprehensive Care (Principal Recipient: Indonesian Ministry of Health/Directorate General of Disease Control and Environmental Sanitation), *supra* note 349.
[532] *Id.* at Annex A. Program Implementation Abstract.

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(1) Voluntary HIV counseling and testing;

(2) Treatment and prophylaxis for opportunistic infections;

(3) Antiretroviral treatment and monitoring;

(4) Palliative care;

(5) Reducing stigma;

(6) Health system strengthening; and

(7) Procurement and supply management capacity building.[533]

The second goal includes:

(1) Decreasing the number of HIV infections among sex workers and transgender people through condom use promotion, voluntary HIV counseling and testing, care, and support;

(2) Increasing sex workers' participation in STI management; and

(3) Rolling out intervention services targeting injecting drug users and their sex partners using indigenous leader outreach.[534]

The third goal includes:

(1) Reducing high-risk behavior among workers;

(2) Developing policies to support prevention, anti-discrimination, and STI and HIV treatment in the world of work; and

(3) Increasing the capacity of Occupational Safety and Health inspectors to facilitate and monitor company workplace prevention programs.[535]

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[533] *Id.*
[534] *Id.*
[535] *Id.*

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One thing that is present in all three goals is voluntary HIV counseling and testing (VCT), as mandated by the civil society's Pacet Declaration back in the 1990s. It is safe to say that this particular GFATM proposal intended to scale up HIV testing, especially in priority provinces. The earlier decrees on epidemiology surveillance had enabled the health administrators to reveal priority areas that were helpful in the 2005 upscaling plan.[536]

The VCT and surveillance program relate to the upscaling of antiretroviral therapy (ART).[537] ART is vital in reducing HIV mortality and morbidity. The success of ART is the foundation of successful HIV prevention. Those who are in antiretroviral therapy have gone through the counseling process, which means that they have the necessary knowledge on how to prevent HIV transmission. Moreover, getting antiretroviral therapy means that they know the referral system to a certain extent. Furthermore, if they succeed in the therapy, they will have an undetectable viral load, which means that their HIV is untransmissible.

In this 2005 GFATM contract, the Indonesian government increased the presence of international norm entrepreneurs. In the 2003 contract, there were only two individuals (the WHO and UNAIDS). In the 2005 contract, there were nine international actors in the CCM, including the WHO, UNAIDS, the United Nations Children's Fund (UNICEF), the European Union Commission, the Japan International Cooperation Agency (JICA), the World Bank,

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[536] Health Ministerial Decree No. 1479 on the Guidelines for the Integrated Epidemiology Surveillance System of Infectious and Non-infectious Diseases, *supra* note 471.
[537] Contract No. IDN-404-G04-H: Indonesian HIV/AIDS Comprehensive Care (Principal Recipient: Indonesian Ministry of Health/Directorate General of Disease Control and Environmental Sanitation), *supra* note 364 at Annex A. Program Implementation Abstract.

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USAID, the Canadian International Development Agency (CIDA), and the German development agency *Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH* (GTZ.)[538]

Successful treatment requires accessible voluntary HIV counseling and testing as the entry point. It is logical that later in October, the Ministry of Health adopted a decree on the Guidelines for Voluntary Counseling and Testing Services.[539] The Minister adopted this decree after the previous week's adoption of the decree on the formation of the HIV/AIDS Response Working Group.[540] This decree also justifies the funding resources, which include foreign aid. The adoption of the decree then strengthened these two decrees on the Medium Term Workplan of 2005–2009 HIV/AIDS Care, Support, Treatment, and Prevention.[541]

With these three decrees, plus the 2005 GFATM grant, the Ministry of Health was well-equipped in terms of funding, the working group, practical guidelines on HIV testing, and a medium-term work plan. The earlier decrees on referral hospitals' appointment and national antiretroviral guidelines support this 2005 progress.

The decree on the Medium Term Workplan of 2005–2009 HIV/AIDS Care, Support, Treatment, and Prevention explicitly states that the upscaling of antiretroviral treatment intends to copy the success of the treatment in the United States (70% in 1996) and Brazil.[542] In Brazil, antiretrovirals have been distributed for free from 1996 to 2002, at a cost of US$1.8 billion.[543]

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[538] *Id.* at Annex A. Program Implementation Abstract.
[539] Health Ministerial Decree No. 1507 on the Guidelines for Voluntary Counseling and Testing Services (2005).
[540] Health Ministerial Decree No. 1441 on Ministry of Health's HIV/AIDS Response Working Group (2005).
[541] Health Ministerial Decree No. 1508 on the Medium Term Workplan of 2005–2009 HIV/AIDS Care, Support, Treatment, and Prevention (2005).
[542] *Id.* at Annex.
[543] *Id.*

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This investment saves the country US$2.2 billion in other expenses.[544] The country has also witnessed the indirect impact that people living with HIV can live productively.[545]

The third goal emphasizes HIV intervention among workers.[546] It is therefore relevant to see how the labor sector approaches the epidemic. In June, the Ministry of Labor adopted a Regulation on Narcotics, Psychotropics, and Other Addictive Substances Abuse and Illicit Traffic Prevention and Response in Work Place.[547]

The theme of narcotics in the workplace is in line with the Ministry of Health's HIV/AIDS program. However, the Ministry of Labor's regulation does not cite the national Health Law as the primary reference in the health sector.[548] The regulation does cite the 1997 Narcotics Law, 1997 Psychotropic Law, 2003 Labor Law, and 2002 Presidential Decree on the formation of the National Narcotics Board.[549] The regulation also cites a regional recommendation from the ASEAN Senior Official Meeting on Drug Matters in 2004.[550]

The regulation does not cite either the 1992 Health Law or the 1999 Human Rights Law.[551] The regulation bases its purposes on the 1997 Narcotics Law, which is rooted in the 1988 Narcotics Convention.[552] Here, we can sense a political gap between the ideals of the fight against narcotics and public health.

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[544] *Id.*
[545] *Id.*
[546] *Id.*
[547] Labor and Transmigration Ministerial Regulation No. 11 on Narcotics, Psychotropics, and Other Addictive Substances Abuse and Illicit Traffic Prevention and Response in Work Place (2005).
[548] *Id.*
[549] *Id.* at Preamble.
[550] *Id.*
[551] *Id.*
[552] *Id.*

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In terms of content, the regulation mainly describes the obligation of employers to develop an in-company narcotics policy as a part of a workplace safety program.[553] The regulation grants employers the right to ask an employee to take a narcotics test at any authorized test center.[554] The appointed physician shall decide whether an employee requires a rehabilitation program.[555] Furthermore, the regulation grants employers the right to include a narcotics program as a term in employment agreements.[556] Under this regulation, the employer has the right to impose disciplinary sanctions on employees who do not cooperate with the company's narcotics policy.[557] Similarly, the regulation obliges the employer to report drug possession or distribution by an employee to the police department.[558]

In general, this regulation reaches the point where employers are allowed to use employment terms as a deterrent. For drug users, this could lead to a risk of unemployment, which could lead to socioeconomic problems.

In April, in the midst of the Asian-African Summit 2005, Nane Annan, the spouse of the United Nations Secretary-General Kofi Annan, had the opportunity to meet 20 Indonesian PLHIV during her visit to Spiritia's office in Jakarta.[559] It was a strategic meeting where the Indonesian PLHIV civil society addressed their challenge to one of the prominent HIV champions.[560]

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[553] *Id.* art. 2.
[554] *Id.* art. 6.
[555] *Id.*
[556] *Id.* art. 7.
[557] *Id.*.
[558] *Id.* art. 8.
[559] Spiritia Foundation, *supra* note 308.
[560] *Id.*

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At the local level, the City of Probolinggo in East Java adopted its HIV/AIDS Prevention and Response law.[561] Probolinggo's law cites East Java's provincial regulation of 2004.[562] This law has been supportive in allowing civil society to take part in the city's HIV programs. It states that civil society can take on the roles of outreach workers, counselors, case managers, or any other coordination with related government agencies.[563]

This law tries to eliminate discrimination, especially in healthcare facilities. It states that all healthcare facilities, including privately owned ones, must not refuse services to HIV-positive patients.[564] It also ensures the implementation of voluntary HIV counseling and testing, as well as the confidentiality of one's HIV status.[565]

The regulation goes so far as to impose a criminal sanction of six months of prison time or a US$5,000 equivalent fine for discrimination as mentioned earlier against HIV-positive patients or breach of HIV status confidentiality.[566]

The regulation also mimics the provincial law, as it also places the burden of HIV prevention on HIV-positive people. It threatens six months' prison time for people living with HIV who fail to disclose their HIV status before sexual intercourse, share a needle, donate their blood, or commit any illegal acts that have the risk of HIV transmission.[567]

In summary, this regulation has much support to enable city-level HIV programs. At the same time, it also raises discussions on the effectiveness of imposing harsh criminal sanctions for some aspects of the law.

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[561] Probolinggo City Regulation No. 9 on HIV/AIDS Prevention and Response (2005).
[562] *Id.* at Preamble.
[563] *Id.* art. 9.
[564] *Id.* art. 5.
[565] *Id.*
[566] *Id.* art. 10.
[567] *Id.* art. 7.

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At the global level, the WHO adopted the International Health Regulations (IHR) in 2005.[568] It entered into force on 15 June, 2007.[569] The Fifty-Eighth World Health Assembly adopted it on 23 May 2005.[570]

As mentioned in the foreword, the IHR's purposes are "to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade."[571]

The IHR introduces several provisions:

(1) A scope not limited to any specific disease or manner of transmission, but covering "illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans";

(2) State Party obligations to develop certain minimum core public health capacities;

(3) Obligations on States Parties to notify the WHO of events that may constitute a public health emergency of international concern according to defined criteria;

(4) Provisions authorizing the WHO to take into consideration unofficial reports of public health events and to obtain verification from States Parties concerning such events;

(5) Procedures for the determination by the Director-General of a "public health emergency of international concern" and issuance of corresponding temporary recommendations, after taking into account the views of an Emergency Committee;

(6) Protection of the human rights of persons and travelers; and

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[568] International Health Regulations (2005), *supra* note 355.
[569] *Id.*
[570] *Id.*
[571] *Id.* at Foreword.

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(7) The establishment of National IHR Focal Points and WHO IHR Contact Points for urgent communications between States Parties and the WHO.[572]

The IHR uses the term "legislation, regulations and other instruments" (at times shortened to "legislation") in a broader sense, referring to a range of legal, administrative, or other governmental instruments that may be available for States Parties to implement the IHR (2005) and are not necessarily limited to instruments adopted by the legislature.[573]

Following up the adoption of the IHR, the AIDS Society of Asia Pacific organized the Seventh International Congress on AIDS in Asia and the Pacific in Kobe, Japan. Activists from Indonesia presented to the congress, including sharing the results of the Second Documentation of Human Rights Violations against PLHIV in Ten Provinces.[574] The conference was also a hospitable place where Indonesian civil society had the chance to arrange a forum with Indonesian political leaders attending the congress.[575] One of the topics of the meeting was that to highlight the importance of the civil society's voice and the need to expand the national HIV treatment program. As a follow-up, Spiritia conducted the first National PLHIV Congress in September attended by 120 participants. At the local level there were already 55 peer support groups operating throughout the country.[576] The congress resulted in *Pernyataan Lembang*/Lembang Declaration which was then submitted to the National AIDS Commission as a recommendation.[577] Subsequently, the National AIDS Commission released the 2005

[572] *Id.*
[573] *Id.* art. 3.
[574] Spiritia Foundation, *supra* note 308.
[575] *Id.*
[576] SPIRITIA FOUNDATION: 2004-2005 ANNUAL REPORT (2005).
[577] Spiritia Foundation, *supra* note 308.

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Acceleration Program targeting 100 regencies/cities that was officially launched by the Vice President of Indonesia in the World AIDS Day commemoration event in December.

3.3.2. Period of 2006–2017

In 2006, two provincial regulations and three regency regulations were adopted. The province of Bali adopted an HIV law in March.[578] The law cites the 1992 Health Law, 1999 Human Rights Law, 2002 Child Protection Law, and 2004 Medical Practice Law. However, it does not cite the 1997 Narcotics Law or the 1997 Psychotropics Law.[579]

This law reflects the National Strategy on AIDS.[580] It backs HIV screening on donated blood, sperm, or organs/tissues. It also says that all screenings must be both unlinked to personal data and anonymous.[581] In the area of HIV prevention, it recognizes HIV prevention measures among injecting drug users, the prevention of vertical transmissions, and the use of information, education, and communication promotional measures.[582]

In the field of healthcare services, it supports the implementation of voluntary HIV counseling and testing, including in the implementation of maternity-related HIV prevention.[583] The law also introduces family counseling and partner notification.[584] In terms of human rights, the law guarantees that all kinds of notifications must have the person living with HIV's

[578] Bali Provincial Regulation No. 3 on HIV/AIDS Response (2006).
[579] *Id.*
[580] *Id.*
[581] *Id.*
[582] *Id.*
[583] *Id.* art. 11.
[584] *Id.* art. 13.

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consent.[585] The law outlaws any discrimination against people living with HIV in the health sector.[586]

In the programmatic area, the law justifies the use of the provincial budget for HIV programs.[587] It also allows the use of other funding resources to fund all parts of the programs.[588] This openness to other funding resources is beneficial in anticipating foreign aid.

This law also introduces the criminalization of at least eleven acts:[589]

(1) An HIV-positive person who fails to take preventive measures toward her/his sexual partner;
(2) An HIV-positive person who donates her/his blood;
(3) An HIV-positive person who donates his sperm;
(4) An HIV-positive person who donates her/his organs or tissue;
(5) Everyone who fails to take preventive measures toward her/his sexual partner;
(6) Everyone who fails to use a sterile needle;
(7) A healthcare worker who conducts surveillance and screening without making it unlinked and anonymous;
(8) A healthcare worker who does not implement VCT on PMTCT;
(9) Everyone who implements mandatory HIV testing;
(10) Everyone who breaches the confidentiality of a person's HIV status; and
(11) A healthcare worker who discriminates HIV-positive patients.

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[585] *Id.* art. 12.
[586] *Id.* art. 14.
[587] *Id.* art. 21.
[588] *Id.*
[589] Bali Provincial Regulation No. 3 on HIV/AIDS Response, *supra* note 578.

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In June, the province of Riau also adopted its HIV Provincial Regulation.[590] Compared to Bali's law, it covers a broader area, reaching sectors outside the health sector. If we look at the cited laws, Riau's HIV Provincial Regulation cites more laws than Bali's. It cites the 1970 Workplace Safety Law, 1992 Health Law, 1997 Narcotics Law, 1997 Psychotropics Law, 1999 Human Rights Law, 2002 Child Protection Law, 2003 Labor Law, and 2004 Medical Practice Law.[591] It also cites the 1994 Presidential Decree on the formation of the National AIDS Commission; 1992 Ministry of Health's Decree on HIV Screening on Donated Blood; 1998 Ministry of Health Regulation on Medical Consent; 1995 Ministry of People's Welfare Decree on Information, Education, and Communication for HIV Prevention; 1996 Ministry of People's Welfare Decree on National AIDS Strategy; and 2004 Ministry of Labor Decree on HIV in Workplace.[592]

In the area of HIV screening, the law adds an explicit rule on screening donated blood for sexually transmitted diseases and hepatitis.[593] In the area of prevention, Riau's law explicitly mentions the importance of applying universal precaution.[594] It also includes provisions explicitly about the use of sterile shaving and cosmetic equipment as parts of HIV prevention measures.[595]

The law's main characteristic is its extensive provisions on human rights outside the health sector. It explicitly prohibits discrimination against people living with HIV in the areas of

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[590] Riau Provincial Regulation No. 4 on HIV Prevention and Response (2006).
[591] *Id.* at Preamble.
[592] Riau Provincial Regulation No. 4 on HIV Prevention and Response, *supra* note 590.
[593] *Id.*
[594] Riau Islands Provincial Regulation No. 15 on HIV/AIDS and STDs Prevention and Response in Riau Islands (2007).
[595] Riau Provincial Regulation No. 4 on HIV Prevention and Response, *supra* note 590.

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the workplace, housing, and education.[596] It also says that there must be equal rights of confidentiality for prison inmates, equal rights to access to healthcare for prison inmates, and no mandatory HIV testing in prison, except for surveillance and court investigation purposes.[597]

Regarding the obligations of people living with HIV/AIDS, the law adds that they have to use sterile needles as well as be prohibited from donating breastmilk.[598] Moreover, this law introduces the obligation for vulnerable groups and high-risk group members to check their health regularly.[599]

According to this law, vulnerable groups are groups of people whose behavior involves the risks of HIV, including sex workers, homosexuals, prison inmates, and injecting drug users.[600] High-risk groups, on the other hand, are groups of people whose jobs involve risks of HIV, including long-haul drivers, sailors, beauty salon workers, and hotel workers.[601]

The violation of the obligations attached to people living with HIV who know their status and vulnerable group members attracts criminal sanctions of a maximum of six months prison-time and IDR 50 million fine; people in high-risk groups are excluded.[602]

In August, the authority declared that HIV in West Papua and Papua provinces has turned into a "generalized epidemic" where HIV was not only found among specific subpopulations. At the regency level, there were three Regency Regulations adopted in 2006. Two of them are in

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596 *Id.*
597 *Id.*
598 *Id.* art. 10.
599 *Id.* art. 11.
600 *Id.*
601 *Id.*
602 *Id.*

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West Papua Province (Manokwari and Teluk Bintuni), and the other one is in the Serdang Bedagai regency in North Sumatra Province.[603]

Adopted in December, Manokwari's law extensively puts attention on reaching out to sex workers, pimps, bar owners, hotel owners, and landlords.[604] It places multiple obligations and prohibitions on sex workers.[605] They must provide condoms during sexual intercourse, check their HIV and STD statuses regularly, and only take clients with condoms, and they are prohibited from working in unofficial sites. Sex workers with HIV or STDs are prohibited from working, and they must not take minor clients.[606]

It also places certain obligations and prohibitions on pimps.[607] They must report their recruited sex workers to the local government and must educate sex workers about condom use and health checks.[608] Furthermore, they must also deactivate sex workers who have HIV or other STDs.[609] As a form of child protection, pimps are not allowed to recruit minors nor take minor clients.[610] In order to protect the sex workers, the law prohibits pimps from taking money from sex workers who refuse to undertake unprotected sex with clients.[611]

Similarly, bar owners have their own obligations and prohibitions. While pimps have their roles toward sex workers under their supervision, bar owners have specific roles toward

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603 Manokwari Regency Regulation No. 6 on HIV/AIDS and STDs Prevention and Response (2006); Teluk Bintuni Regency Regulation No. 21 on HIV/AIDS and STDs Prevention and Response (2006); Serdang Bedagai Regency Regulation No. 11 on HIV/AIDS Response in Serdang Bedagai Regency (2006).
604 Manokwari Regency Regulation No. 6 on HIV/AIDS and STDs Prevention and Response, *supra* note 603.
605 *Id.*
606 *Id.*
607 *Id.*
608 *Id.*
609 *Id.*
610 *Id.*
611 *Id.*

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entertainer ladies on their respective premises.[612] However, entertainer ladies receive slightly different treatment. Bar owners are obliged to facilitate care, support, and treatment for entertainer ladies with HIV or STDs.[613] To a certain extent, however, this could reflect an intrusive authority over hostesses' personal health decisions.

