

Study on HIV-AIDS Prevention in Kendari City

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Abstract

As the capital of Southeast Sulawesi Province, Kendari City experiences high population mobility and has recorded a continued increase in HIV/AIDS cases over the past six years, despite the enactment of Regional Regulation No. 7 of 2017 and Regional Regulation No. 19 of 2014 concerning infectious disease control and HIV/AIDS management. This policy paper aims to formulate strategies to accelerate the initiation of antiretroviral therapy (ART) among people living with HIV (PLHIV), locally referred to as Orang dengan HIV (ODHIV), in Kendari City through problem identification, root cause analysis, and policy option assessment. The prioritization of problems using the Urgency, Seriousness, and Growth (USG) method revealed that the primary challenge was the suboptimal identification of PLHIV and their subsequent linkage to treatment under the Test and Treat approach. Root cause analysis using Failure Mode and Effects Analysis (FMEA) identified two priority issues: the absence of systematic anti-stigma regulations and community education programs, and disparities in the competencies of counselors providing HIV care, support, and treatment (Perawatan, Dukungan, dan Pengobatan [PDP]). Four policy alternatives were evaluated using Multi-Criteria Decision Analysis (MCDA) based on five criteria: effectiveness, budget efficiency, administrative feasibility, stakeholder support, and speed of impact. The assessment findings supported an integrated policy approach encompassing stronger anti-stigma regulations and community education, equitable capacity building for PDP counselors, integrated service delivery through a one-stop service model, and enhanced interoperability of the HIV/AIDS Information System (Sistem Informasi HIV/AIDS [SIHA]).

INTRODUCTION

National health development is currently guided by the National Long-Term Development Plan (Rencana Pembangunan Jangka Panjang Nasional [RPJPN]) for 2025–2045, established under Law No. 59 of 2024, which serves as the primary framework for national development over the next two decades toward the Golden Indonesia Vision 2045. The document outlines eight development missions and five vision targets, with equitable regional development serving as one of its key priorities. Social Transformation constitutes a fundamental component of this framework, with "Health for All" designated as the first development priority, alongside equitable access to quality education and adaptive social protection. Improving public health outcomes, including controlling infectious diseases such as HIV/AIDS, is therefore not merely a sector-specific health concern but also a prerequisite for realizing the demographic dividend and developing high-quality human resources essential to achieving the Golden Indonesia Vision 2045, as stipulated in Law No. 59 of 2024.

The strategic direction of the RPJPN was subsequently translated into operational priorities through the National Medium-Term Development Plan (Rencana Pembangunan Jangka Menengah Nasional [RPJMN]) for 2025–2029, guided by the vision "Together, Indonesia Advances Toward Golden Indonesia 2045." This national vision was further translated into sector-specific priorities by the Ministry of Health through its vision of "A Healthy and Productive Society to Realize Golden Indonesia 2045."

In the context of HIV/AIDS control, this policy direction aligns with the global commitment to ending AIDS as a public health threat by 2030 and achieving the UNAIDS 95–95–95 targets, which aim to ensure that 95% of people living with HIV (PLHIV) know their HIV status, 95% of those diagnosed receive antiretroviral therapy (ART), and 95% of those receiving treatment achieve viral suppression. These targets complement the broader vision of zero new HIV infections, zero AIDS-related deaths, and zero discrimination (Haghdoost & Karamouzian, 2012; Palchaudhuri et al., 2016). Achieving these commitments requires accelerating HIV case detection, expanding treatment coverage, and improving viral suppression among PLHIV, locally referred to as Orang dengan HIV (ODHIV), through coordinated efforts across all levels of government, from national to local authorities.

At the regional level, these national policy priorities provide a framework for preparing the Kendari City Regional Medium-Term Development Plan (Rencana Pembangunan Jangka Menengah Daerah [RPJMD]) for 2025–2029, which has been formalized through a regional regulation. The plan outlines the regional vision and missions, development goals and objectives, policy directions, strategies, programs, and regional performance indicators. As a regional planning instrument aligned with the RPJPN and RPJMN, the Kendari City RPJMD should incorporate HIV/AIDS control into its health-sector development performance indicators to support the achievement of national and global targets.