The law also gives obligations and prohibitions to hotel owners and landlords. The regulation grants them the authority to monitor guests' activity. Hotel owners and landlords must monitor whether there are any prostitution practice on their premises.[614] They must not facilitate any form of sexual transaction, and they are obliged to report any sexual transaction that occurs.[615]

This law also governs the role of clients of the sex industry in Manokwari. The law prohibits clients from buying sex without a condom; carrying weapons; making a nuisance; or using violence or force in order to get sex services.[616]

By reaching out to pimps, hotel owners, bar owners, and clients, the law has the potential to balance the power relations toward sex workers, hostesses, and guests. It is harsh enough that the regulation imposes criminal sanctions on all of the obligations and prohibitions, except those applicable to pimps.

In the same month, the regency of Teluk Bintuni adopted its HIV law.[617] The content analysis of the law suggests that Teluk Bintuni's regulation has a 100% content similarity to Manokwari's.

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[612] *Id.*
[613] *Id.*
[614] *Id.*
[615] *Id.*
[616] *Id.*
[617] Teluk Bintuni Regency Regulation No. 21 on HIV/AIDS and STDs Prevention and Response, *supra* note 603.

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The regency of Serdang Bedagai in North Sumatra adopted a less-detailed HIV Provincial Regulation. It shares a similar approach to HIV screening on donated blood and organs/tissue.[618] It also shares similar provisions on condom 100% policy, behavior change, universal precaution, epidemiological surveillance, voluntary HIV counseling and testing, confidentiality, antiretroviral treatment, and non-discrimination in healthcare services.[619]

Serdang Bedagai's law, however, does not have specific provisions for populations other than people living with HIV. It only has the prohibitions and obligations for people living with HIV, and they bear the burden of HIV prevention.[620] The prohibitions include the prohibitions on donating blood, semen, and organs/tissue.[621] The law imposes criminal sanctions on these actions.[622] This law furthermore criminalizes the breach of HIV status confidentiality and discrimination against people living with HIV in healthcare.[623]

In 2007, there were several major events that bridged the civil society and HIV lawmakers. In July, Spiritia held the Second National PLHIV Congress in Lido, West Java.[624] Some of the participants was then advocating in the Eights International Congress on AIDS in Asia and the Pacific in Colombo, Sri Lanka.[625] One of the outcomes of the congress was that Indonesia was selected to host the Ninth International Congress on AIDS in Asia and the Pacific in 2009.[626] The civil society looked on this as progress in gaining a stronger traction for the

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[618] Serdang Bedagai Regency Regulation No. 11 on HIV/AIDS Response in Serdang Bedagai Regency, *supra* note 603 art. 6.
[619] *Id.* art. 6.
[620] Serdang Bedagai Regency Regulation No. 11 on HIV/AIDS Response in Serdang Bedagai Regency, *supra* note 603.
[621] *Id.*
[622] *Id.*
[623] *Id.*
[624] Spiritia Foundation, *supra* note 308.
[625] *Id.*
[626] *Id.*

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sustainability and the development of national HIV programming.[627] Typically, the organization of a congress involves a strong network between the host country government, PLHIV decisive participation, donor agencies, the United Nations, and international NGOs. Following up this development, a number of PLHIV activists and their families got the chance to meet President Susilo Bambang Yudhoyono during the World AIDS Day event.[628]

Also, in 2007, three provinces adopted HIV laws: East Kalimantan (adopted in October), Riau Islands (adopted in November), and East Nusa Tenggara (adopted in September). The three regulations cite the same seven pieces of national legislation that are considered as related to HIV. The laws are the 1992 Health Law, 1997 Psychotropics Law, 1997 Narcotics Law, 1999 Human Rights Law, 2002 Child Protection Law, 2006 Presidential Regulation on National AIDS Commission, and 1981 Criminal Procedure Law.[629] Only East Nusa Tenggara's Regulation cites the 1970 Workplace Safety Law.[630] It also cites the 1996 Ratification of Psychotropics Convention, the 1997 Ratification of Narcotics Convention, and the 2004 Domestic Violence Law.[631] The three regulations also share the following areas:

(1) HIV screening on donated blood;

(2) Condom 100% program;

(3) Promotion through information, education, and communication;

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[627] *Id.*
[628] *Id.*
[629] East Kalimantan Provincial Regulation No. 5 on HIV/AIDS and STDs Prevention and Response (2007); Riau Islands Provincial Regulation No. 15 on HIV/AIDS and STDs Prevention and Response in Riau Islands, *supra* note 594; East Nusa Tenggara Provincial Regulation No. 3 on HIV/AIDS Prevention and Response (2007).
[630] East Nusa Tenggara Provincial Regulation No. 3 on HIV/AIDS Prevention and Response, *supra* note 629.
[631] *Id.*

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(4) Universal precaution;

(5) STDs surveillance;

(6) HIV surveillance;

(7) Behavior surveillance;

(8) Voluntary HIV counseling and testing;

(9) Confidentiality and consent;

(10) ARV procurement;

(11) Opportunistic infection drugs procurement;

(12) STDs treatment procurement;

(13) Basic healthcare services;

(14) Referral system through continuum of care; and

(15) The use of state budget and other funding resources.

Among the three provincial regulations, only East Kalimantan's do not have provisions on the prohibition of discrimination outside the health sector. Both Riau Islands and East Nusa Tenggara have provisions prohibiting discrimination against people living with HIV in the specific areas of the workplace, housing, and education. However, only East Nusa Tenggara prohibits general discrimination against people living with HIV.[632]

East Nusa Tenggara's also covers more prohibitions. The regulation obliges people living with HIV who know their status to prevent sexual HIV transmission.[633] Additionally, it prohibits them from donating blood, semen, organs, and tissues.[634]

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[632] *Id.*
[633] *Id.*
[634] *Id.*

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For everyone in general, it prohibits the transfer of blood, semen, organs, or tissues with HIV to any donor recipient.[635] It also obliges everyone to use sterile needles to prevent the sharing of used needles.[636] East Nusa Tenggara's is also the only regulation that has a provision that says cultural practices with HIV risks must include screening procedures accordingly.[637]

In East Nusa Tenggara, there is a widespread cultural practice called Sifon.[638] Sifon is a ritual of circumcision for males to mark their transition to adult life.[639] The practice of Sifon uses bamboo as the cutting blade. Right after the circumcision, the person must have sex with an appointed woman, who is not his wife or partner.[640] The belief is that this practice will "chill" the heat of the circumcision. However, according to known HIV transmission modes, the engagement of plasma, open wounds, and a broader sexual chain carries an increased risk of HIV transmission.

In 2008, the collaboration between the civil society and the National AIDS Commission was able to organize the National Harm Reduction Meeting in Makassar, South Sulawesi. Through this meeting, the civil society voiced that HIV policies should take into account the issues faced by injecting drug users. The voice was listened by the Aburizal Bakrie, the Coordinating Minister of People's Welfare who endorsed the prison condom program.

Similarly, during the Seventh Indonesian Children Congress in Jakarta, the civil society addressed the importance the inclusion of HIV/AIDS in reproductive health program.[641]

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[635] *Id.*
[636] *Id.*
[637] *Id.*
[638] *Open Research: Engaging and Serving Men in the Indonesian Reproductive Health Program: Issues and Obstacles*, 5, https://openresearch-repository.anu.edu.au/handle/1885/41471 (last visited Jul 29, 2019).
[639] *Id.*
[640] *Id.*
[641] Spiritia Foundation, *supra* note 308.

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President Susilo Bambang Yudhoyono followed up the mandate by giving direct orders to his minsters in the moments of Indonesian Children Day.[642]

The growing PLHIV activism across Indonesia has led to the creation of an organization called *Jaringan Orang Terinfeksi HIV Indonesia*/the Indonesian PLHIV Network (JOTHI).[643] Abdullah Denovan, an activist in Greater Jakarta area was voted as the national coordinator for members in 27 provinces.[644] One of the works of JOTHI was a demonstration calling for the improvement of UNAIDS contribution in Indonesia. It collaborated with the Association of Drug Victims and *LBH Kesehatan/*the Health Legal Aid Institute organized.[645] The collaboration, called *Masyarakat Peduli AIDS Nasional*/the National AIDS Care Society (MAPAN), felt that the new UNAIDS management was not able to give a positive contribution as before. The rise of PLHIV activism in the year of 2008 has also managed to block the new Papua province bill on HIV that proposed the implant of microchip for all Papuans with HIV.[646]

At the local level, there were two more provinces and five more regencies that adopted HIV-specific laws. The two provinces were West Nusa Tenggara and the Special Region of Jakarta.[647] The five regencies were Fakfak Regency (West Papua), Badung Regency (Bali), Jembrana Regency (Bali), Malang Regency (East Java), Bulukumba Regency (South Sulawesi), and Tasikmalaya City (West Java).[648]

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[642] *Id.*
[643] *Id.*
[644] *Id.*
[645] *Id.*
[646] *Id.*
[647] West Nusa Tenggara Provincial Regulation No. 11 on HIV and AIDS Prevention and Response (2008); Special Region of Jakarta Provincial Regulation No. 5 on HIV and AIDS Response (2008).
[648] Fakfak Regency Regulation No. 8 on HIV and AIDS Prevention, Control, and Response in Fakfak Regency (2008); Badung Regency Regulation No. 1 on HIV and AIDS Response (2008); Jembrana Regency Regulation No. 1 on HIV and AIDS Response (2008); Malang Regency

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In the timeline histogram, 2008 is in the middle of the uptrend of local law adoption. Not only did local politicians pay attention to HIV, but there was also a considerable HIV budget. According to the UNGASS Country Report for the 2006–2007 reporting period, the budget had increased from Rp. 8 billion in 2004 to Rp. 57 billion in 2007 across twenty-three provinces.[649] In terms of funding sources, the Indonesian government contributed less than 30% of the total HIV budget.[650]

In terms of the legal process, the same report shows the strategic role of the National Composite Policy Index (NCPI). The NCPI questionnaire aims to measure the suitability of current HIV policies with its practice, as reported by stakeholders.[651] The NCPI survey involves various participants, including NGOs, the Indonesian Red Cross, spokespeople of youth, people living with HIV, the Association of Indonesian Family Planning, the International Labor Organization (ILO), UNICEF, UNAIDS, and the National AIDS Commission.[652]

The NCPI questionnaire was successful in proving that different parties, regardless of the power structure, could be heard through a national forum. This form of consultation did not necessarily occur in the same way as in local-level lawmaking processes; however, the completion of the NCPI itself presents the contrast between national and local stakeholder interactions. Bali was the only province that had an HIV-positive group representative at the

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Regulation No. 14 on HIV and AIDS Response in Malang Regency (2008); Bulukumba Regency Regulation No. 5 on HIV/AIDS Response (2008); Tasikmalaya City Regulation No. 2 on HIV and AIDS Prevention and Response (2008).

[649] Country Report on the Follow Up to the Declaration of Commitment on HIV/AIDS (UNGASS) Reporting Period 2006–2007, 11 (2008).

[650] *Id.*

[651] HIV/AIDS Asia Pacific Research Statistical Data Information Resources—AIDS Data Hub, *Indonesia National Composite Policy Index 2007: Ministry of Social Affairs Indonesia (2008)*, https://www.aidsdatahub.org/indonesia-national-composite-policy-index-2007-ministry-of-social-affairs-indonesia-2008 (last visited Jul 29, 2019).

[652] *Id.*

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forum.[653] This means that at least five provinces adopted their local laws in 2008 without consulting with HIV-positive umbrella groups.

In 2009, the HIV program was scaled up. A Global Fund contract was signed with three different Principal Recipients: The National AIDS Commission; the Ministry of Health; and the National Planned Parenthood Association.[654]

The arrangement looks strategic, where the National AIDS Commission's role shows the intersectoral approach. The Ministry of Health's presence in this case shows the leadership of the health sector as the primary healthcare provider across the country. The National Planned Parenthood Association's presence reflects the strategy to approach HIV from a non-medical angle. All three organizations share the same characteristic of an extensive presence across the country, reaching out to city-level offices. This characteristic is strategic to ensure countrywide implementation.

In that year, the Ministry of Health adopted several decrees that strictly administered HIV programs nationally.[655] This shows the Ministry's leadership in supporting the work that was scaled up by the Global Fund contracts. One of the decrees covers voluntary counseling and testing trainers.[656] This decree supports the policy to open more HIV testing centers.[657] The decree explicitly mentions that the Global Fund and HCPI should fund the training.[658]

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[653] *Id.*
[654] Health Ministerial Decree No. 1278 on the Guidelines for TB and HIV Control Collaboration (2009).
[655] Health Ministerial Decree No. 60 on HIV/AIDS Voluntary Counseling and Testing Trainers (2009); Health Ministerial Decree No. 1226 on the Hospital-based Integrated Services Guidelines for the Victims of Violence against Women and Children (2009); Health Ministerial Decree No. 1278 on the Guidelines for TB and HIV Control Collaboration, *supra* note 654.
[656] Health Ministerial Decree No. 60 on HIV/AIDS Voluntary Counseling and Testing Trainers, *supra* note 655 at 60.
[657] *Id.*
[658] *Id.* at Preamble.

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The Ministry of Health also adopted the Guidelines for TB and HIV Control Collaboration.[659] The adoption of this guideline was in response to the findings that TB was the primary opportunistic infection around the world.[660] A 2007 survey in Jayapura showed that thirteen out of forty HIV patients had TB.[661] The survey's result exceeded the WHO's 2007 estimation of 0.8% national TB prevalence among HIV-positive people.[662] The guideline says that Indonesia is the country with the third-most substantial TB burden, following India and China.[663]

Also in 2009, Indonesia hosted the Ninth International Congress on AIDS in Asia and the Pacific (9th ICAAP).[664] The congress was held in Bali and drew more than four thousand participants from around the globe.[665] As the second-largest scientific congress after the International AIDS Conference, the 9th ICAAP brought together Indonesian policy actors to work as the local organizing committee.[666] In the opening speech, President Susilo Bambang Yudhoyono acknowledged universal access for AIDS prevention, care, support, and treatment.[667] The address also revisited the commitment made in 2001.[668]

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[659] Health Ministerial Decree No. 1278 on the Guidelines for TB and HIV Control Collaboration, *supra* note 654.
[660] *Id.*
[661] *Id.*
[662] *Id.*
[663] *Id.*
[664] *Five-Day Congress on AIDS in Asia-Pacific Concludes*, KAISER HEALTH NEWS (2009), https://khn.org/morning-breakout/gh-081309-aids-congress/ (last visited Jul 29, 2019).
[665] *Id.*
[666] Australian Embassy Indonesia, *Australia Supports Major HIV Congress in Bali* (2009).
[667] Susilo B. Yudhoyono, *Speech of His Excellency Mr. Susilo Bambang Yudhoyono, President of the Republic of Indonesia on the Occasion of the Opening of the 9th International Congress on AIDS in Asia and the Pacific* (2009).
[668] Declaration of Commitment on HIV/AIDS, *supra* note 395.

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The preparation for the 9th ICAAP displays the connection between global and national actors.[669] The joint committee between the Indonesian local organizing committee and the AIDS Society in the Asia Pacific (ASAP) as the steering committee strengthened the international assemblages.[670] This cooperation transferred ideas and norms regarding the best way to reverse the epidemic.

One of the highlights of 2010 was the adoption of Supreme Court Circular Letter No. 4 Year 2010 on Placing Narcotics Addict and Abusers into Medical and Social Rehabilitation Facility.[671] This Circular Letter marks the introduction of public health measures to the judiciary.

The Circular Letter mandates that all judges grant rehabilitation orders to drug addict defendants.[672] Nonetheless, this Circular Letter does not have complete support from the 2009 Narcotics Law as the higher law, which makes any rehabilitation orders non-mandatory.[673]

The year 2011 was marked by the adoption of the controversial Government Regulation No. 25 Year 2011 on Mandatory Reporting for Narcotics Users.[674] This Government Regulation has been under intense criticism due to its counterproductive provision—the regulation mandates that all drug addicts report their addiction to any listed reporting center.[675]

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[669] Yudhoyono, *supra* note 667.
[670] *Id.*
[671] Supreme Court Circular Letter No. 7 on Placing Narcotics User in Rehabilitation and Therapy Center (2009).
[672] Supreme Court Circular Letter No. 4 on Placing Narcotics Addict and Abusers into Medical and Social Rehabilitation Facility (2010).
[673] Law No. 35 on Narcotics, *supra* note 438.
[674] Government Regulation No. 25 on Mandatory Reporting for Narcotics Users (2011).
[675] *Id.*

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The mandatory nature of this provision, however, does not consider the infrastructure support required to put all reporting drug users into standardized rehabilitation centers.[676] Moreover, drug addicts are reluctant to report themselves because they fear that could lead to their incrimination.[677] The regulation also puts a criminal liability on parents who do not report their children's addiction.[678]

Regardless of the suitability of the content, one can see HIV laws at all levels of jurisdiction. This massive presence of HIV laws at the same time reflects the extent of contradiction or disconnectedness between laws on different levels. As a proxy of this contradiction, in 2012, the UNDP adopted its anti-criminalization global recommendation.[679]

The year of 2013 was the year with the most HIV-related laws. There were nine Regency Regulations, three City Regulations, and one Provincial Regulation adopted in this year.[680] In

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[676] DAHLAN, PROBLEMATIKA KEADILAN DALAM PENERAPAN PIDANA TERHADAP PENYALAH GUNA NARKOTIKA (EN. PROBLEMATIZING JUSTICE IN THE USE OF CRIMINAL LAW AGAINST NARCOTICS USERS) 73 (Ramon Nofrial ed., 2017).

[677] Fena Suparman, *Takut Dipenjara, Alasan Pecandu Narkoba Tak Mau Direhabilitasi (En. Fear of Imprisonment, the Reason Why Drug Addicts Avoid Rehabilitation)*, BERITASATU, August 29, 2013.

[678] Government Regulation No. 25 on Mandatory Reporting for Narcotics Users, *supra* note 674.

[679] Global Commission on HIV and the Law: Risk, Rights, Health, *supra* note 368.

[680] Sumedang Regency Regulation No. 5 on Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome Prevention and Response (2013); Tanah Bumbu Regency Regulation No. 7 on HIV and AIDS Response (2013); Banjarnegara Regency Regulation No. 13 on HIV and AIDS Response in Banjarnegara Regency (2013); Kendal Regency Regulation No. 15 on HIV and AIDS Control in Kendal Regency (2013); Jepara Regency Regulation No. 10 on HIV and AIDS Disease (2013); Kebumen Regency Regulation No. 2 on HIV Response (2013); East Lampung Regency Regulation No. 2 on Prevention and Eradication of Narcotics Abuse and Trafficking, and HIV/AIDS Response (2013); Purwakarta Regency Regulation No. 6 on HIV/AIDS and STDs Control in Purwakarta Regency (2013); Denpasar City Regulation No. 1 on HIV and AIDS Response (2013); Semarang City Regulation No. 4 on HIV and AIDS Response (2013); Surabaya City Regulation No. 4 on HIV and AIDS Response (2013); Southeast Sulawesi Provincial Regulation No. 2 on HIV and AIDS Prevention and Response (2013).

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terms of funding, there were four GFATM contracts in force.[681] The four GFATM contracts involved four different Principal Recipients: the Indonesian Planned Parenthood Association, Nahdlatul Ulama, the National AIDS Commission and the Ministry of Health/Directorate General of Disease Control and Environmental Sanitation. Each of these organizations has offices across the country, which makes resource mobilization a lot easier.

The Ministry of Health also passed new laws to support the upscaling due to the massive influx of funding. These laws cover the following areas:

(1) Prevention of mother-to-child transmission, known as vertical transmission;[682]

(2) Drug-resistant tuberculosis;[683]

(3) Mandatory reporting for drug addicts;[684]

(4) Logistics financing;[685]

(5) A methadone substitution program;[686] and

[681] *See supra* note 363. Contract No. IDN-H-IPPA: Indonesia Response to HIV Government and Civil Society Partnership in 12 Province (Principal Recipient: Indonesian Planned Parenthood Association); Contract No. IDN-H-NU: Indonesia Response to HIV Government and Civil Society Partnership in 21 Provinces (Principal Recipient: Nahdlatul Ulama); Restated Contract No. IDN-S10-G16-H: Indonesia Response to HIV Government and Civil Society in 33 Provinces (Principal Recipient: National AIDS Commission) (2013); Restated Contract No. IDN-S10-G17-H: Indonesia Response to HIV Government and Civil Society Partnership in 33 Provinces (Principal Recipient: Ministry of Health/Directorate General of Disease Control and Environmental Sanitation) (2013).
[682] Health Ministerial Regulation No. 51 on the Guidelines for Prevention of Mother to Child HIV Transmission (2013).
[683] Health Ministerial Regulation No. 13 on Integrated Control Management of Drug Resistant Tuberculosis (2013).
[684] Health Ministerial Regulation No. 37 on the Implementation of Mandatory Reporting for Narcotics Addicts (2013).
[685] Health Ministerial Regulation No. 21 on HIV and AIDS Response (2013).
[686] Health Ministerial Regulation No. 57 on the Implementation of Methadone Substitution Therapy (2013).

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(6) The government's use of TRIPS flexibility on antiretrovirals.[687]

In 2014, more than half of the provinces had their own HIV-specific laws. At this point, HIV-positive umbrella groups existed in fifteen provinces (83% of the twenty-four total umbrella groups identified until 2018). Therefore, this study sees 2014 as the year for which an observer could better evaluate the lawmaking processes. The ample adoption of executive-issued laws shows that the executive branch was leading the country's HIV response. Until 2014, however, this study finds that the role of local civil society organization was mostly to assist the government in delivering externally-funded programs. This year, UNAIDS adopted the 90-90-90 policy. The policy document mandates that

> By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.[688]

The adoption of this document signifies the global community's optimism about reversing the pandemic two decades after the UNGASS Declaration.

The year 2015 is when the Spiritia Foundation, as the national secretariat of HIV-positive people's umbrella groups, took on the role of GFATM Principal Recipient.[689] The acceptance of this position by the Country Coordinating Mechanism (CCM) shows the recognition of Spiritia's national scope of work.

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[687] Health Ministerial Decree No. 109 on the Appointment of P.T. Kimia Farma (Persero) for and on Behalf of the Government to Use Antiviral and Antiretroviral Patents (2013).
[688] UNAIDS, 90-90-90 An ambitious treatment target to help end the AIDS epidemic (2014).
[689] Contract No. IDN-H-SPIRITI-954: Indonesia HIV Response: Accelerating the Achievement of the Three Zeros (Principal Recipient: Spiritia Foundation), *supra* note 363.

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Moreover, the Spiritia Foundation's close engagement with local peer support groups created a bigger chance to increase civil society's role in implementing the needed HIV prevention upscaling.[690] Nonetheless, the focus has been mainly on service delivery, with minimal attention to the normative aspect of local laws.[691]

The main highlight of 2016 is Presidential Regulation No. 124 Year 2016 on the Amendment of Presidential Regulation No. 75 Year 2006 on the National AIDS Commission.[692] This regulation dissolves the National AIDS Commission. The existing National AIDS Commission had until 31 December 2017 to finalize its work.

According to the law, the "ministry dealing with the health issue" will handle the policymaking role of the National AIDS Commission.[693] Similarly, the "relevant coordinating ministry" will handle the coordinating role of the commission.[694]

With the dissolution of the National AIDS Commission, the HIV program is entirely under the Ministry of Health's leadership. Previously, non-government components had their seats in the National AIDS Commission. After the dissolution, NGOs are utterly dependent on the executive agencies' policy agenda.[695]

3.4. Conclusion

The historical development of the Indonesian HIV legal environment suggests that local HIV laws are significant in terms of both quantity and content. They appear in most years, in

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690 *Id.*
691 *Id.*
692 Presidential Regulation No. 124 on the Amendment of Presidential Regulation No. 75 Year 2006 on National AIDS Commission (2016).
693 *Id.*
694 *Id.*
695 Interview Respondent 1, *supra* note 524.

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most places in Indonesia. This chapter also finds that the NGOs were instrumental in shaping the legal and policy environment at the national level.[696] The growth of Indonesian civil society has been able to advocate the emerging global HIV norms, in the frame of human rights, toward the National AIDS Commission and the Ministry of Health.[697] This continuous advocacy works has been able to ensure meaningful civil society's participation by taking strategic seats in the National AIDS Commission. In this case, participation is necessary for PLHIV because they can take a decisive role in national HIV program design process.

In the absence of a national HIV law, this mechanism is necessary to initiate and substantiate local HIV laws with ideals from the National AIDS Strategy. That means that the creation of local HIV laws has been mostly moderated, both substantially and formally, by NGOs at the national level who internalized the emerging global HIV norms.[698] This suggests that studying local laws in the following chapter promises robust inferences in global health jurisprudence scholarship.

The existence of national laws is dominated by laws issued by the Ministry of Health. These laws were the implementation tool for the National AIDS Strategies. Other laws, such as the Narcotics Law, were created not specifically to address HIV-related problems. As the 2015 consultation has suggested, while Indonesia does not have a national HIV law, incongruity occurs between related laws. [699]

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[696] PHILIP ALSTON, RYAN GOODMAN & HENRY J. STEINER, INTERNATIONAL HUMAN RIGHTS: TEXT AND MATERIALS 1053 (2013).
[697] *Id.*
[698] *Id.*
[699] NATIONAL CONSULTATION ON LEGAL AND POLICY BARRIERS TO HIV IN INDONESIA, *supra* note 2.

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At the local level, HIV laws are the product of legal processes the legislature, the executive, and other actors. The contents of these laws are derived from the National AIDS Strategies and also from the ministries. This fact justifies helps to observe the national internalization of global norms more closely, including in examining possible legal barriers.

Based on these historical findings, this study finds that HIV legal norms exist across the global, national, and local levels. Hence, the use of the transnational legal process is justifiable. Moreover, the intense focus on local laws also renders a follow-up analysis that will help find out whether the legal barrier is a factor in global norm internalization.

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4. Tracing and Prospecting Transnational Legal Process

4.1. Introduction

As the title suggests, this chapter analyzes the findings from the previous chapter in order to reach an answer to whether the perpetuation of legal barriers to HIV prevention is evidence of a deficient Indonesian national internalization of global health jurisprudence. This chapter finds that the determination of criminalization as a legal barrier proves the unsuccessful internalization of global health jurisprudence, specifically on HIV.

The chapter portrays two variables: (1) Indonesian legal barriers to HIV prevention; and (2) Indonesian internalization of global health jurisprudence. First, the chapter characterizes the global emergence of HIV norms. Subsequently, the chapter juxtaposes such process with the national internalization process. Next, the chapter traces the norms in a “bottom to top” approach to see the national internalization at a normative level. The norm-tracing begins with the local HIV laws and continues to the global-level laws. This process shows the contrast between the mainstream HIV norms and the insular ones.

The analysis finds that criminalization is a separate policy. Using Gostin and Mann’s test, it is also confirmed that criminalization is an undesirable policy in the HIV program. Lastly, the analysis includes the dynamic between actors to explore the flaws of HIV legal process analysis. The analysis establishes the relationship between the two variables. It shows that disconnections between actors during the legal process lead to the generation of legal barriers.

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4.2. The Global Market of HIV Norms

This chapter revisits the stages of Koh's transnational legal process and subsequently applies the stages to HIV norms. Koh's transnational legal process involves six stages: (1) Norm emergence via norm entrepreneurs; (2) The enlistment of governmental norm sponsors; (3) The formation of epistemic communities; (4) The staging of interpretive communities and law-declaring fora; (5) The formation of bureaucratic compliance procedures; and (6) The existence of issue linkages.[700]

According to Koh, the transnational legal process results in three forms of internalizations: (1) Executive internalization through executive actions; (2) Legislative internalization, which "occurs when international law norms become embedded into binding domestic legislation"; and (3) Judicial internalization, which "occurs when litigation in domestic courts provokes judicial incorporation of international law norms into domestic law, statutes, or constitutional norms."[701] Identification of these forms in the Indonesian HIV context would help characterize the relationship between the two variables in question: The perpetuated legal barrier and national internalization of global HIV norms.

The first characteristic of a norm entrepreneur is that they act to drive public sentiment and political support both within their host land and elsewhere.[702] Second, these entrepreneurs excite like-minded groups in other countries.[703] Third, they have an essential function in taking

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[700] Koh, *supra* note 61 at 646.
[701] *Id.* at 643.
[702] Nadelmann, *supra* note 65 at 482.
[703] *Id.*

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purposes that exceed their association with the state interest of their government.[704] Lastly, they focus their endeavors on external audiences, "promoting universal moral sense."[705]

Before discussing the context of HIV prevention in Indonesia, it must be noted that the notion of HIV norm entrepreneurs shares its history with the development of HIV prevention norms in general. At the stage of global norm emergence, *issue linkages* have had catalyzed the norms. HIV is not an insular problem. In his book *Human Right to Health*, Jonathan Wolff observes that the development of the HIV narrative has been instrumental in boldening global health norms.[706] Since the beginning of the pandemic in 1981, HIV was out of the spotlight until Nelson Mandela said in 2003 that "AIDS is no longer a disease, it is a human rights issue."[707] Events like World AIDS Day and regular conferences served to build momentum and offered individuals with various backgrounds and expertise opportunities to meet.

Like other diseases, HIV/AIDS was first responded to as a health issue, and therefore its individual and population health norms have continuously been emerging throughout the timeline of HIV.[708] In November 1983, the WHO held its first meeting on AIDS and came up with a global surveillance initiative.[709] Surveillance reports among developed countries that shared a similar pattern of AIDS distribution were the basis of that meeting. The meeting then called for global collaboration to gather a better understanding of the disease.[710] The WHO called for coordinated and accelerated control efforts to address the disease. These efforts had to

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704 *Id.*
705 *Id.*
706 JONATHAN WOLFF, THE HUMAN RIGHT TO HEALTH 39 (2012).
707 *Id.* at 40.
708 CURRENT TRENDS UPDATE ON ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)—UNITED STATES 507 (1982). This the report where the term "AIDS" was used for the first time.
709 ACQUIRED IMMUNODEFICIENCY SYNDROME—AN ASSESSMENT OF THE PRESENT SITUATION IN THE WORLD: MEMORANDUM FROM A WHO MEETING (1984).
710 *Id.*

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continue through collaborative laboratory as well as epidemiological and clinical research between countries.[711] Ever since, the WHO, together with epidemiologists, clinical researchers, has been an influential norm entrepreneur.

Countries were likely to implement their existing public health measures first. When they responded to AIDS as an infectious disease, they were looking to measures such as

(1) Isolation;
(2) A requirement to disclose HIV status to sexual partners;
(3) Forced treatment;
(4) Restrictions on who could enter the country or donate blood or breastmilk;
(5) Forced screening of risk groups (including pregnant women, prostitutes and their clients, prisoners, medical personnel, or even the whole population);
(6) Contact tracing; registration and notification of change of address;
(7) Restrictions on marriage;
(8) Criminalization of, or assigning civil liability for, knowing or reckless transmission;
(9) Compulsory sterilization of HIV-positive women or abortion;
(10) Exclusion of children from school; and
(11) Special regulations about the disposal of bodies after death.[712]

However, the association of AIDS with a specific group of patients escalated the attention to areas beyond health. During the first appearance of AIDS, people called it GRID: Gay-Related Immune Deficiency, the gay plague.[713] There has also been the association of AIDS with the 5Hs: homosexuals, heroin users, hemophiliacs, Haitians, and hookers.[714] This association drags

[711] *Id.*
[712] WOLFF, *supra* note 706 at 46.
[713] *Id.* at 42.
[714] *Id.* at 42; Robert C. Gallo, *A Reflection on HIV/AIDS Research after 25 Years*, 3 RETROVIROLOGY 72 (2006); PETER BALDWIN, DISEASE AND DEMOCRACY: THE INDUSTRIALIZED WORLD FACES AIDS 27 (1. paperback print ed. 2006).

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moralism into the realm of HIV, where the media start to raise a dichotomy about who the innocents and who the bad guys are.[715]

Subsequently, the world tested the implementation of the "normal" public health measures above. In West Australia, they made it a crime "for a seropositive to board a public bus without notifying the driver."[716] The European Court of Human Rights (ECHR) decided that Sweden violated the human right of an HIV-positive man when putting him in forced isolation.[717] In the United States, reproduction and abortion policies were remarkably delicate because drug users and partners to addicts were disproportionately black and Hispanic—groups that historically languished under sterilization, eugenics policies, and discrimination.[718]

Peter Piot notes that civil society plays a significant part in creating balance by driving advocacy activities.[719] History records that post–Stonewall Riot gay rights campaigns started the movement. The movement included groups such as the "Gay Men's Health Crisis and San Francisco AIDS Foundation; the Terence Higgins Trust; AIDES, founded by Daniel Defert, the partner of philosopher Michel Foucault who had died of AIDS in 1984."

The entrepreneurship of AIDS civil society has brought new offerings to HIV norm-making, as stipulated in a 1983 statement known as the Denver Principles:

THE DENVER PRINCIPLES

> We condemn attempts to label us as "victims," a term which implies defeat, and we are only occasionally "patients," a term which implies passivity, helplessness, and dependence upon the care of others. We are "People With AIDS."

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[715] WOLFF, *supra* note 706 at 43.
[716] BALDWIN, *supra* note 714 at 53.
[717] Enhorn v. Sweden, App. No. 56529/00, 7 Eur. Ct. H.R. (2005).
[718] WOLFF, *supra* note 706 at 47; BALDWIN, *supra* note 714 at 96.
[719] REALIZING THE RIGHT TO HEALTH, 333 (Andrew Clapham ed., 2009).

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Recommendations for All People

1. Support and membership in our struggle against those who would fire us from our jobs, evict us from our homes, refuse to touch us or separate us from our loved ones, our community or our peers, since available evidence does not support the view that AIDS can be spread by casual, social contact.
2. Not scapegoat people with AIDS, blame us for the epidemic or generalize about our lifestyles.

Recommendations for People with AIDS

1. Form caucuses to choose their own representatives, to deal with the media, to choose their own agenda and to plan their own strategies.
2. Be involved at every level of decision-making and specifically serve on the board of directors of provider organizations.
3. Be included in all AIDS forums with equal credibility [to] other participants, to share their own experiences and knowledge.
4. Substitute low-risk sexual behaviors for those which could endanger themselves or their partners; we feel that people with AIDS have an ethical responsibility to inform their potential partners of their health status.

Rights of People with AIDS

To live as full and satisfying sexual and emotional lives as anyone else.
To receive quality medical treatment and quality social service provision without discrimination of any form, including sexual orientation, gender, diagnosis, economic status or race.
To obtain full explanations of all medical procedures and risks, to choose or refuse their treatment modalities, to refuse to participate in research without jeopardizing their treatment and to make informed decisions about their lives.
To ensure privacy and confidentiality of medical records, to receive human respect and the right to choose who their significant others are.
To die—and to LIVE—in dignity.[720]

The Denver Principles provided the basis of the Paris AIDS Summit 1994, where forty-two countries agreed on the Greater Involvement of People Living with HIV/AIDS (GIPA) Principles. The summit called for the creation of supportive political, legal, and social

[720] Advisory Committee of People with AIDS, *Denver Principles* (1983).

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environments for people living with HIV/AIDS.[721] Post-1994, the idea that HIV was more than a medical issue strengthened, especially after the creation of UNAIDS:

> The range of entry points to engage in order to prevent the transmission of HIV, as well as the range of impacts in highly affected countries, illustrated that AIDS was more than a health issue—being effective meant tackling the epidemic through health, education, employment, social security, law and law enforcement, public administration and finance. This complexity was in part the motivation for the creation of the Joint United Nations Programme on HIV/AIDS—UNAIDS—in 1996.[722]

Over time, the norms found political and legal stages with broader endorsers like the 2001 Declaration of Commitment on AIDS, agreed upon by 186 countries, as well as the 2006 High-Level Meeting on AIDS, attended by 192 country representatives. This development shows that civil society in the early days of HIV met all of Nadelmann's criteria for norm entrepreneurs. They were able to move ideas, stimulate the development of comparable groups abroad, affect external audiences, and bring human rights as a universal value over a single moral subset of one society.[723]

Looking at this historical development, international policy norms of HIV have evolved, too, into global legal norms. The converging development of HIV and human rights has brought international human rights law into a prominent position. The *Enhorn* case before the European Court of Human Rights proves that human rights law interpretation on HIV works. The revisiting of this pre-UNGASS 2001 history of HIV norm emergence sets the ideals for the desired HIV response by norm entrepreneurs throughout history.

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[721] UNAIDS, *Policy Brief: The Greater Involvement of People Living with HIV/AIDS* (2007).
[722] REALIZING THE RIGHT TO HEALTH, *supra* note 719 at 335.
[723] Nadelmann, *supra* note 65 at 482.

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In the transnational legal process, interpretation happens to describe how the internal processes internalize a norm produced by an interaction. This normative bridge involves the existing route of reasoning. In this area, the interpretation involves international human rights law, which serves as a body of law with the capacity to generate legal obligations at the domestic level.[724]

Given the vast array of global norm-making interactions, it is helpful to see how these norms become law and thus can be framed as an aggregated global health jurisprudence. Hammonds et al. use the transnational legal process to see how norms created by global institutions' interactions interpret norms as binding laws.[725] In their study, global norms have been interpreted as binding laws by nation-states through human rights interpretation.[726] In the case of Indonesia, the analysis starts with its obligations towards the right to health as mandated by the International Covenant on Economic Social and Cultural Rights (ICESCR). The Office of the United Nations High Commissioner for Human Rights states that:

> Article 2 (1) of the ICESCR requires States "to take steps" to the maximum of their available resources to achieve progressively the full realization of economic, social and cultural rights. The reference to "resource availability" reflects a recognition that the realization of these rights can be hampered by a lack of resources and can be achieved only over a period of time. Equally, it means that a State's compliance with its obligation to take appropriate measures is assessed in the light of the resources—financial and others—available to it.[727]

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[724] REALIZING THE RIGHT TO HEALTH, *supra* note 719.
[725] Rachel Hammonds, Gorik Ooms & Wouter Vandenhole, *Under the (legal) radar screen: global health initiatives and international human rights obligations*, 12 BMC Int. Health. Hum. Rights 31 (2012).
[726] *Id.*
[727] OHCHR, *What Are the Obligations of States on Economic, Social and Cultural Rights?* http://www.ohchr.org/EN/Issues/ESCR/Pages/WhataretheobligationsofStatesonESCR.aspx (last visited Apr 1, 2018).

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In addressing domestic HIV constraints, each nation-state can see that "financial and other resources" are widely available through the proliferation of non-state actors. As can be seen in Table 2, Indonesia can "take steps" by entering into contracts with the GFATM as an "appropriate measure" to address its lack of resources. Furthermore, by receiving grants from the GFATM, Indonesia has increased its available resources. This means that Indonesia has increased its obligations surrounding the right to health.