Although the Kendari City Government has enacted Kendari City Regional Regulation No. 7 of 2017 concerning Infectious Disease Control and Kendari City Regional Regulation No. 19 of 2014 concerning HIV and AIDS Control, supported by programs implemented by relevant regional government agencies, conditions on the ground indicate persistent challenges in achieving these policy objectives. Data from the Kendari City Health Office indicate an increasing trend in reported HIV/AIDS cases over the past six years, as presented in Table 1. National health development is currently within the broad framework of the National Long-Term Development Plan (RPJPN) for 2025–2045 which was stipulated through Law Number 59 of 2024, as the main reference for the direction of national development over the next twenty years towards the Golden Indonesia Vision 2045. In the document, the Golden Indonesia Vision 2045 is

Table 1. Development of the Discovery of HIV-AIDS Cases in Kendari City.

Description	Year						
	2020	2021	2022	2023	2024	2025	2026
HIV+	41	61	271	273	232	215	
AIDS	0	47	74	48	79	131	171 *

Source: Kendari City Health Office. Year 2026

*) Remarks: Provisional data on HIV-AIDS until August 2026.

Based on Table 1. above, the increase in HIV-AIDS cases is inseparable from the existence of Kendari City as the capital of Southeast Sulawesi Province, where Kendari City is the center of economic growth, inter-regional trade traffic routes, and higher education centers, so that the mobility of the population is very high. The dynamics of urbanization and social changes in society have direct implications for the pattern of the spread of infectious diseases, especially sexually transmitted diseases (STDs) and HIV-AIDS (Ramadan & Ahmad, 2026). Ketut *et al.* (2018) in Salbila Isal & Usiono, (2023) stated that HIV damages human immunity and decreases immunity, so that sufferers are susceptible to other infections.

Based on the above, in Ellfi's opinion, (2026) there are 8 groups of people classified as vulnerable to HIV-AIDS, namely:

1. Pregnant women (pregnant women);
2. Patients who are proven to be infected with TB and are receiving TB-related services;
3. Patients who are proven to be sexually transmitted infections (STIs) and are receiving STI-related services;

4. People with a history of using narcotics and/or other injectable substances (injectable drug users);
5. A person who has sexual intercourse with another party as a primary or additional source of livelihood, in exchange for money, goods, or services (sex peddlers);
6. Men who have had sex with other men (MSM), either occasionally, occasionally, or regularly, regardless of their sexual orientation (heterosexual, homosexual, or bisexual);
7. People with gender identities or expressions that are different from the sex assigned at birth, often called transgender or transvestites;
8. Correctional inmates who are under the guidance of the Ministry of Law and Human Rights and have received a permanent sentence.

These eight groups face a high risk of being infected with HIV-AIDS. Without wise handling, this condition will backfire on the Kendari City Government. Hetli (2013) warned that HIV-AIDS that is not seriously tackled from now on will become a time bomb, threatening the next generation of the nation and damaging the socio-cultural life order of the Indonesian people in the future.

The Kendari City Health Office's screening data in 2026 confirms this urgency, as presented in the following Table 2:

Table 2. Kendari City HIV and AIDS Data based on SPM Achievements until August, 2026

No.	Puskesmas	Target 2026 BUMIL	IM S	WP S	LSL	WB P	TB C	WARI A	Total Targ et	Achieveme nts 2026 BUMIL	IM S	WP S	LSL	WB P	TB C	WARI A	Total Achieveme nts
1	Mata	340	3	0	1	0	29	0	373	196	22	1	2	0	12	0	233
2	Kandai	317	1	93	74	0	43	2	530	145	19	2	5	0	30	0	201
3	Benu-Benua	490	22	115	191	0	40	8	866	312	18	76	283	0	26	11	726
4	Kemaraya	425	9	164	518	0	25	33	1174	173	46	83	102 2	0	11	17	1352
5	Labibia	331	2	0	0	0	33	1	367	147	15	0	0	0	26	0	188
6	Puuwatu	755	8	0	31	174	72	1	1041	414	23	0	62	181	67	2	749
7	Mekar	415	8	42	10	0	41	2	518	309	14	42	2	0	14	2	383
8	Jati Raya	343	5	11	114	0	29	3	505	247	18	53	156	0	22	0	496
9	Perumnas	798	1	116	125	0	22	9	1071	363	14	63	57	0	29	2	528
10	Wua-Wua	586	9	0	24	0	31	8	658	320	23	1	63	0	32	6	445
11	Lepo-Lepo	633	56	61	342	643	56	23	1814	701	160	127	467	584	47	22	2108
12	Mokou	510	7	0	126	0	42	2	687	323	56	1	87	0	24	0	491
13	Poasia	952	22	9	4	0	35	0	1022	565	78	2	8	0	77	0	730
14	Abeli	457	2	0	26	0	39	2	526	238	8	0	27	0	24	0	297
15	Nambo	196	2	0	41	0	18	1	258	77	0	0	42	0	12	0	131
16	RSUD KOTA KENDARI	58	3	5	14	0	5	2	87	64	10	9	44	0	150	0	277
17	RSU BAHTERAMA S	78	6	7	42	0	6	0	139	4	0	0	13	0	4	0	21
18	RS BHAYANGKA RA	93	0	0	0	0	8	0	101	91	0	0	3	0	0	0	94
19	RS SANTA ANNA	55	2	0	1	0	4	1	63	102	1	1	4	0	3	0	111
20	RS JIWA KDI	0	0	0	0	0	1	0	1	0	0	0	1	0	1	0	2
21	RS HERMINA	70	6	6	37	0	0	0	119	500	0	0	0	0	0	0	500
22	RS ANTERO HAMRA	83	0	0	0	0	8	0	91	13	0	0	0	0	2	0	15
Kota Kendari		7.985	174	629	1.72 1	817	587	98	12.01 1	5.304	525	461	2.34 8	765	613	62	10.078