Regarding the right to health as a part of economic, social, and cultural rights, once a state has ratified the International Covenant on Economic, Social, and Cultural Rights (ICESCR), it is bound by the obligations therein. Member states are the authoritative institutions to implement programs and legislation within their jurisdictions in line with human rights obligations. The critical points of the obligations are to take steps, by all appropriate means, particularly the adoption of legislative measures, to achieve the full realization of the rights progressively, using the maximum of its available resources, without discrimination, through international assistance and cooperation.[728]

Article 12 of the International Covenant on Economic Social and Cultural Rights mandates that all signatory states recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. As for the health system operations, General Comments 14 of the United Nations Committee on Economic, Social, and Cultural Rights interprets the provisions in further detail. It sets out the states' obligations to ensure the availability, accessibility, acceptability, and quality of health facilities, goods, and services.

[728] International Covenant on Economic, Social and Cultural Rights, *supra* note 155.

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When domestic resources constrain a state in realizing the right to health, it must seek international assistance from those in a position to assist.[729] The proliferation of non-state actors in global health governance increases a state's opportunities to deal with this constraint. Based on this presupposition, a decision not to enter into a contract with the Global Fund for AIDS, Tuberculosis, and Malaria constitutes neglect of human rights obligations.

In practice, however, challenges get in the way regardless of how large the amount of money invested in HIV is. During Spiritia's supervisory meeting with a Sub-Recipient (SR) organization and a Sub Sub-Recipient (SSR) organization in Central Java province, members of the three organizations crunched their target numbers. The meeting culminated with the idea that with the GFATM funding, the remaining work lay in putting the right strategy into practice. Spiritia acknowledged that the work would not be as easy given the field situation, institutional situation, human resource capacity, and managerial performance.

One of the SR officers started the meeting by presenting the cascade of outreach-to-treatment achievement and gaps. Chart 3, in summary, shows how low the use of ART among HIV-positive men who have sex with men (MSM) in the sample regency was relative to the outreached MSM population. Compared to the estimated number of HIV-positive MSM in the sample regency, there is a significant gap from the perspective of the SR's documentation. According to the Ministry of Health's HIV/AIDS Information System (SIHA) 2012–2016, the estimated number of HIV-positive MSM is 487. This means that the SR reached 0.6% of the estimated population (3 HIV-positive MSM out of the estimated 487).

[729] Hammonds *et al.*, *supra* note 725 at 6.

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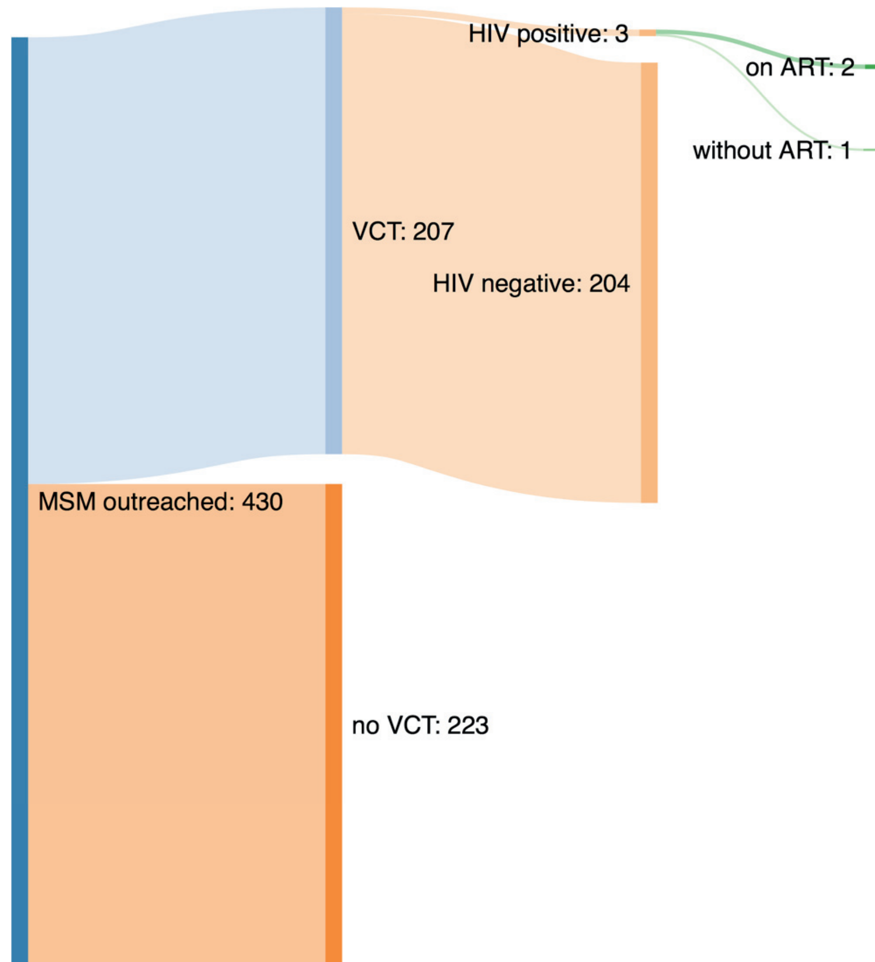
Chart 3. Treatment Reach among MSM in a Sample Regency as Assessed by SR



The current ART policy is "Test and Treat," meaning that physicians must administer ARV once a person is known to be HIV-positive, regardless of their clinical situation. With this policy, an SR could make an assessment of the treatment gap by looking at the HIV-positive rate against the estimation or their outreached population.

4.3. Norms Reverse Tracing

The law-indexing process took place in the winter and spring quarters of 2019. The indexing process was done by reading individual legal documents while actively writing down

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the categorization of each provision. This work indexes for Provincial, Regency, and City Regulations. As mentioned earlier, these types of laws present a strong association with the legal process that could be verified by other actors.

In order to have a more meticulous examination of the transnational legal process, this study seeks to trace the flow of norms during a specific period, in contrast to what Koh suggests. In order to do that, this study generates a Sankey Diagram. A Sankey Diagram, also known as River Plot, can display the flow of units among "nodes." In this study, the nodes would be the individual laws, and the units are the number of norms gathered from the indexing process.

First and foremost, this study sorts the norms contained in local HIV laws based on their frequency from highest to lowest. This procedure is the starting point of the uprooting process. Subsequently, this study selects the top five norms as the sample. This selection method allows at least 50% representation of the norm population in an index category.

Next, this study assigns higher-level legal and policy instruments that cover the selected norms from the local laws. The assignment process involves a qualitative content analysis in the documents within the whole collection of legal documents in this study. Subsequently, this study goes to the next higher level by assigning relevant norms at the global level.

Not all global norms are present before the adoption of a local law. This fact makes it impossible to assign a later global law to an earlier national law. As a solution, the process of global norm assignment focuses on institutional norm inclination instead of merely textual reading. For example, the assignment of a UNAIDS policy document will look at the overall UNAIDS perspective on and ideals for a particular area of HIV prevention. In maintaining the time logic of the diagram, this study assigns the oldest relevant global norm whenever possible.

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Table 6 below shows an example of how the multilevel assignment works. In this example, the provisions on confidentiality and consent in local laws have the same ideas as the National AIDS Strategies and human rights law. Similarly, National AIDS Strategies and human rights law, based on the textual and contextual reading, could be linked to WHO guidelines and the international human rights law. This study labels such linkages as "coherence."

The "Coherence" column shows the percentage of local laws that contain each of the norms in the "Norms" column. Table 6 shows the top five most coherent norms provided by local laws and their "higher" laws. The population of Table 6 is the existing seventy-one HIV-specific local laws across the country. From the table, we can see that voluntary HIV testing and counseling (VCT) is the norm that has the most substantial coherence, as sixty out of seventy-one local laws (84.51%) in Indonesia have at least one VCT provision. Furthermore, these VCT provisions are traceable to multiple National AIDS Strategies, which are derived from the WHO Guidelines.

In this single example, this study infers that confidentiality and consent provisions in local laws adhere to or are derived from national laws and global norms. The Sankey Diagram is intended to see the aggregate model of this approach. By doing so, this study reveals some anomalies that could deserve attention. For example, due to Indonesia's hierarchical legal system, it is typically assumed that local norms shall never be contradictory to national norms. However, this study discovers that there are abundant contradictions that may exist beyond the knowledge of lawmakers themselves.

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Table 6. Linking the Norms

n=71 local HIV laws

Norms	Coherence	National Laws	Global Laws or Policies
VCT	84.51%	1998 Health Ministerial Regulation on Medical Consent	WHO Guidelines
Confidentiality and consent	81.69%	National AIDS Strategies, 1999 Human Rights Law, 2009 Health Law	WHO Guidelines, International Human Rights Law
Family counseling	69.01%	Health Ministerial Regulation, National AIDS Strategies	WHO Guidelines (Treatment as Prevention)
VCT on vertical transmission	66.20%	Health Ministerial Regulations	WHO Guidelines
Consent by PLHIV for partner notification	63.38%	Health Ministerial Regulations	WHO Guidelines, International Human Rights Law
Blood donation by PLHIV is a crime	0%	N/A	N/A
Organs/tissue donation by PLHIV is a crime	0%	N/A	N/A
Breach of confidentiality is a crime	0%	N/A	N/A
Sperm donation by PLHIV is a crime	0%	N/A	N/A
Failure to prevent HIV by PLHIV is a crime	54.93%	Penal Code	N/A

One of the main discoveries of this study is the considerable amount and variation of criminalization that exist in the data population. The data show, as in Table 7, that the Criminalization category accounts for 22.85% of policy provisions (830 out of 3,633).

Because of its strong presence, it is intellectually worth drilling down on the topic of criminalization in the Sankey Diagram. This study will discuss this particular topic in the subsequent section.

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Table 7. Categories

No.	Categories	# of provisions	Percentage
1	Criminalization	830	22.85%
2	Prevention	462	12.72%
3	Obligations & Prohibitions of PLHAs	367	10.10%
4	Care, Support, and Treatment	344	9.47%
5	HIV Testing, Confidentiality	338	9.30%
6	Obligations & Prohibitions of Other Groups	275	7.57%
7	Governance and Funding	261	7.18%
8	Screening	239	6.58%
9	Obligations & Prohibitions in General	222	6.11%
10	Surveillance and Reporting	193	5.31%
12	Non–Health Sector	102	2.81%
	Total Indexed Provisions	**3,633**	100.00%

This study uses the top five norms from each category to build the Sankey Diagram using the SankeyMatic (BETA) application. The total number of provisions of this sample shall be the total number of units distributed according to the links (assignments) from the previous process. Based on the established links, the application generates the Sankey Diagram. A higher resolution of the Sankey Diagram is available on HIVLaw.ID. The nodes on the left-hand side are the “source” nodes, and the right-hand nodes are the “target” nodes.

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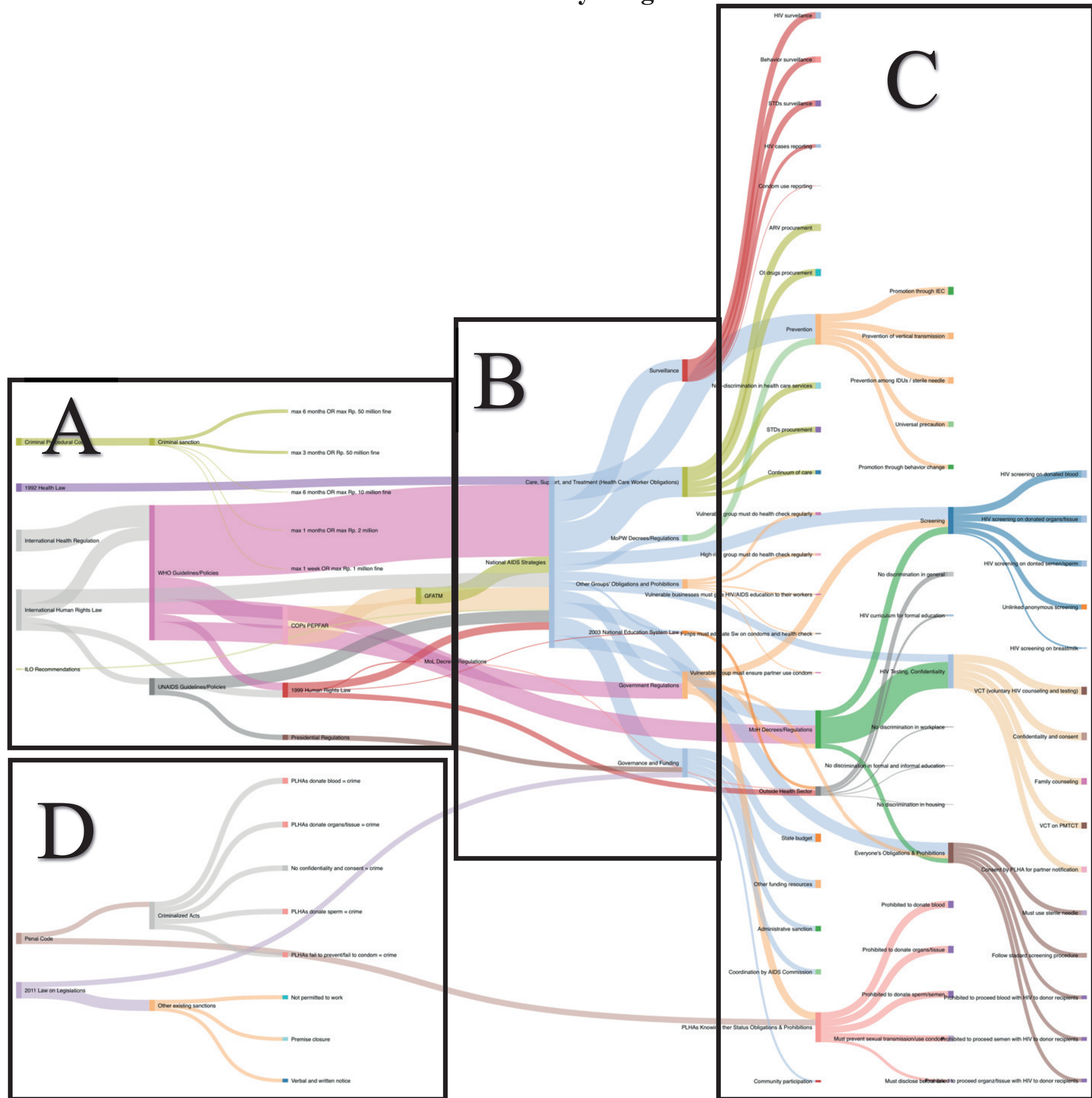
Chart 4. Sankey Diagram



The colored ribbons represent the links assigned between two nodes. The thickness of the ribbons represents the number of norms involved in that particular link. The rightmost nodes are

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the local laws, representing the end-target of the flow of norms. The chart could be divided into four different zones as the rectangles indicates. The following table is the list of names of each node based on their respective zones:

Table 8. Sankey Diagram Nodes and Zones

A **Global norms**	B **National laws**	C **Local provisions**	D **Insular local provisions**
International Health Regulations; International human rights law; ILO Recommendation; WHO Guidelines; UNAIDS Guidelines; PEPFAR; GFATM	National AIDS Strategies; 1999 Human Rights Law; Health Ministerial Laws; 2003 National Education System Laws; Presidential Regulations; Labor Ministerial Laws; Government Regulations; National NGOs; People's Welfare Ministerial Laws.	Surveillance: HIV surveillance; behavior surveillance; STD surveillance; condom use reporting. Care, Support, and Treatment: ARV procurement; opportunistic infection treatment; non-discrimination in health care services; STD treatment; continuum of care. Prevention: education; vertical transmission prevention; sterile needle; universal precaution; behavior change. HIV Screening: donated blood; donated organs/tissues; donated sperm/semen; donated breastmilk; unlinked anonymous. HIV Testing: confidentiality; VCT; family counseling; VCT to prevent vertical transmission; partner notification consent.	Criminalized acts: blood donation; semen/sperm donation; breach of confidentiality. Penalties: not permitted to work; premise disclosure; verbal and written notice; prison; fines.

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		Governance: state budget; other funding resources; administrative sanctions; coordination by the NAC. Everyone's obligation: use sterile needle; screening procedure; blood mobilization procedure; disclosure prior donations. Prohibitions: regular health check; employers must educate their employees; pimps have to give their employees access to health care; ensue condom use. Obligations of PLHIV: prohibited to donate blood; semen/sperm; organs/tissue; must use condoms/prevent HIV; must disclose before married.	

While some nodes are located in the same zone, they also connected to each other. For example, many Ministry of Health's laws are rooted from the National AIDS Strategy. Looking at the grand structure, the Sankey Diagram shows the reader that there is also a massive association between Indonesian National AIDS Strategies and the WHO's policies. This thick pink ribbon between Zone A and Zone B represents the strong association between the pink node (WHO) and the National AIDS Commission (light blue node in the middle). Next, a reader can observe that the National AIDS Commission distributes the norms into various categories.

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Based on the interview with Respondent 2, the director of Spiritia Foundation, this study found that the interaction of local actors in global forums is also a determinant of global-to-local transfer of norms.

> First of all, we need to understand that our advocacy goal is to ensure that the influx of foreign funding is sustainable, like the GFATM. In this kind of work, the voice of the community is considerably significant. Spiritia is a member of APCASO's Council of Representatives (Board Member). Spiritia is also a member of the GFATM Advocate Network. It is a body of civil society doing an advocacy work to push GFATM donors to keep funding the GFATM or increase their contribution. At the same time, we are also advocating domestic government to increase their domestic share. Countries could decide what intervention they want to take, but the GFATM strongly encourages countries to take innovative approaches proven successful in many places.[730]

This interview passage is a piece of evidence that local actors' *interaction* with global norm-making processes could alter the *interpretation* level beyond the adjudicative dimension. Influencing public health funding through the global route is a strong example of the non-adjudicative transnational legal process. The increase of state-level financial capability by the influx of the GFATM money presents an increase in human rights obligations under the ICESCR mandate's interpretation. Countries make laws as the legal basis for turning the money into programmatic results. Hence, the adoption of local HIV laws to enable this goal could be considered as a legislative process to ensure this conversion. Therefore, the success/failure of this legislative process indicates the success/failure of the national internalization process.

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[730] Interview Respondent 2, *Interview on HIV and the Law in Indonesia* (2018).

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The strong presence of global HIV norms in Indonesian HIV programming also represents Martha Finnemore and Kathryn Sikkink's definition of *internalization*.[731] Their definition is comparable to Koh's, whereas Finnemore and Sikkink explicitly mention that internalization involves a norm cascade when norms become widely accepted by actors to the point of automatic conformance.[732] They suggest that networks of norm entrepreneurs and international organizations play the roles of social campaigners, including in pressing for the adoption of new policies, laws, ratifications, and international standards compliance.[733] The strong presence of international actors among local actors in Indonesia is evidence of this notion of internalization, where the Sankey Diagram resembles the norm cascade.

4.4. Probing HIV Criminalization as a Legal Barrier

The diagram also reveals the abovementioned anomaly of criminalization. Criminalization in this legal environment seems to be an insular system, isolated from the mainstream HIV norms. The Sankey diagram indicates that HIV criminalization does not have any association with WHO guidelines or the underlying international human rights law. HIV criminalization in this environment starts by itself from the Penal Code.

This study did not find any criminal cases resulted from these laws; however, based on the interview with Respondent 1, a legal aid institute coordinator, the criminalization itself presents an active threat in the long run.

> Definitely, because we still have the threat. Is it an immediate threat? Perhaps not, but the threat is in place. It shows the lack of awareness among

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[731] Martha Finnemore & Kathryn Sikkink, *International Norm Dynamics and Political Change*, 52 INT'L ORG. 887–917 (1998); DAVID S. WEISSBRODT, JOAN FITZPATRICK, & FRANK C. NEWMAN, INTERNATIONAL HUMAN RIGHTS: LAW, POLICY, AND PROCESS 1029 (3d ed. 2001).
[732] Finnemore and Sikkink, *supra* note 731; WEISSBRODT *ET AL.*, *supra* note 731 at 1029.
[733] WEISSBRODT *ET AL.*, *supra* note 731 at 1029.

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> lawmakers. What kind of HIV response [do] we expect if the lawmakers and officials do not have the required understanding about the epidemic? So, while the threat is not immediate, we still have the threat.[734]

Respondent 1 worried that without an adequate understanding, policy makers will make inaccurate HIV programs and thus neglecting the human right to health.

The most legislated HIV crime is when an HIV-positive person who knows their status donates blood. Fifty-one local laws have legislated this crime. While a safe blood donation system is one of the HIV prevention mandates, both the National AIDS Commission and WHO guidelines do not sanction such criminalization. The closest law is the Indonesian Penal Code. In Article 351 (4), the Penal Code says that "[blood donation] with maltreatment shall be identified as intentional injury to the health." As a comparison, transmitting HIV has been included as maltreatment in other jurisdictions. Violation of this article attracts a maximum of five years' imprisonment. The top five HIV-related crimes involve the attachment of criminal liability to people living with HIV.

[734] Interview Respondent 1, *supra* note 524.

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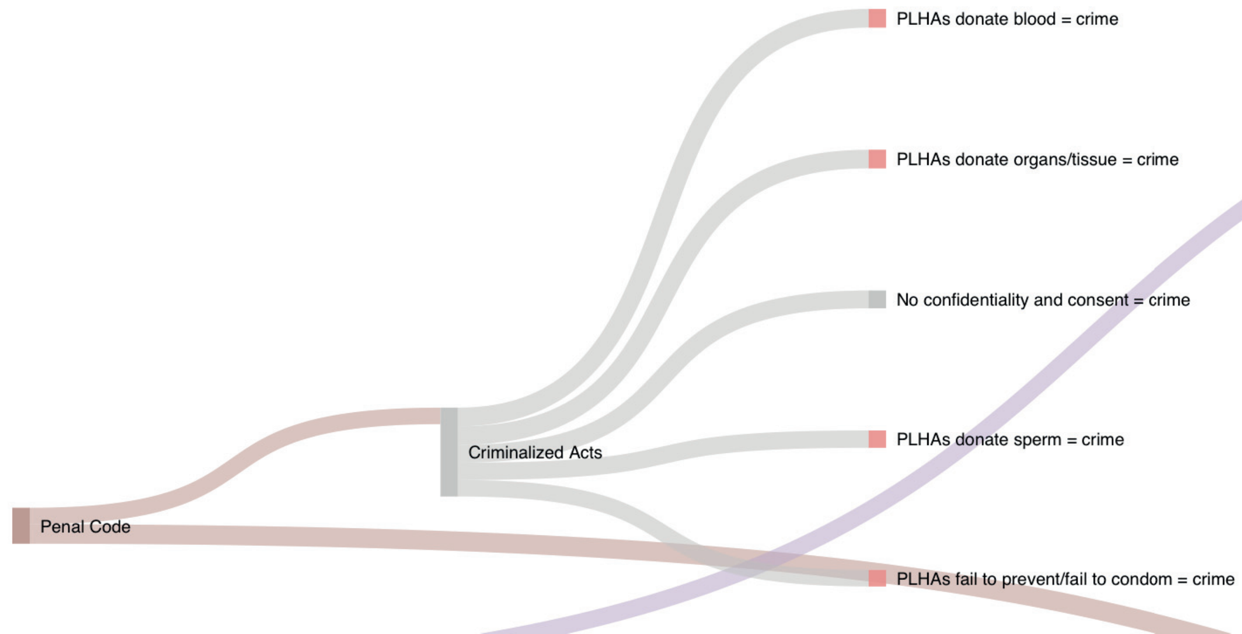
Chart 5. Top Five HIV-Related Crimes



If we look at the Sankey Chart on the insular position of criminalization (Zone D on Table 8), this study asserts that mainstream HIV norms never transferred the norm of using criminal law to reduce HIV transmission. Global discussion on criminalization has been nearly unanimous that there is no compelling evidence that putting people in jail will ever reduce the number of HIV transmissions. The significant number of criminalizations within the body of the "supportive" laws provides evidence that the internalization of the transnational legal process has been partial.

In the area of transnational criminal law, the interpretation of the 1961 Single Convention has been more straightforward. Lindsey and Nicholson find that the adoption of the Narcotics Law 2009 has been a direct effort to meet the Convention's obligations.[735] Moreover, ASEAN includes narcotics in the list of transnational organized crimes deemed as a collective enemy.

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[735] TIM LINDSEY & PIP NICHOLSON, DRUGS LAW AND LEGAL PRACTICE IN SOUTHEAST ASIA: INDONESIA, SINGAPORE AND VIETNAM 37 (2016).

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Various ASEAN ministerial-level meetings in 1997, 1998, and 2000 to strengthen the collaborative response against transnational organized crime have shown the prominence of the regional framework as the mechanism of interpretation.[736]

Given the strong presence of criminalization, this study needs to determine whether it imposes a legal barrier. To determine this position, Gostin and Mann provide an objective assessment tool to evaluate the human rights impact of public health policy.[737] At this point of internalization, the study has established the human rights law interpretation of global HIV norms. The following section tests whether criminalization in local HIV laws is a barrier. Gostin and Mann suggest seven steps to consider:

(1) Clarify the public health purpose;
(2) Evaluate likely policy effectiveness;
(3) Determine whether the public health policy is well targeted;
(4) Examine possible human rights burdens;
(5) Determine whether the policy is the least restrictive alternative that can achieve the public health objective;
(6) If a coercive public health measure is truly the most effective, least restrictive alternative, base it on the significant-risk standard; and

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[736] *Id.* at 38. Indonesia, Vietnam, and Singapore have similar laws on narcotics mirroring the 1961 Single Convention.
[737] Lawrence O. Gostin & Jonathan M. Mann, *Toward the Development of a Human Rights Impact Assessment for the Formulation and Evaluation of Public Health Policies*, *in* HEALTH AND HUMAN RIGHTS: A READER, 54 (Jonathan M. Mann *et al*. eds., 1999).

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(7) If a coercive measure is truly necessary to avert a significant risk, guarantee fair procedures to persons affected.[738]

By following the steps mentioned above, this dissertation could not find a compelling reason that criminalization was helpful to prevent HIV in Indonesia. Elaboration of each step accumulated to the conclusion that criminalization acts as a legal barrier.

Public Health Purpose of Criminalization

There are many guiding principles provided by UNAIDS regarding the use of a punitive approach in domestic laws.[739] The document stipulates that "preventing the transmission of HIV should be the primary objective, and this, rather than any objective, should guide policy-makers in this area."[740] The document requires policymakers, in considering the path of criminalization, to assess whether the function of criminal law would contribute to the objective of preventing HIV transmission.[741] With these principles, UNAIDS does not sanction the use of criminalization to prevent HIV. Instead, it warns domestic legislators to be careful in using a punitive approach.

This study considers three of the most criminalized acts as representing criminalization policy: (1) Prohibition of HIV-positive people donating blood; (2) Prohibition of everyone from discriminating against HIV-positive people in healthcare settings; and (3) Requiring HIV-positive people to prevent sexual transmission of HIV.

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[738] *Id.* at 55–68.
[739] UNAIDS, Criminal Law, Public Health and HIV Transmission: A Policy Options Paper 5 (2002).
[740] *Id.*
[741] *Id.*

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At the national level, the creation of local HIV laws has been mandated by the National AIDS Strategies as a tool to sustain national HIV prevention programs.[742] Nonetheless, the objectives of individual crimes do not appear anywhere. The "nearest" objective statement appears at the beginning of each local HIV law using the different but similar meaning of "to prevent HIV transmission." One could interpret that this objective applies to all provisions in that law, including the criminal provisions. At this point, it appears that the legislators believe that the placing of criminal sanctions on the three criminalized acts is a form of contribution to the public health goal of HIV prevention.

Evaluate Criminalization Policies' Likely Effectiveness

This second inquiry is to test to what extent a particular policy is potentially effective in achieving its purpose. In this regard, this inquiry questions to what extent criminalization could be useful in preventing HIV in Indonesia.

The first inquiry suggests that criminalization in our sample is a way to support a broader public health policy: HIV prevention. Therefore, the effectiveness should be tested in a more limited sense by categorizing the acts as regulatory offenses. However, it is also likely that such

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[742] Rencana Aksi Nasional Penanggulangan HIV dan AIDS di Indonesia 2003–2007 (En. National Action Plan for HIV and AIDS Response in Indonesia 2003–2007), *supra* note 530 at 16; Rencana Aksi Nasional Penanggulangan HIV dan AIDS di Indonesia 2007–2010 (En. National Action Plan for HIV and AIDS Response in Indonesia 2007–2010) at 13 & 39 (2007); Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS di Indonesia Tahun 2010–2014 (En. National Action Plan for HIV and AIDS Response in Indonesia 2010–2014), *supra* note 376 at 75; Rencana Aksi Nasional Penanggulangan HIV dan AIDS di Indonesia 2015–2019 (En. National Action Plan for HIV and AIDS Response in Indonesia 2015–2019) at 65 & 99 (2015).

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criminalization increases the moral judgment.[743] Without actual effectiveness, these internal constraints would constitute overcriminalization.[744]

Gostin and Mann suggest an inquiry on whether the policy in question is likely to be effective.[745] This study's online survey asks a question about the likelihood that a person who was aware of his HIV-positive status and deliberately did not disclose his HIV status to his sexual partner would be prosecuted. More than half of respondents were pessimistic: 68% said that he had violated the law but would never be prosecuted.

The effectiveness of putting criminal sanctions on these policies could attract questions regarding the substance of the law, the structure of the law, and the culture of legal factors.[746] As Asa also finds, the three crimes are ill-formulated, were passed without considering the ability of local legal enforcers in the field of HIV, and ignore the low public participation in upholding such laws.[747] The stipulations often lack clear separation between the elements of the crime. The use of general words like "discrimination" without referring to a particular act that is presentable to the court leaves an ocean of a gap of interpretation between the court and the statutory law. Regardless, without full empowerment of legal enforcement agencies regarding HIV-related crimes, it is also unlikely that any case will go to court.

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[743] DOUGLAS N. HUSAK, OVERCRIMINALIZATION: THE LIMITS OF THE CRIMINAL LAW 103–119 (2009).
[744] *Id.* at 122.
[745] Gostin and Mann, *supra* note 737 at 56.
[746] LAWRENCE M. FRIEDMAN & GRANT M. HAYDEN, AMERICAN LAW: AN INTRODUCTION 6 (3d ed. 2017).
[747] Asa, *supra* note 254 at 148.

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Gostin and Mann encourage assessment to see if there is a better alternative to the policy in question. In line with that, UNAIDS's criminal law guideline reminds domestic legislators to "weigh other public policy factors that might mitigate against the use of criminal sanction."[748]

All the local HIV laws in this study include a special section on prevention. The prevention section includes promotion through information, education, and communication (84.51%); prevention of vertical transmission (70.42%); promotion of sterile needles (69.01%); universal precaution (57.75%); and behavior change programs (46.48%). These programs have been well funded and continuously appear in national AIDS strategies. This availability of policy alternatives also answers the inquiry to "determine whether the policy is the least restrictive alternative that can achieve the public health objective."

Determine Whether the Public Health Policy Is Well-Targeted

Gostin and Mann state that the ideal public health policy should consider the people who will benefit. Therefore, all public health policies will create "a class of people to whom the policy applies and a class to whom it does not."[749]

To run this test, Gostin and Mann suggest the use of diagrams. There are three possible verdicts: (1) Permissible under-inclusion, (2) Impermissible under-inclusion, and (3) Over-inclusion. They signal that "sound public health policies must avoid both under- and over-inclusiveness."[750] Under-inclusiveness could be permissible when a policy reaches some, but not all, the targeted population.[751] It is permissible because that indicates room for more extensive

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[748] UNAIDS, *supra* note 739 at 5.
[749] Gostin and Mann, *supra* note 737 at 57.
[750] *Id.* at 58.; Joseph Tussman & Jacobus tenBroek, *The Equal Protection of the Laws*, 37 CAL. L. REV. 341 (1949).
[751] Gostin and Mann, *supra* note 737 at 58.

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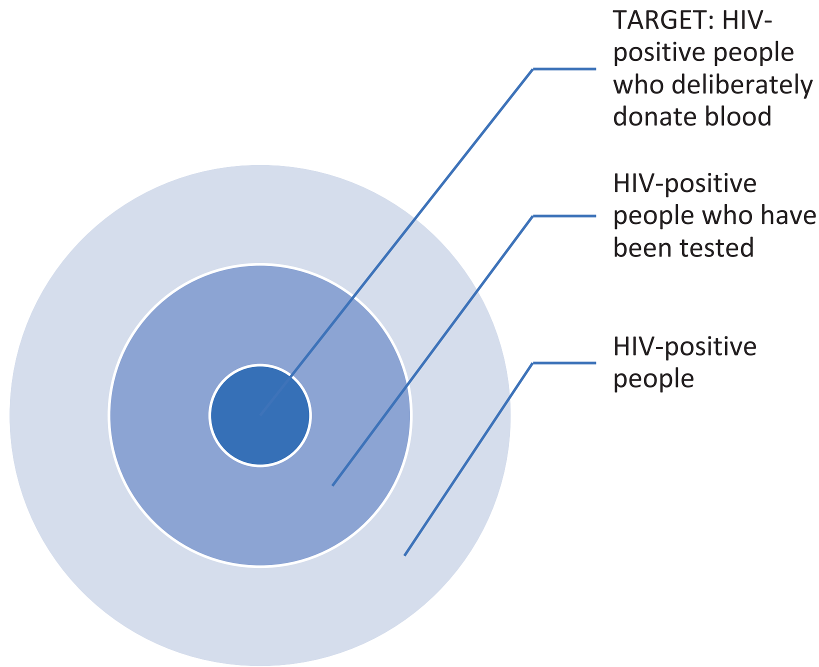
mobilization. Over-inclusiveness, on the other hand, "occurs when a policy extends to more people than necessary to achieve its objective."[752]

Chart 6. Policy: Punish HIV-positive People Who Donate Blood



Preventing HIV-positive people from donating their blood could be a permissible under-inclusion. Typically, it is not the only policy set at a provincial or national scale for HIV prevention. Nonetheless, the policy to criminalize such an act could work differently. Such criminalization disincentivizes untested HIV-positive people's getting tested.

[752] *Id.* at 60.

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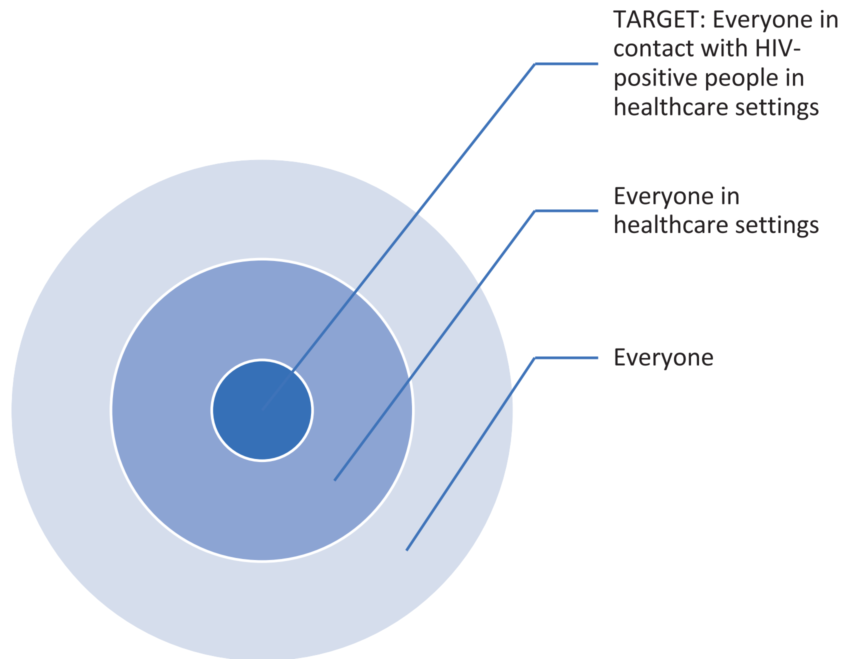
Chart 7. Policy: Punish Everyone Who Discriminates against HIV-positive People in Healthcare Settings



As an effort to eliminate discrimination against PLHIV, this policy might look like impermissible underinclusion. It would be impermissible because discrimination also occurs in settings other than healthcare. However, putting a criminal sanction on this act could turn the situation into overinclusion. First, without addressing the cause of discrimination, removing individuals from their posts would cost the whole healthcare system on human resources. When a "criminal" goes to prosecution, someone else will need to replace him or her. This replacement process, if the enforcement is working at all, will jeopardize the quality of service for everyone.

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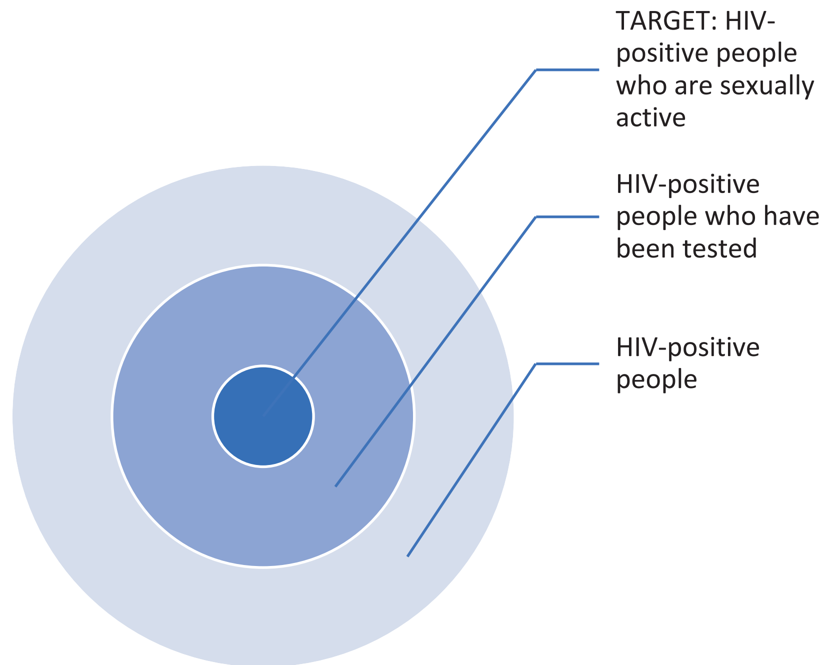
Chart 8. Policy: Punish HIV-positive People Who Fail to Prevent Sexual Transmission of HIV



This policy could be problematic in another way. The burden of proof to uphold a guilty decision in cases like this is very high. Since these cases are unlikely to reach the court, it is safe to say that this policy is impermissibly underinclusive. What will happen, according to the survey, is that putting a criminal sanction on this act will disincentivize unaware HIV-positive people from getting tested. That means that HIV-positive people who are unaware of their own HIV status—who account for the majority of HIV-positive people—will unknowingly infect others. It is the burden of silence that prevents people from accessing the available ART.

Examine Each Policy for Possible Human Rights Burdens

The survey asked about how the criminalization policy whereby "HIV-positive people must prevent sexual transmission of HIV" impacted their decision to get an HIV test. The survey

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reports that 34.5% would cancel their test out of fear of punishment, 27.3% would proceed with the test because they believed they would comply, and 32.7% would proceed with the test because they thought enforcement was unlikely. This report suggests that there is a significant likeliness that people will be reluctant to get tested. This is an apparent contradiction of all HIV response norms, which posit that more people need to get tested, educated, and treated. In other words, the likeliness that criminalization will deter people from taking HIV tests is the potential human rights burden of the law.