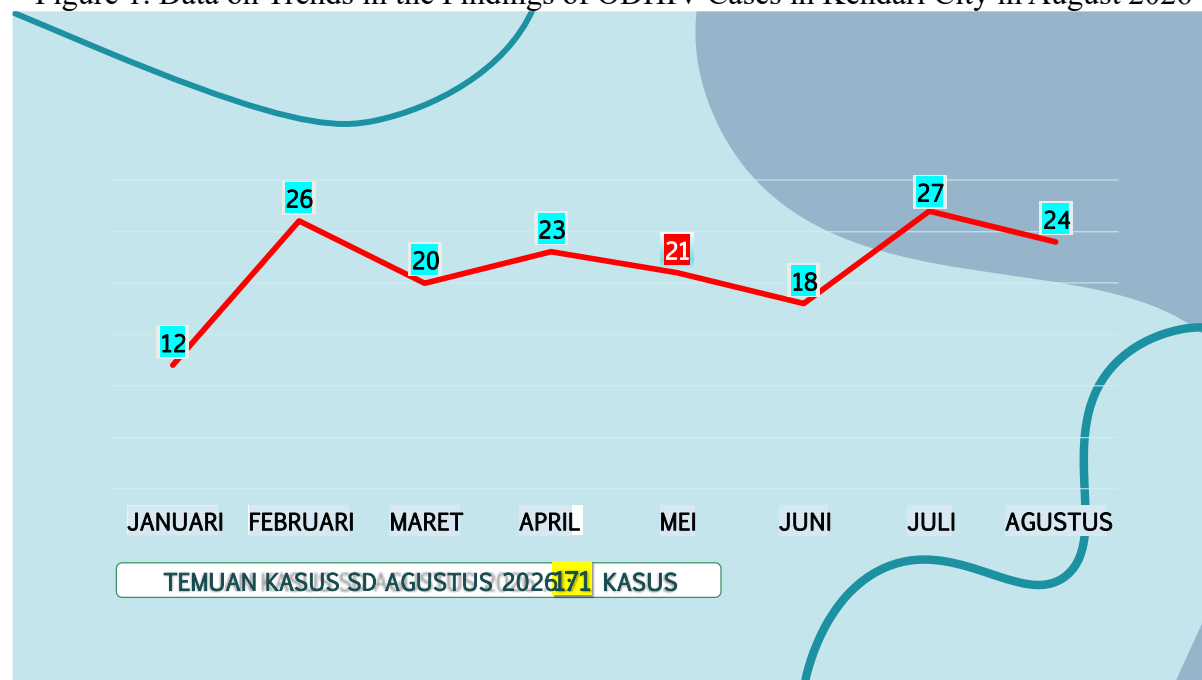
Source: Kendari City Health Office, 2026

Description: Bumil : Pregnant Women
 STIs : Sexually Transmitted Infections
 WPS : Female Sex Workers
 LSL : Male sex man
 TB : Tuberculosis

Based on the data in Table 2 above, it shows that the total screening results until August 2026 amounted to 10078 cases. This finding is based on the results of screening of all health centers and several hospitals appointed by the Kendari City government as health centers and referral hospitals that are HIV-AIDS screening and treatment services.

The findings of ODHIV cases in Kendari City until January - August 2026 can be presented in Figure 1 below.

Figure 1. Data on Trends in the Findings of ODHIV Cases in Kendari City in August 2026



Source: Kendari City Health Office, 2026

For the scope of Southeast Sulawesi Province, the indicators, targets, and achievements of HIV-AIDS control in 2026 are presented in the following Table 3.