Concerning the policy that "HIV-positive people are prohibited from donating blood," there are two possibilities. First, the policy will mean nothing in practice because, due to fear of punishment, people will not be taking HIV tests in the first place. Second, people will keep donating their blood unaware of their HIV status, hence creating a higher blood management burden. That second possibility means that the policy will not contribute anything to preventing HIV. Instead, it could worsen the spread of HIV if blood supply security is not guaranteed.

The policy that "everyone is prohibited from discriminating against HIV-positive people in healthcare settings" has a slightly different elaboration. This policy is not targeted at PLHIV specifically. Instead, it tries to protect PLHIV from possible discrimination by everyone in healthcare settings. Nonetheless, the success of this policy depends on the assessment of whether there is a promise of successful enforcement.

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The Significant-Risk Standard

This inquiry questions the individual determination of whether a person poses a significant risk to the public.[753] Gostin and Mann provide six factors applicable to infectious diseases, including HIV/AIDS:

> (1) Nature of risk (i.e., mode of transmission);
> (2) Probability of the risk (i.e., how likely it is that the transmission will occur);
> (3) Severity of harm (i.e., the harm to the person if the infection were transmitted);
> (4) Duration of the risk (i.e., the length of time the person is infectious);
> (5) The risk to the public must be probable (i.e. not merely speculative or remote); and
> (6) The harm must be substantial (i.e., great severity and high probability).[754]

By considering these factors, public health policies can address the problem accurately. Gostin and Mann warn that these factors must be assessed at the individual level and not to determine the risk of a class of people.[755] This significant-risk test requires scientifically strengthened knowledge. Since epidemiology and medical research find that HIV has a limited mode of transmission, legislators must take the facts into account.

As mentioned before, preventing HIV-positive people from donating blood could be a justifiable public health policy, but attaching imprisonment to doing so might not be. Since the mode of HIV transmission involves sexual activity and sharing contaminated injection

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[753] *Id.* at 66.
[754] *Id.* at 67.
[755] *Id.* at 66. Gostin and Mann provide the example that exclusion of HIV-infected children from school based on the fear of biting, spitting, or rough play in sports activities would not meet the significant-risk test. As another example, a person could transmit HIV by biting, but the actual risk is extremely low (approaching zero). To bring criminal charges for this behavior lacks a public health justification. Potential harms of great severity (e.g., HIV infection) do not justify coercion if the probability of transmission is exceedingly low.

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equipment, the legislator must take into account whether imprisonment would intercept that mode of transmission. If reports suggest that putting HIV-positive people in prison will not stop their sexual activity or sharing injecting equipment, then there is no use in launching that policy. On the contrary, reports show that injecting drug use and unprotected sex among inmates are continually happening; therefore, such a policy could worsen the epidemic. This test is also applicable to the policy that punishes HIV-positive people who fail to prevent HIV transmission.

The policy of punishing people who discriminate against HIV-positive people in healthcare settings is not directly testable. Nonetheless, putting the "criminal" in prison may not necessarily reduce HIV transmission, let alone discrimination. In fact, the Inter-Parliamentary Union and UNAIDS explicitly suggests the ineffectiveness of HIV criminalization.

> Draconian measures that prohibit HIV-positive people from having sex, even with informed consent, are impossible to enforce and undermine public health campaigns designed to encourage people to present themselves early for counselling, testing, treatment and support. Use of preventive measures should be a full defence against charges relating to exposure without consent – either inherently, because there would be no intention to expose to infection where, for example, condoms are used, or explicitly.[756]

In 2007, the Inter-Parliamentary Union held the First Global Parliamentary Meeting on HIV/AIDS in Manila, the Philippines. They concluded that HIV criminalization must be carefully formulated. In their deliberations, they conclude that could further stigmatize persons living with HIV and places a disincentive to HIV testing.

[756] WATCHIRS, *supra* note 168 at 53.

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4.5. Locating Internalization Blind Spots

As the continuation of the analysis, this subsection analyzes the nexus between the existence of HIV criminalization and the workings of process norms established in an earlier chapter. There are at least seven process norms that have been identified from the historical review on how global HIV norms move transnationally: (1) The creation of an inter-ministerial committee; (2) The creation of a parliamentary committee on HIV/AIDS; (3) The creation of multisectoral advisory bodies; (4) Community engagement; (5) Participatory process in lawmaking, reform, and review; (6) Identification of the domestic and international basis for human rights claims through public and private litigation; and (7) Identification of prospective international law-declaring fora to influence domestic legal process. This subsection focuses on the first five process norms. The remaining two are examined in the following subsection.

The first one is regarding the process norm of "the creation of an inter-ministerial committee on HIV/AIDS." It is clear that historically, Indonesia has created a National AIDS Commission based on a presidential decree in 1994. The National AIDS Commission comprises different ministries: Coordinating Minister of People's Welfare, Minister of State for Health, Minister of Religious Affairs, Minister of Social Affairs, Minister of Civil Affairs, Minister of Citizenship/Head of Family Planning Coordinating Body, Minister of Interior, Minister of Justice Affairs, Minister of Information, Minister of Tourism, Minister of Education, Minister of State for Women's Role.[757]

Since its first inception, the commission has been designed to be working in the Indonesian decentralized political and administrative landscape. Article 7 of the decree stipulates that provincial AIDS commissions shall be led by the governor of the province. With this

[757] Presidential Decree No. 36 on National AIDS Commission, *supra* note 321 at 36.

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structure, the commission was expecting strong political support, structure, and coordination throughout the country. Since 2003, until its dissolution in 2016, the commission has regularly created multi-year National AIDS Strategies and Action Plan. The national strategies have been acting as the national reference for local HIV response and laws. While the National AIDS Strategies mandate the creation of local laws, none of them have sanctioned HIV criminalization as determined in the previous sections. In fact, the National AIDS Strategies were created through strong involvement from the communities, UNAIDS, and international agencies. The National AIDS Commission itself was a GFATM Principal Recipient for the rounds of 2009, 2010, 2013, and 2016. These global actors, such as the UNAIDS, are the leading norm entrepreneurs who actively promote the limited use of criminal law to address the pandemic in many parts of the world.

With that in mind, Indonesia's AIDS response trajectory has shown that there is "the creation of an inter-ministerial committee" as a transnational process norm in place, at least until 2016. In its workings, the provincial AIDS commission has been actively involved in informing local lawmakers during the "peak season" of local HIV laws that started in 2003.

To date, no criminal cases based on criminal provisions under the seventy-one local HIV laws have been identified. Respondent 1, the Coordinator for Research and Policy Advocacy at LBH Masyarakat (Community Legal Aid Service), asserts that she is not aware of any cases where PLHIV were held criminally liable based on a local HIV law.[758] This assertion, admittedly, does not equal a total absence of rights violations. Interview Respondent 1 adds that these cases, if any, could happen beyond the radar of her Jakarta-based organization.[759]

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[758] Interview Respondent 1, *supra* note 524.
[759] *Id.*

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Regarding the "creation of a parliamentary committee on HIV/AIDS", Indonesia utilizes the existing Indonesian Forum of Parliamentarians on Population and Development (IFPPD) to address HIV issues among the legislative members.[760] In 2007, staged in the middle of the analysis timeframe, IFPPD was in cooperation with AusAID and USAID.[761] The collaborative work launched a number of advocacy workshops for new parliament members.[762] The goal was to increase the awareness among new parliament members regarding HIV-related stigmatization and discrimination.[763] They also conducted legal reviews on HIV-related laws including the 1984 Outbreak Law, the 1997 Psychotropic Law, 1997 Narcotics Law, and the 1992 Health Law.[764] At that time, IFPPD concluded that the law "are no longer sufficient" to address HIV.[765] It suggested an amendment to the Outbreak Law, however, the amendment has yet to happen until now. It also suggested that the new Health Law shall cover HIV challenges. While the current 2009 Health Law has included general provisions on infectious diseases, most of HIV-specific provisions are regulated by agency laws under the Ministry of Health. In the report, USAID observers also recognizes the need for a determination on which national laws that would be the basis for local laws.[766] It suggests that "the creation of parliamentary committee" process has exclusively happened at the national level.

Regarding the "community engagement" process, this study controls the factors by focusing on HIV-positive peer groups. HIV-positive people have been the center of HIV responses throughout history around the globe. The scaling-up of care, support, and treatment in

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[760] KAI SPRATT *ET AL*., *Indonesia HIV/AIDS Strategy Audit* 15 (2007).
[761] *Id.*
[762] *Id.*
[763] *Id.*
[764] *Id.*
[765] *Id.*
[766] *Id.* at 16.

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Indonesia since the inception of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) shows that HIV-positive people are at the forefront of stopping the spread of HIV.[767] At the same time, HIV-positive people have also been the object of perpetual stigmatization, discrimination, and human rights violations.[768] For this reason, this study posits that the perspective of HIV-positive people is instrumental in understanding the legal process of Indonesian HIV-specific laws.

Since 1995, the number of HIV-positive peer groups has been growing relative to the increasing HIV response in the country. Since the establishment of the National AIDS Commission, HIV-positive people's and other civil society organizations' involvement has been increasing.[769] As of 2018, there are more than three hundred peer support groups in thirty-one provinces in Indonesia. Most of these peer groups have been working closely with larger provincial umbrella groups, of which there are currently twenty-four. The relationships between the peer groups and the umbrella groups are both ideological and pragmatic. While they share values regarding the progressive position of HIV-positive people in the overall HIV response, the umbrella groups also administer funding for local peer groups. This relationship establishes the notion of association among the groups.

Regarding the "participatory process" norm, after carrying out an online survey of the twenty-four umbrella organizations between December 2018 and February 2019, the study received eighteen responses (75%). The survey asks a series of questions regarding the involvement of HIV-positive organizations in the lawmaking process in their respective

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[767] Wilson, *supra* note 307 at 93.
[768] Paxton *et al*., *supra* note 345.
[769] Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS Tahun 2010-2014 (En. National HIV and AIDS Strategy and Action Plan 2010–2014), *supra* note 376.

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jurisdictions: (1) The organization's role in local legislation-making processes, (2) The organization's advocacy strategy in local legislation-making processes, (3) The organization's expectation gap related to its advocacy strategy, (4) The chance of HIV-positive people knowing the substance of HIV-specific laws in their areas, and (5) The main legal barriers to the HIV response.

Each respondent operates in a jurisdiction with HIV-specific policies in place. Their respective HIV-specific laws include the criminalization of HIV-positive status non-disclosure to any sexual partner as well as the failure to employ an HIV-preventative measure when running the risk of HIV transmission.

According to most of the respondents, however, the chance of HIV-positive people knowing the substance of HIV-specific laws has been low. If so, that means that most compliance and noncompliance with HIV criminal laws are not related to knowledge about the laws. This gap also explains the response to the topic of the leading legal barriers to the HIV response. None of the respondents mentioned HIV criminal laws. The responses were mainly about care, support, treatment, and stigmatization.

On the organization's participation in the legal process, most of the respondents agreed that they worked with other civil society organizations more than with the legislative body or existing administrative agencies. However, they agreed that they were not always satisfied with how they worked with these other civil society organizations.

Respondent 1's interview was also in line with this finding when she responded to the question, "Who are your organization's closest allies?" She responded by saying,

> UNAIDS definitely. They have a human rights adviser now. All of the key population networks. No one is closer than anyone else. Atma Jaya AIDS

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> Research Center shares our voice, too. We also ally with the Indonesian AIDS Coalition, which has been working on policy advocacy.[770]

What Respondent 1 mentioned were an international organization, networks of the most-affected population, a university-based research center, and a PLHIV national organization. Furthermore, Respondent 1 clearly said that her organization saw the lawmakers not as allies, but as objects where advocacy works are directed:

> The Ministry of Health is the most strategic object. However, we are doing soft advocacy with them. Unlike with the National Narcotics Board, where we always tend to fight each other, with the Ministry of Health we are more like taking an assisting role. Local governments are also our advocacy objects, especially these days. But the problem is *access*, especially for areas outside Jakarta—it is hard to make friends with them. So, we took official procedures.[771]

Almost all of the organizations agreed that the law must follow the HIV public health imperative. However, in line with the above findings, the study also finds that most of the organizations had passive roles during lawmaking forums with the legislative body. This finding is in line with the interview with Respondent 1, who said that NGOs tend to prioritize allying with other NGOs in the legal process.

In terms of institutional competence, discussions emerged when a set of arguments on HIV criminalization was established. Nonetheless, Gostin and Mann's test on criminalization suggests that there is an incomplete procedure in terms of institutional competence. The test shows that there is a fundamental disconnection of thoughts and practices between legislators, HIV experts, and civil society.

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[770] Interview Respondent 1, *supra* note 524.
[771] *Id.*

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Indonesia relies on the participation of different parties in the process of legislation. However, this study finds a significant gap between the legislature and HIV-positive people as beneficiaries. HIV-positive activists work more with other civil society organizations, which explains the disconnection. Consequently, the decisions to pass a massive number of criminal laws were insulated from the just public health measures to which these organizations claimed to adhere. To give a general picture, almost 60% of the surveyed organizations admitted that they had never been involved in any processes of law-making at all levels.

There is also considerable skepticism regarding the future of actor coordination after the dissolution of the National AIDS Commission (NAC) in 2016. It appears that the NAC's coordinating role has been missing since its dissolution into the Ministry of Health. Respondent 1 did not seem satisfied with the government's decision in this regard:

> I would say not positive. It should be dissolved under the Coordinating Ministry for Human Development and Cultural Affairs (CMHDCA), but the Ministry was not prepared. It is not merely about the name of an institution, but the function has gone. It actually would have been better if the coordinating function had been taken by the CMHDCA. At the beginning there was such hope, but it turned out that the CMHDCA itself did not seem serious.[772]

Not only did a disconnection occur between organizations dealing with HIV programs, but the absence of a national commission also cut the transfer of non-biased HIV information to the public.

> Recently, we had a meeting with journalists. They said that in the past, the NAC always supplied them with updates like current prevalence, improvements, and trainings. Now, with the absence of the NAC, they do not get those things anymore. We have to understand that not all news channels have their own decent research and development division. So, the NAC's role in providing positive, or at least non-biased, HIV information

[772] *Id.*

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to the media was crucial in developing society's awareness. Now, that is not happening.[773]

The online survey allows this study to examine the gap between the year when an HIV peer support group was formed and the year the governing HIV-specific was law adopted. This historical knowledge provides an insight into how much time an umbrella group had to influence their local lawmaking processes.

Table 9. Umbrella Groups and Local Laws

No.	Umbrella Group	Year Founded	Location	Law in Location	Year of Law	Year Gap	Involved in Legal Process
1	Yayasan Spirit Paramacitta	2001	Bali	Provincial Regulation	2006	5	Yes
2	Yayasan Pontianak Plus	2003	West Kalimantan	Provincial Regulation	2009	6	No
3	Yayasan Medan Plus	2003	North Sumatra	City Regulation	2012	9	No
4	NAD Support Group	2003	Aceh	Provincial Regulation	2013	10	Yes
5	Victory Plus	2004	Central Java	Provincial Regulation	2010	6	N/A
6	Saburai Support Group Lampung	2004	Lampung	Regency Regulation	2013	9	Yes
7	Yayasan Sebaya Lancang Kuning	2005	Riau Islands	Provincial Regulation	2007	2	No
8	Sriwijaya Plus	2005	South Sumatra	City Regulation	2007	2	Yes
9	Yayasan Flobamora support	2006	East Nusa Tenggara	Provincial Regulation	2007	1	No
10	Yayasan Kotex Mandiri	2006	Jakarta	Provincial Regulation	2008	2	Yes
11	Kotex Mandiri Banten	2006	Banten	Provincial Regulation	2010	4	Yes
12	Yayasan KOMPAK	2007	Riau Islands	Provincial Regulation	2007	0	No
13	Yayasan Kanti Sehati Sejati	2007	Jambi	Mayor Regulation	2012	5	No
14	Yayasan Mahameru	2009	East Java	Provincial Regulation	2004	-5	Yes
15	Yayasan Sorong Sehati	2009	West Papua	City Regulation	2013	4	Yes

[773] *Id.*

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16	Yayasan Peduli Kasih	2010	Central Java	Provincial Regulation	2010	0	N/A
17	KP Mahakam Plus	2016	East Kalimantan	Provincial Regulation	2007	-9	No
18	Female Plus	2016	West Java	Provincial Regulation	2012	-4	Yes

The initial finding from the database shows that there was a proliferation of Regency/City Regulations in the period of 2010–2015. This finding relates to the contextual history of the HIV response during the same time slice.

The survey asked whether each organization had been involved in either the making or reform of an HIV law. The table shows that nine out of eighteen organizations (50%) claimed that they had been involved to some extent in the legal process in their respective area of work. However, at least five of the involved organizations admitted that their involvement had been passive and tended toward tokenism.

The interview with Respondent 3—an umbrella group leader in West Nusa Tenggara province—implies that their involvement in the legal process was full of hurdles:

> Based on our experience, the process of Provincial Regulation is dependent on who initiated the bill. If both the legislative and the executive initiated a particular bill, then it will speed up the process. You know, the local legislative body has their list of priorities included on a legislative agenda. So, the homework is to include HIV in the agenda. On HIV, we were involved in a consultative meeting with our local Health Office; it was facilitated by the AIDS Commission. But we were not involved in the redactional formulation. We did not attend the legislative meeting either. We did receive the revised version from the AIDS Commission, but that was it. If only we were like the National Narcotics Board, which has a national law, the work would be much easier. We do not have a national governing law on HIV.[774]

[774] Interview Respondent 3, *Local Legal Process* (2019).

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This legal process also touches the political landscape within the local parliaments. Respondent 3's experience shows that connections with lawmakers should be built strategically:

> We do have a contact. A lady from *Partai Persatuan Pembangunan* (*the United Development Party*, *a political party*). She has been very open to our voice. She is willing to learn from us about HIV, ART, stigma, discrimination, and other HIV topics . . . the lady admitted that her party is not a dominant political party, so it is going to be a steep effort. Our local legislative body is dominated by other political parties, with which we still need to build connections. They also have their own political agenda. Furthermore, unfortunately, the lady was not elected for the current period. So, we lost the legislative contact for now.[775]

Respondent 3's experience shows that "community engagement" process only is not sufficient to significantly influence the law. Even though there was a provincial AIDS commission in place, a prospective strong parliamentary could be of support when it comes to local legal process.

The adoption of the National HIV and AIDS Strategy and Action Plan 2010–2014 was evident as an effort to partially integrate the problem-driven, donor-funded programs into the overall healthcare system. Furthermore, the recognition of HIV as a social developmental issue also provides room to preserve the existing non-medical HIV-specific programs. The plan aims to operationalize the General Comments 14 of the United Nations Committee on Economic, Social, and Cultural Rights (availability, accessibility, acceptability, and quality).

The history of global health challenges in halting communicable diseases could go back to the malaria control efforts of the 1970s, when an increase of drug resistance in humans, widespread mosquito resistance to insecticides, massive population movements, and lack of community participation made long-term efforts impossible to sustain.[776] The resistance to

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[775] *Id.*

[776] Global Health History Online Course—Eradication Efforts: Malaria vs. Smallpox, http://www.uniteforsight.org/global-health-history/module4 (last visited Feb 14, 2017); S.