Table 3. Data on Indicators, Targets and Achievement of Case Findings in Southeast Sulawesi Province.

Yes	Indicator	Target (%)	Reach (%)
1.	The percentage of people at risk of being infected with a virus that weakens the human immune system who get HIV screening	100	77,80
2.	Percentage of people with HIV (ODHIV) newly found who are receiving ART treatment	95	61,52
3.	ODHIV is undergoing ARV treatment whose viral load is suppressed	95	52,04

Source: Bappeda of Southeast Sulawesi Province, 2026

Based on Table 3 above, the findings in Sulawesi Province show that the results of HIV screening (77.80%), people with HIV ODHIV (61.52%) and the findings of ODHIV cases are 52.04% have not reached the target (100%). The government's target for HIV elimination indicators is to meet 95; 95; 95 is still far from the target set by the government, so it is

necessary to increase the implementation of ATM program activities and synergy across related sectors (Adinkes Sulawesi, 2026).

The data in Table 2 and Table 3 above, show that local governments, both at the city, provincial, and national levels, need to deal with this problem seriously. At the national level, the government's seriousness is increasingly evident with the issuance of Presidential Regulation Number 124 of 2016, and the Regulation of the Minister of Home Affairs Number 20 of 2007 affirming this commitment by authorizing the National and Regional AIDS Control Commission (KPA) to lead, manage, control, monitor, and evaluate the implementation of HIV-AIDS control at each regional level. Furthermore, Presidential Regulation Number 18 of 2020 sets Indonesia's target to end (eliminate) AIDS, Tuberculosis, and Malaria (ATM) by 2030, (Adinkes Sulawesi, 2025); (Syafuruddin, 2025).

The Kendari City Government tackles HIV-AIDS through two regional regulations; (1) Kendari City Regional Regulation Number 7 of 2017 concerning Infectious Disease Control, and (2) Kendari City Regional Regulation Number 19 of 2014 concerning HIV and AIDS Control, but in reality ODHIV continues to increase every year.

Based on the above background, it shows the need for an HIV-AID Mitigation Study in Kendari City.

Problem Formulation

List of Issues

Kendari City, as a *HUB* in Southeast Sulawesi Province, faces the highest spread of HIV-AIDS coming from the mobility of migrant workers, including mining workers in Morosi, Konawe Regency, and Nightlife Venue (THM) workers. HIV-AIDS transmission occurs through four main routes; sexual contact, blood transfusions, joint syringe use, and mother-to-child transmission during pregnancy, childbirth, or breastfeeding.

Based on the above, it can be formulated 7 problems list as follows:

ODHIV found has not all started treatment for HIV (*Test and Treat* are not optimal);

1. The availability of *viral load cartridges* is still very lacking;
2. Some HIV-AIDS services in Kendari City have not implemented *a one-stop service* (OSS);
3. The Kendari City Health Office has not received reports of HIV-AIDS screening data from a number of workplaces;
4. A number of businesses do not provide access to HIV-AIDS screening;
5. Access to HIV screening services to the HIV-AIDS INFORMATION SYSTEM (SIHA) is still limited;
6. *Polymerase Chain Reaction* (PCR) facilities are still limited in number.

Among the 7 problems listed above, it will be selected and determined which is the main problem (priority of the problem to be solved) using the ultrasound (*Urgency, Seriousness, Growth*) methodology framework in collaboration with the Likert scale, the determination of scores from range 1 to 5 based on how big the impact is as presented in the following table 4:

Table 4. Ultrasound (*Urgency, Seriousness, Growth*) analysis in determining priority issues (Main Issues)

No. Respondents	List of Issues	Respondent Name					Score	Ranking
	List of Issues	Elfi	Asriani	putu Agustin	Attica	Hasnawati	Score	Ranking
1	ODHIV that was found had not all started ODHIV treatment (<i>test and</i>	14	12	15	11	11	63	1

	<i>treatment were not optimal);</i>							
3	The availability of <i>viral load cartridges is still very lacking</i>	13	12	15	9	11	60	2
4	Some HIV-AIDS services in Kendari City have not implemented a <i>one-stop service (OSS)</i> ;	15	9	12	12	12	60	2
5	The Kendari City Health Office has not received reports of HIV-AIDS screening data from a number of workplaces;	12	9	15	12	12	60	2
6	A number of businesses do not provide access to HIV-AIDS screening;	11	12	12	12	12	59	3
7	Access to HIV screening services to the HIV-AIDS INFORMATION SYSTEM (SIHA) is still limited;	13	9	15	9	12	58	4
2	<i>Polymerase Chain Reaction (PCR)</i> facilities are still limited in number;	12	9	15	9	12	57	5

Source : Data Analysis Results in Processing, Year 2026

Based on the results of the ultrasound analysis above, the main problems are **ODHIV found has not all started ODHIV treatment (*Test and Treat*) not optimal**. This is the cause of the high number of ODHIV in Kendari City.