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insecticide happened because of the reliance on one type of attack strategy and hence ignoring the vector control, including the consideration of the biology of the mosquito, the epidemiology of the parasite, and human behavior.[777] As a follow-up, there was an effort to shift from a vertical to an integrated system. Afterward, in 1978, by the adoption of the Alma-Ata Declaration, countries started to examine their malaria control programs.[778] One of the mandates of the Alma-Ata Declaration 1978 is to address the main health problems in the community using an integrated primary healthcare system, with resource limitations in mind.[779]

The General Comments 14 of the United Nations Committee on Economic, Social and Cultural Rights set out the state's obligations to ensure the availability, accessibility, acceptability, and quality of health facilities, goods, and services.[780]

Availability means that functioning public health and healthcare facilities, goods, and services, as well as programs, have to be available in sufficient quantity.[781] Accessibility means that health facilities, goods, and services have to be accessible to everyone without discrimination.[782] Acceptability means that all health facilities, goods, and services must be respectful of medical ethics and culturally appropriate, that is, respectful of the culture of

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Litsios, *Malaria Control, the Cold War, and the Postwar Reorganization of International Assistance*, 17 MED ANTHROPOL 255–278 (1997).

[777] Clive Shiff, *Integrated Approach to Malaria Control*, 15 CLIN. MICROBIOL. REV. 278–293 (2002).

[778] Contract No. IDN-H-MOH-949: Indonesia HIV Response: Accelerating the Achievement of the Three Zeros (Principal Recipient: Ministry of Health/Directorate General of Disease Control and Environmental Sanitation), *supra* note 364.

[779] UNICEF, WHO & International Conference on Primary Health Care, *Declaration of Alma Ata: International Conference on Primary Health Care,* (1978).

[780] The United Nations Committee on Economic, Social and Cultural Rights, General Comment No. 14 on The Right to the Highest Attainable Standard of Physical and Mental Health, *supra* note 158.

[781] Sofia Gruskin *et al.*, *Human Rights in Health Systems Frameworks: What Is There, What Is Missing and Why Does It Matter?* 7 GLOBAL PUB. HEALTH 337–351, 341 (2012).

[782] *Id.*

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individuals, minorities, peoples, and communities; sensitive to gender and lifecycle requirements; as well as designed to respect confidentiality and improve the health status of those concerned.[783] Quality means that health facilities, goods, and services must be scientifically and medically appropriate and of good quality.[784]

Regarding availability, despite the limited coverage of the HIV program, the National HIV and AIDS Strategy and Action Plan 2010–2014 rationally chose to cover only 137 districts, representing 31% of all districts in Indonesia's thirty-three provinces. This decision considered the calculated risk of HIV transmission, inherent HIV-related burdens, and the condition/quality of the AIDS response.[785] With such geographic focus, the activities could efficiently reach 94% of injecting drug users (205,860 people), 92% of female sex workers (203,000 people), and 85% of PLHIV (164,000 people).[786]

In terms of accessibility, as well as acceptability and quality, it is evident that HIV intervention requires the use of "high technology" with high user engagement. This type of intervention includes harm reduction programs (needle exchange and methadone substitution programs), ART administration to at-risk population, prevention of mother-to-child transmission, and outreach to key populations. These programs represent the complexity of HIV integration due to its specific problem-driven program development.[787] As a vivid example, CHPM finds that an exclusive HIV program has been using different nomenclatures for human resources that

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[783] *Id.*
[784] *Id.*
[785] Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS Tahun 2010-2014 (En. National HIV and AIDS Strategy and Action Plan 2010–2014), *supra* note 376.
[786] *Id.* at 9.
[787] Atun et al., *supra* note 379 at 107.

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are hardly compatible with the general health services.[788] This gap poses a challenge in setting quality standards, especially for non-medical workers.

Regarding accessibility, this study suggests that the influx of an ample amount of money does not necessarily solve the problem. This study includes an interview with Respondent 2, the Chief Executive Officer of the Spiritia Foundation. This organization has been one of the Principal Recipients (PRs) of the GFATM since 2016. As a PR, Spiritia Foundation must ensure that its money usage follows its promises. The GFATM works as a gap-filler in the in-country HIV program. Respondent 2 says that it is the task of the country to justify its proposal with robust evidence combined with domestic funding's share:

> In responding the epidemic, we know the size of the gap. In our Strategic and Action Plan we know how large the gap is, and how many people we have to work to tame the epidemic. That ends up with an agreed target and budget. The GFATM enters based on our application. Since there has to be a counterpart in this scheme, Indonesia must also provide a portion of the budget, too. For example, we want to roll out 60% of an intervention, even though we need 100%. To succeed with the said 60% of an intervention, we need money—10,000. So, to illustrate, Indonesia will provide 4,000, and then we request 6,000. So, the GFATM money helps to fill the gap.[789]

Respondent 2's assertion on gap-filling is related with a report by Desai et al. that shows despite the full integration of HIV and TB programs under the Global Fund scheme, such integration has had unintended consequences:

> (1) In terms of service delivery, incentive disparity between the HIV program and other diseases has yielded staff shifting and could jeopardize other disease programs in the health system;
> (2) In terms of financing, the vertical program freed up the Ministry of Health's budget for other programs, yet it did not have a robust exit strategy for sustainability;

[788] CHPM, *supra* note 382 at 54.
[789] Interview Respondent 2, *supra* note 730.

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> (3) In terms of demand generation, it creates a greater need for integration due to other co-infections such as TB-leprosy.[790]

It means that immediate full integration has its own trade-offs, however, the GFATM's presence might help to mitigate these unintended consequences.

From CHPM's findings, it is evident that local governments have been unable to accommodate the full engagement of key populations in planning, implementation, monitoring, and evaluation.[791] Therefore, as also confirmed by the National HIV and AIDS Strategy and Action Plan 2010–2014, there is a need to scale up the intervention to respond by using "structural interventions" where key HIV programming includes key populations.[792] This approach is an active effort to reduce stigma and discrimination, support behavior change, and improve the sustainability of program implementation.[793] Moreover, the National HIV and AIDS Strategy and Action Plan 2010–2014 recognizes HIV/AIDS as a broader social developmental issue instead of a medical or health problem.[794]

Regarding these structural interventions, Respondent 2 says that local HIV-specific laws could be one of the forms:

> With the presence of laws in most provinces, regencies, or cities, will that help the response? Indeed, because with these laws, so long as it is a supportive law, it will help to open the access and ease the intervention. The law will provide a legal basis. As a legal basis, it will support the implementation according to the national AIDS strategy. What is the impact of the GFATM money? Since the GFATM's money is being used for implementation, these laws will smoothen the work. The GFATM helps in terms of money, but [in terms of] how it can be implemented, local law is

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790 Desai *et al.*, *supra* note 380 at i46.
791 CHPM, *supra* note 382 at 12.
792 Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS Tahun 2010-2014 (En. National HIV and AIDS Strategy and Action Plan 2010–2014), *supra* note 376.
793 *Id.*
794 *Id.*

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> one of the factors. With a supportive law, programs supporting the GFATM should run more effectively.[795]

Respondent 2's statement also carries the message that there is a condition for laws to be helpful: they must be supportive. Therefore, local HIV law has a strategic position, given the fact that it provides a legal basis to include HIV program needs in the local government budget. However, Respondent 2 also states that this is incomplete. Local interest groups must monitor the whole process and apply continuous pressure if they are to win money for the cause:

> The laws are the tool helping to open local funding access. The best way to get funding access is through a law so they could put a budget item. Will it work directly? We do not know, but that is the door. That is the strongest legal basis, regardless of the availability of the fund. In program implementation, local government also has the constraint of priority. So, with or without a law, priority is an inherent constraint. For example, a local government could have prioritized education over anything else. If it is within the health sector, disease A could be prioritized over disease B. Each local government has its own analysis and decision.[796]

In this regard, umbrella organizations have a vantage point to play the watchdog role. Respondent 2 reports that some of the umbrella organizations are also NGOs involved in the making of local HIV laws. They are also doing advocacy in terms of local funding disbursement processes.[797]

The National HIV and AIDS Strategy and Action Plan 2010–2014 explicitly represents the elements of equality and non-discrimination.[798] It states that the HIV and AIDS response must consider religious and cultural values and societal norms and be respectful of human pride

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[795] Interview Respondent 2, *supra* note 730.
[796] *Id.*
[797] *Id.*
[798] Strategi dan Rencana Aksi Nasional Penanggulangan HIV dan AIDS Tahun 2010-2014 (En. National HIV and AIDS Strategy and Action Plan 2010–2014), *supra* note 376.

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and dignity, as well as giving due attention to justice and gender equality.[799] Compliant with the structural intervention principle, in terms of human resource management related to HIV and AIDS, the action plan considers gender equality, meaningful involvement of people living with HIV, as well as the appropriateness of personnel management and development of staff knowledge (social and technical) about the field of HIV and AIDS.[800]

This element of the legal and policy context is closely related to the element of accountability. Formulation of policy and law on HIV and AIDS has been using the mechanism of policy formulation common to local governments with the involvement of the Health Office, the local AIDS committee, government working units, non-governmental organizations, key populations' representatives, and international development partners.[801] However, these stakeholders have different power and interest levels. Health Offices and Mayors/Regents have been holding the most power, while key populations have the least power but the greatest interest.[802] At the individual programmatic level, programs financed by foreign donors have followed the donor's mechanism.[803]

One of Spiritia's managers, Respondent 4, shared how this power disparity takes place in both policymaking and practice:

> Problems with *Test and Treat*, SUFA (Strategic Use of Antiretroviral): people experienced side effects and they think that they are sicker than before. Adherence was not prepared when the policy was initiated. FDC (Fixed Dose Combination of ARVs) was meant to be distributed among sex workers, but then it was administered to broader clients.[804]

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[799] *Id.* at 25.
[800] *Id.*
[801] CHPM, *supra* note 382 at 47.
[802] *Id.* at 33–38.
[803] *Id.* at 48.
[804] Interview Respondent 4, *Local Legal Process* (2019).

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Regarding the position of HIV-positive peer groups among other players at the implementation level, she added that there are intricate existing structural barriers at the local level:

> [H]ospitals under local governments' administration tend to be reluctant to adopt the Ministry of Health's regulations. For example, we are dealing with the constant challenges of referring newly diagnosed HIV-positive people to peer support. They left the facility without any support, especially in starting the ART.[805]

Overall, the strength of the health system at the local level is influential in integrating the HIV program. CHPM identifies that several functions in the local health system are not optimal (e.g., health financing, human resources, and strategic information management).[806] But if the functions of the health system in the HIV program were integrated with an unready health system, the results might be worse.[807]

It is particularly noticeable that there is also an "inverted" version of interaction where global actors are involved in local legal processes. While Respondent 2 asserts that countries get to decide on their own HIV programs, the fact is that Indonesia did not decide on its HIV program without the presence of global actors in its country-level proposal development. WHO officials, as global actors, have been working closely on Indonesia's evidence-building process. UNAIDS representatives have been involved in CCM membership for multiple rounds. This is not to mention the continuous presence of foreign donor agencies and consultants who have been contributing to building HIV knowledge in Indonesia.

This study finds that there are alternatives—such as the adjudicative dimension—in this political, legal process. This one-sided legal process makes the local interaction between actors

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[805] *Id.*
[806] CHPM, *supra* note 382 at 74.
[807] *Id.*

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as the display of internalization part of the transnational legal process of HIV norms in the frame of global health jurisprudence. What remains in this Indonesian case is what Hart and Sacks call the legislative process. This means that the Indonesian HIV legal process appears as internalization through the lens of the legislative process. PLHIV organizations' experiences with the local HIV laws indicate that the *internalization* is deficient.

As a way to convey the summary of this analysis, this study displays the idea of the transnational legal process of global health jurisprudence in the form of a linear equation. Carol Galletly and Steven Pinkerton use an identical approach when they develop mathematical modeling to find out whether any type of known HIV exposure law, flexible or strict, would work.[808] This dissertation adopts the approach as follows:

$$TLP_{GHJ} = G_F + I_K + I_i + I_D$$

$$TLP_{GHJ} = A_G P_G + A_L P_G + A_G P_L + A_L P_L$$

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[808] Carol L. Galletly & Steven D. Pinkerton, *Preventing HIV Transmission via HIV Exposure Laws: Applying Logic and Mathematical Modeling to Compare Statutory Approaches to Penalizing Undisclosed Exposure to HIV*, 36 J. L. MED. ETHICS 577–584 (2008). The study finds that the use of logical analysis and mathematical modeling techniques can provide a rational basis, especially for deciding controversial public health policy issues. The results of the analysis show that under most conditions, HIV exposure laws can contribute better to the prevention of HIV transmission than the no-law alternative. Let D represent the proportion of sexual encounters in which HIV-positive persons disclose their serostatus, and let L and H represent the proportions of encounters that involve "low-risk" or "high-risk" sexual activities, respectively, without prior serostatus disclosure. Let R* represent the average risk of HIV transmission to uninfected partners associated with the new behaviors. RD, RL, and RH, respectively, denote the transmission probabilities associated with "post-disclosure sex" and with low- or high-risk sex in the absence of disclosure. The average probability of HIV transmission during a particular sexual encounter is R: $R = DR_D + LR_L + HR_H$. The impact of HIV exposure laws on HIV risk would be R—R*: $R—R^* = (D-D^*)R_D + (L-L^*)R_L + (H-H^*)R_H$.

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The key concepts here are Actors (A) and Process (P), which could be Local (L) or Global (G). The combinations of these variables amount to each of the theoretical aspects selected for this study.

Transnational Legal Process	$= TLP_{GHJ} =$	norms coherence
Global health norms	$= G_F = A_G P_G =$	global actors in global process
Interaction	$= I_K = A_L P_G =$	local actors in global process
Inverted interaction	$= I_i = A_G P_L =$	global actors in local process
Domestic legal process	$= I_D = A_L P_L =$	local actors in local process

This study seeks to answer whether the perpetuation of national legal barriers to Indonesia signals a deficiency in global health jurisprudence. Using this linear equation, that would mean that *internalization* is the gap between existing global HIV jurisprudence and the remaining equation components.

$$I_D = TLP_{GHJ} - [G_F + I_K + I_i]$$

$$A_L P_L = TLP_{GHJ} - [A_G P_G + A_L P_G + A_G P_L]$$

The Sankey Diagram supports this equation. The creation of the Sankey Diagram represents TLP_{GHJ}. By creating the indexing system, which became the beginning of the HIVLaw.ID database, this study establishes TLP_{GHJ} as the overall situation of connectedness. The Sankey Diagram in Chart 5 is self-explanatory, spanning from local to global. As a support, the historical examination, interview, survey, and fieldwork provide substantive justification to determine the global/local adjective. Chart 6 presents $I_D = A_L P_L = criminalization$ as the gap because the

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chart does not relate with and is not supported by any *interaction*. This study does not identify any narration about local actors championing HIV criminalization in any global processes. This study also does not find any global actors championing HIV criminalization in local legal processes.

This study does not find any global actor championing HIV criminalization at the global level. Indeed, UNAIDS was one of the earliest actors against HIV criminalization. The Sankey diagram shows the insularity of HIV criminalization. While it is not formally against the higher laws, HIV criminalization in local HIV laws contradicts the goals of the HIV program. The closest coherence of HIV criminalization is with the Penal Code. However, this coherence is rather weak because of the fundamental difference between the Penal Code and most HIV laws. While the Penal Code pursues individual retribution, local HIV laws pursue population health objectives.

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4.6. Justifying a Judicial Review of Transnational Character

Through the earlier historical description, this dissertation described the transnational nature of HIV norms in Indonesia. It also progressed to the discovery of HIV criminalization as an impediment by presenting a potential violation of human rights. At this point, it is intriguing to examine the extent of transnational public law in the Indonesian legal process. Accordingly, probing possible ways to address this legal barrier is particularly compelling, especially under the discourse of the transnational legal process. It is helpful to reread Koh's introduction of the transnational legal process:

> [T]he transubstantive process in each of these issue areas whereby states and other transnational private actors use the blend of domestic and international legal process to internalize international legal norms into domestic law.[809]

This description allows a further elaboration how a transnational interest could be embedded in domestic compliance procedure in a form of judicial review. In the previous part, this article proposed that judicial review is the way to remove the barrier of HIV criminalization. This part proposes that in this era of global health jurisprudence, such judicial review could contain some extent of transnational public law.

Koh suggests that transnational public law litigation happens when an actor claims a right based on a body of transnational law.[810] Historically, the global HIV crisis has formed a particular body of transnational public law. Accordingly, when a petitioner submits a judicial review based on this, the litigation constitutes a transnational public law adjudication.[811]

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[809] Harold Hongju Koh, *Why Transnational Law Matters*, 24 PENN ST. INT'L L. REV. 745, 746 (2006).
[810] Koh, *supra* note 91 at 2348–2349.
[811] *Id.* at 2348–2349.

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Removing HIV crimes from legislation requires an argument that it impedes the efforts to address the global HIV crisis. Therefore, any effort to bring a judicial review based on this matter will constitute domestic litigation of a transnational character. The presence of a transnational argument against a legal barrier, in this regard, will drive "a judicial articulation of a norm of international law."[812]

Koh states that transnational public law litigation has five characteristics: (1) Transnational party structure; (2) Transnational claim structure; (3) Prospective focus; (4) transportability of those norms; and (5) Institutional dialogue.[813] The first suggests that the involved parties could be both state and non-state actors. While Indonesian judicial review is not intended to justify an individual claim, it provides that the petitioner must have legal standing. The petitioner could come from an array of classes: an individual, a tribal group, a private entity, or a public entity. Nonetheless, there is a boundary that judicial review may only be submitted by Indonesian nationals. This limitation distinguishes the Indonesian judicial review process from its United States counterpart in *Filartiga*, where an alien enjoys legal standing, hence making further elaboration possible.[814]

The judicial review process requires a petitioner to assume a potential loss due to the law in question. In terms of HIV treatment, as the Gostin and Mann tests show, PLHIVs have the highest interest. Notably, the Indonesian PLHIV population is shaped by the work of transnational norm entrepreneurs. The disruption of HIV in Indonesia has brought the intertwined roles of both domestic and foreign actors in the dichotomy of national and international fora. The growing networks of entities such as international NGOs, funders,

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[812] *Id.*
[813] *Id.* at 2371.
[814] Filartiga v. Pena-Irala, 630 F.2d 876 (2d Cir. 1980), *supra* note 120.

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officials, PLHIV groups, and researchers have created what Koh calls "interpretive communities." During the period of 2003–2017, the upscaling of HIV programs through massive foreign funding succeeded in bringing about the test and treat policy. This part of internalization is the foundation of someone having legal standing, such as an Indonesian PLHIV embodying transnational interests.

Notably, the UN human rights instruments bind member states, including Indonesia, with numerous human rights obligations. This international relations sphere exhibits what exactly human rights political conception is, as meant by John Rawls in his book *The Law of Peoples*.[815] Rawls asserts that human rights justifications can be found by identifying their role in the political sphere. With this assertion, historically, HIV global health imperatives have been well contained within the functioning of human rights in the current international system. This has proved Rawls's idea that violations or non-fulfillment of human rights does trigger *international intervention*, transcending the sovereignty of states as duty-bearers.[816]

Without undermining the cleavage of the orthodox conception of human rights adherents, any international human rights justification relies on domestic legal construction. Judicial review of HIV crimes in a local law will have to answer the question whether these crimes contradict the human right to health as set out by the 2009 Health Law. The political conception of human rights increases the judiciary's ability to extract the teleological meaning of the local law.

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[815] James Nickel, *Human Rights*, THE STANFORD ENCYCLOPEDIA OF PHILOSOPHY (Edward N. Zalta ed., Summer 2019 ed. 2019); JOHN RAWLS, THE LAW OF PEOPLES: WITH "THE IDEA OF PUBLIC REASON REVISITED" (5th pr ed. 2003).

[816] RAWLS, *supra* note 815 at 70; Joseph Raz, *Human Rights without Foundations*, *in* THE PHILOSOPHY OF INTERNATIONAL LAW, 328 (Samantha Besson & John Tasioulas eds., 2010).

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Judicial review requires that the petitioner be able to demonstrate that HIV criminalization has a causal relationship with their potential loss. This process will involve a construction process including the interpretation of both the local law in question and the higher law.

Koh's second characteristic suggests that the claim structure must display a violation of both domestic and international law. The historical development of global HIV norms has shown the prominence of human rights in ensuring the success of global HIV prevention programs. The taking of international law-declaring fora by HIV norm entrepreneurs displays the representation of the political conception of human rights. In line with the historical facts, Koh advocates for human rights to be the universal value governing the ways to solve global problems, including the global AIDS problem. He specifically champions the idea of using "the globalization of human freedom" to effectively solve these transnational problems.[817] In the growing body of transnational law, Koh suggests that the discourse of constitutional law cannot be undertaken exclusively without incorporating, for example, human rights treaties.[818]

The case laws from the section on global health jurisprudence shows that the transnational legal process shall involve two processes of determination: (1) The identification of domestic and international basis for human rights claims through public private litigation; and (2) The identification of prospective international law-declaring fora to influence domestic legal process. Since the 2009 Health Law is not the specific "parent" law of the local HIV law, the task of crafting such an argument requires the construction of a normative justification. Judicial review in this regard shall aim to demonstrate that HIV criminalization is a form of human rights

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[817] Harold Hongju Koh, *The Globalization of Freedom*, 26 YALE J. INT'L LAW 305, 311 (2001).
[818] *Id.* at 306.

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violation or non-fulfillment. Gostin and Mann's public health tests conclude that HIV criminalization is a policy that will worsen the spread of HIV, fuel the existing stigma, and inhibit people from getting tested and treated. Article 5 of the 2009 Health Law provides that "everyone has the equal right to access health resources."[819] In the preamble, the law states that health is one of the human rights as stipulated in the Indonesian Constitution. The global health jurisprudence is built on multiple case laws that led to the adoption of various international norms such as the International Guidelines on HIV/AIDS and Human Rights. The process norm suggests that HIV law provisions, such as HIV treatment as a constitutional right, shall be construed through the interpretation of international human rights law.[820]

As for international law, Indonesia ratified the ICESCR through an implementing law in 2005. Specifically, in the health sector, Indonesia is a member state of the WHO's International Health Regulation (IHR) and bears the concomitant health obligations. In the absence of a national HIV law, global HIV norms have been domesticated via the adoption of National AIDS Strategies as the substantive reference for the local laws. The historical examination and the norms reverse tracing show that the development of these strategies is the product of the interpretive networks. This legal environment suggests that judicial review of HIV criminalization would constitute a transnational claim structure. The Supreme Court, in this regard, could and should adjudicate with less concern regarding the separation of powers.[821]

The third characteristic suggests that transnational public law litigation works toward "obtaining judicial declaration of transnational norms as upon resolving past disputes."[822] Koh

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[819] Law No. 36 on Health art. 5 (2009).
[820] ALSTON *ET AL.*, *supra* note 696 at 1048.
[821] Koh, *supra* note 91 at 2383.
[822] *Id.* at 2371.

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suggests that when there is an implementing domestic statute for an international treaty, the court interprets the statute. In Indonesia, this could be the situation with the ICESCR. The ICESCR has been ratified through Law No. 11 Year 2005 on the Ratification of the ICESCR. Accordingly, the Court would render its decision on the basis of a transnational cause of action.[823] Indonesian membership to multiple human rights treaties allows the process norm of identifying prospective international law-declaring fora to influence domestic legal process. As a member state of international human rights treaties, domestic advocates have the opportunity to file reports to the committee of the treaties. In the context of HIV, the jurisprudence shows that non-binding instruments could also be helpful in shaping domestic legal environment.[824] In some instances, Indonesian PLHIV communities have submitted a shadow report to the UNGASS Declaration of Commitment on HIV/AIDS committee. The *2010 Civil Society Report* was a research by Indonesian UNGASS-AIDS Forum, supported by Gestos, the Latin American and Caribbean Council of NGOs with HIV/AIDS Services (LACCASO,) the Ford Foundation, and Hivos.[825] The strong presence of international actors displays one other example of the inverted interaction in the transnational legal process.

The fourth characteristic concerns the transportability of the norms. While the success of the judicial review of HIV criminalization remains to be seen, the potential to adjudicate

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[823] *Id.* at 2387.

[824] ELLIOTT, CANADIAN HIV/AIDS LEGAL NETWORK, AND JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, *supra* note 153; Edgar Mauricio Carpio Castro *et al.* v. Programa Nacional del SIDA-VIH-ITS & Ministerio de Salud Pública, Constitutional Tribunal (Third Chamber), Decision No. 0749-2003-RA, *supra* note 243.

[825] Aditya Wardhana *et al*., *Civil Society Report* (2010). Gestos is a philanthropic organization founded in 1993 by sociologist Acioli Neto, journalist Alessandra Nilo, sociologist Marcia Andrade and social worker Silvia Dantas. Hivos was one of the first major Dutch NGOs that opened offices in the Global South to operate in the close vicinity of its civil society partners, beneficiaries and other stakeholders there. To date, most of our programs are executed through regional Hivos hubs in Southern Africa, East Africa, Southeast Asia and Latin America.

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international norms in domestic courts is becoming the norm. Yet, the faith placed in the international adjudication of human rights problems is becoming increasingly obscure.[826] This part is related to the fifth characteristic, which suggests the "institutional dialogue among domestic and international, judicial and political fora to achieve ultimate settlement."[827] Judicial review of HIV criminalization does not necessarily raise separation of powers concerns. With the current Indonesian right to health landscape, the Supreme Court would not bear an interpretative burden. Nonetheless, since the cause of action is of transnational character, the decision would have an implication for Indonesian foreign human rights dialogue. The ability of the Court to adjudicate would showcase Indonesia's promotion of the rule of law. However, a dismissal decision would be a red mark on Indonesia's report before the ICESCR committee. While this could be political leverage for a petitioner, it could constitute a substantial separation of powers concern.

4.7. Conclusion

The analysis demonstrates that national legal barriers to HIV prevention are a robust proxy for evaluating HIV prevention global norm internalization. By relying on this argument, this chapter concludes that there is a relationship between such legal barriers and national internalization. Supported by the findings, this analysis upholds that such a relationship not only exists in one slice of time but endures throughout the history of HIV. This is because the timeline indicates that disconnections in the legal process have appeared consistently since the awakening of the HIV response in Indonesia in the early 2000s. It is, however, essential to first determine

[826] Koh, *supra* note 91 at 2371.
[827] *Id.* at 2370.

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that a legal barrier is genuine. The norms reverse tracing process finds that criminalization is not in the mainstream of the HIV legal norm. Therefore, proving that HIV criminalization is a legal barrier is necessary to claim that the internal legal process neglects the emerging global HIV norms.

The analysis also concludes that the transnational legal process enables this study to establish the relationship between national legal barriers and internalization of global norms. The examination of institutional competence, statutory interpretation, and reasoning allows a stronger argument in the evaluation of global norms internalization. However, this analysis does not claim that the absence of legal barriers would necessarily end the HIV epidemic in Indonesia. Instead, it could make the more modest claim that the removal of national legal barriers is necessary for successful global norm internalization.

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5. Conclusion

5.1. Principal Conclusions

Based on the analysis, this chapter formulates the answers to whether the perpetuation of national legal barriers to HIV prevention is associated with Indonesia's internalization of global health jurisprudence.

The answer is yes, it is. The perpetuation of legal barriers to HIV prevention indicates that there is further internalization of global health jurisprudence to be done. The content of local laws is incongruous, primarily in the perpetual ubiquity of HIV criminalization. Specifically, from the analysis on the seven process norms derived from the global HIV jurisprudence, this dissertation finds that there is room for improvements in the transnational nexus between domestic legal process and global norms.

The dissolution of the National AIDS Commission in 2017 has potentially decimated the inter-ministerial and vertical coordination, especially in informing local lawmakers. The transnational legal process has been happening through the form of community engagement, especially in the early days of the epidemic in Indonesia. Indonesian civil society groups were strongly connected with international actors, forming a growing transnational advocacy network. This movement has been the leading part in influencing domestic lawmakers through the interpretations of HIV treatment as a right to health. The activism of PLHIV groups has been influential in terms of placing themselves not only as the evidence of the need, but also as the active actors in decision-making processes. Throughout the peak years of local HIV law

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adoption, however, the survey suggests that participation in lawmaking processes at the local level leaves a considerable room for better inclusion.

In the absence of a national HIV law, domestic advocates could embody transnational interests either in domestic litigation or in international judicial and quasi-judicial fora. In addition, this conclusion is not an isolated answer. This dissertation arrives at this conclusion with several other concluding insights.

It is plausible to use transnational legal process theory in the field of global health.

This dissertation claims that the examination of HIV and the law in Indonesia provides a credible reason to say that transnational legal process theory has the capability to explain the state of internalization of global health norms. The transnational legal process, rooted in the merger between domestic legal process and international law, enables the study to focus on the ability of the domestic legal process and actors to foster international norms in the global AIDS crisis.

This dissertation limits this claim to the area of global health jurisprudence. Until the present, the response to HIV has been driving the emergence of global health legal norms since its appearance in the 1980s. The HIV pandemic fuels the changes in global health governance by drawing global and local actors into the cross-jurisdiction normative landscape. The unprecedented transnational resource mobilization on HIV also reflects the intriguing area of norm interpretation. Hence, the novel theoretical claims of this dissertation, in this case, shall enjoy credible traction in the area of global health jurisprudence.

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Examination of national laws alone is not adequate.

This dissertation claims that hyperlocal examination is essential to analysis of internalization. Had this dissertation stopped at national-level laws, any inferences would have been inaccurate because the legal process is also happening at the local level.

The transnational legal process school suggests that norms' internalization occurs in the dynamic of national lawmaking processes. However, in countries with local legal autonomy like Indonesia, it is necessary to stretch the analysis to local level. In the area of HIV, local-level dynamics are key determinants of achieving the goal to reverse the epidemic.

The hyperlocal examination also enables this dissertation to determine legal barriers in the "blind spot" of national laws. By aggregating local laws, this dissertation reveals and problematizes the normative inquiries of HIV criminalization. HIV criminalization does not exist in national legal instruments. Therefore, the examination of national laws alone is not adequate to capture this legal barrier.

Internalization has a band of measurement.

The transnational legal process school theory is firm that national laws internalize external legal norms through the interconnected processes of interaction, interpretation, and national internalization of global norms. This dissertation supports such proposition by proving that internalization has a band of measurement.

In global health jurisprudence, norm internalization is not merely about whether a country includes global health norms in its legal sources. Further, global health jurisprudence mandates that norm internalization must contribute to the purpose of achieving a global health goal (i.e., HIV prevention), with human rights as the underlying value. Accordingly, an appraisal

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of internalization must look beyond individual norms. Looking only to an individual norm without aggregating it with the whole body of law is likely to disorient its observation.

The aggregation of local laws allows this dissertation to justify that the internalization is deficient. Internalization does happen, but not adequately to halt the spread of HIV in Indonesia. In the frame of global health jurisprudence, this unsuccessful internalization contributes negatively to the global effort to end AIDS by 2030.

Human rights law is a plausible interpretive tool in the transnational legal process.

This dissertation claims that, over the years, the global HIV response has been using international human rights law as an effective way to enter the national legal system. Human rights arguments have endured since the declaration of the Denver Principles in 1983. The 2001 UNGASS Declaration on HIV and AIDS provides leverage to frame HIV and AIDS as a human rights issue.

Over time, the human rights frame of HIV has transitioned to the notion of a "global emergency." The label of "emergency" has taken the political leverage to the next level. It was successful in pressing the adoption of the 2001 Doha Declaration.

In setting the goal of ending AIDS in 2030, the 2016 UN General Assembly's Political Declaration on HIV and AIDS sustains the pandemic as an emergency.

> AIDS continue to constitute a global emergency, pose one of the most formidable challenges to the development, progress and stability of our respective societies and the world at large and require an exceptional and comprehensive global response that takes into account the fact that the

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> spread of HIV is often a cause and a consequence of poverty and inequality.[828]

This declaration allows countries to procure affordable ART, fulfilling their human right to health obligations. Since the declaration, treatment policies have been dependent on this leverage.

5.2. Recommendations

In order to increase the impact of this dissertation, this section describes several recommendations.

A new topic for the Framework Convention on Global Health proposal.

This dissertation acknowledges the current effort to develop the Framework Convention on Global Health (FCGH). Regardless of the controversies surrounding the FCGH proposal, this dissertation suggests that the drafting of the FCGH must consider the topic of "advocating local laws" in the discussion.

The disconnection between actors in the local legal process poses a challenge for norm entrepreneurs at the global level. Future discussions on HIV policies must address hyperlocal dynamics to prevent the further perpetuation of legal barriers. Norm entrepreneurs must recognize the disparity between the national and local legal processes.

[828] Resolution adopted by the General Assembly on 8 June 2016 Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030, *supra* note 406.

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This means that the proposed future treaty must recognize that countries with decentralized political system have unique legal barriers. Accordingly, the treaty should ensure that national governments can pass the interpretation of global HIV norms to the local legal process.

Continuous usage of HIVLaw.ID as an advocacy tool.

This dissertation promotes the use of HIVLaw.ID by all domestic actors in Indonesia. HIVLaw.ID is especially useful for civil society to learn more about the laws governing their activities. At the same time, civil society could share their experiences on the platform and collectively make them an advocacy tool. When the platform has an extensive collection of stories related to a particular law, advocates could strengthen their arguments with collective evidence.

For legislators, HIVLaw.ID would be useful to better understand the legal and policy environment of HIV. As it is a common open platform, everyone will have the same level of understanding about the laws, the potential loopholes, and the best possible future policies to address them.

Besides, this dissertation finds that HIV criminalization is a legal barrier. Advocates or legislators in this area could consider submitting a legislative review before the Indonesian Supreme Court. HIV criminalization is against the purpose of HIV laws. Since they stand as a predicament to the right to health, the constitutionality of these provisions is highly questionable.

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The need for further studies.

Based on its claims, this dissertation suggests several new questions that are worth answering in future studies. First, this study claims that national internalization of global norms has a band of measurement. However, due to the absence of related cases, this dissertation is unable to cover the area of interpretation between the legislative and the adjudicative bodies. Therefore, it would be intriguing to see a similar application of this approach in other civil law jurisdictions where HIV case laws are available.

Secondly, it would be helpful to see an ethnographic study to explore the impact of HIV norms' internalization on other issue areas in Indonesia. This dissertation establishes that Koh's issue linkages do exist in this case; however, the probing of those linkages requires further studies.

Lastly, transnational legal process theory has enabled this dissertation to travel in both retrospective and prospective areas of HIV lawmaking. In this Indonesian case study, the absence of a national HIV law might give a steep way for future judicial review; however, in a rapidly changing issue like HIV, the flexibility of HIV prevention policymaking allows optimal civil society participation. Both the historical examination and the prospective analysis of judicial review have revealed that civil society holds a decisive role in determining Indonesia's success in ending its AIDS epidemic. After this dissertation, transnational legal process theory is absolutely prescriptive for the field of HIV.

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Appendix

Table 10. Field Data Collection

No	Method	Institution	Setting	Date
1	Phone interview	Spiritia Foundation	Jakarta, Jakarta	12/19/18
2	Phone interview	LBH Masyarakat	Jakarta, Jakarta	1/16/19
3	Visit Participaton and Observation	Moewardi State Hospital	Solo, Central Java	9/16/19
4	Visit Participaton and Observation	Ir. Soekarno State Hospital	Solo, Central Java	9/17/19
5	Visit Participaton and Observation	Grogol Community Healthcare Center	Solo, Central Java	9/17/19
6	Visit Participaton and Observation	Mitra Alam Foundation	Solo, Central Java	9/16/19
7	Visit Participaton and Observation	SPEK-HAM Foundation	Solo, Central Java	9/17/19
8	Phone interview	SPEK-HAM Foundation	Solo, Central Java	9/20/19
9	Survey	Yayasan Spirit Paramacitta	Bali	2/6/19
10	Survey	Yayasan Pontianak Plus	West Kalimantan	2/6/19
11	Survey	Yayasan Medan Plus	North Sumatra	2/20/19
12	Survey	NAD Support Group	Banda Aceh, NAD	2/15/19
13	Survey	Saburai Support Group Lampung	Lampung	2/5/19
14	Survey	Yayasan Sebaya Lancang Kuning	Riau	2/11/19
15	Survey	Sriwijaya Plus	South Sumatra	2/21/19
16	Survey	Yayasan Flobamora support	East Nusa Tenggara	2/11/19
17	Survey	Yayasan Kotex Mandiri	Jakarta, Jakarta	2/21/19
18	Survey	Kotex Mandiri Banten	Banten	2/21/19
19	Survey	Yayasan KOMPAK	Riau Islands	2/6/19
20	Survey	Yayasan Kanti Sehati Sejati	Jambi	2/7/19

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21	Survey	Yayasan Mahameru	East Java	2/11/19
22	Survey	Yayasan Sorong Sehati	West Papua	2/8/19
23	Survey	Yayasan Peduli Kasih	Central Java	2/20/19
24	Survey	Yayasan Sehat Peduli Kasih	Central Java	2/20/19
25	Survey	KP Mahakam Plus	East and North Kalimantan	2/12/19
26	Survey	Female Plus	West Java	2/5/19
27	Interview	Cendrawasih Bersatu Merauke	East Java	12/2/19
28	Interview	Yayasan Sebaya Lancang Kuning	Boyolali, Central Java	12/2/19
29	Interview	Yayasan Pontianak Plus	Bali	12/2/19
30	Interview	Yayasan Inset	West Nusa Tenggara	12/2/2019

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UNIVERSITY of WASHINGTON
HUMAN SUBJECTS DIVISION

DETERMINATION OF EXEMPT STATUS

April 12, 2018

Dear Siradj Okta:

On 4/12/2018, the University of Washington Human Subjects Division (HSD) reviewed the following application:

Type of Review:	Initial Study
Title of Study:	The Transnational Legal Process of Global Health Jurisprudence: HIV and the Law in Indonesia
Investigator:	Siradj Okta
IRB ID:	STUDY00004601
Funding:	None

Exempt Status

HSD determined that your proposed activity is human subjects research that qualifies for exempt status (Category 2).

- This determination is valid for the duration of your research.
- This means that your research is exempt from the federal human subjects regulations, including the requirement for IRB approval and continuing review.
- Depending on the nature of your study, you may need to obtain other approvals or permissions to conduct your research. For example, you might need to apply for access to data (e.g., to obtain UW student data). Or, you might need to obtain permission from facilities managers to approach possible subjects or conduct research procedures in the facilities (e.g., Seattle School District; the Harborview Emergency Department).

If you consider changes to the activities in the future and know that the changes will require IRB review (or you are not certain), you may request a review or new determination by submitting a Modification to this application. For information about what changes require a Modification, refer to the **GUIDANCE: Exempt Research**.

Thank you for your commitment to ethical and responsible research. We wish you great success!

Sincerely,

Kristen Wittmann, Administrator
UW Human Subjects Division
(206) 221-2093 kmw89@uw.edu

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