Root Cause Analysis

The analysis of the root of the problem with the main problem, namely ODHIV which was found not to have all started ODHIV treatment (*test* and *treat*) was not optimal, it was lowered to find the root cause through level 1 in the following order:

Cause of level 1 problem.

Internal/External Stigma and Discrimination.

Negative stigma against people with HIV becomes the patient's fear of revealing HIV status to family or social environment, so that they delay or are reluctant to start treatment with *Antiretroviral (ARV)*. Many people with HIV experience discrimination in the community. This stigma arises due to a lack of knowledge and understanding of the disease and transmission of HIV-AIDS, this is in accordance with the opinion (Sen, et.al., 2021).

The stigma of HIV experienced by a person is often accompanied by unfair behavior. The public's lack of understanding of how HIV-AIDS spreads triggers discrimination against those who are infected. This is supported by the opinion of Ummah (2019) who said that at-risk groups often feel afraid to take an HIV-AIDS test because they are afraid of being isolated if the test result is positive which results in a delay in treatment.

Post-test referral and counseling system is not yet strong.

The referral and post-test counseling system is not yet strong, as one of the causes of ODHIV in Kendari City, not all have started treatment with the quality of *post-test counseling*

(*post-test counseling*) which is not optimal in building patient awareness, as well as the slow flow of referrals from the test location to the HIV treatment clinic.

In the HIV service flow, after a person is declared reactive or positive through an HIV-AIDS test (either hospitals, health centers, VCT clinics, *mobile testing*, or other health facilities), ideally he or she should immediately receive adequate post-test counseling, then be actively referred and monitored to treatment, support, and treatment (PDP) services to start antiretroviral therapy (ARV).

The weak point referred to here is that in these two chains, counseling and referral are not yet strong, so that many ODHIV are lost between the moment of diagnosis and the moment of starting treatment (a phenomenon that in the HIV literature is called *loss to follow-up* at the *linkage to care stage*).

Accessibility Barriers and Transportation Costs.

Accessibility barriers and transportation costs, as one of the causes of ODHIV in Kendari City, have not all started treatment. The burden of operational costs or transportation of patients to come periodically to health services, especially for ODHIV from vulnerable or low-income groups. The root of this problem highlights that starting and maintaining ARV treatment is not a one-way event, but a lifelong process that demands regular visits to PDP facilities for monthly medication collection, periodic *viral load* checks, and clinical consultations. For ODHIV from low-economic groups, key groups (sex workers, injection drug users, transvestites, etc.), or those who live in suburban areas, far from service facilities, the burden of costs and time to access services regularly becomes a real barrier even if the medicine itself is free.

Cause of level 2 problem for Problem 1a.

There is no systematic anti-stigma regulation/education in the community.

There is still a lack of HIV-AIDS literacy campaigns targeting families and the general community, so that the public's understanding of HIV-AIDS transmission is still wrong and triggers moral judgment. If the root of the previous problem (1a) highlights stigma as the experience felt by ODHIV, then the root of the problem highlights the root cause in terms of governance, namely stigma and discrimination against ODHIV continues, because there is no form of regional regulation or systematic and sustainable public education program.

This is according to information from the Kendari City Health Office that only a small percentage of ODHIV are willing to open about their HIV-AIDS status to officers, an indication that the social environment in Kendari City is not systemically safe enough for ODHIV to open up and access services without fear of social consequences. The limitation of psychosocial assistance services (*Peer Educator/Peer*) as one of the causes of ODHI in Kendari City has not all started treatment.

Kendari City as a medium city, where social relations between residents tend to be close and know each other, the risk of being caught is much more real than a big city that is more anonymous. This makes the issue of confidentiality much more sensitive and has a big influence on a person's decision to access services at facilities closest to their domicile.

The city of Kendari found that only a small number of people are willing to open up to officers regarding their HIV-AIDS status. The fear of this status is not only a matter of social stigma in the community in general, but also a matter of specific trust in the health facility system itself whether the patient is sure that once he steps into the HIV service room, his status is completely safe from information leakage in the environment where he lives and works.

Limitations of Psychosocial Assistance Services (*Peer Educator/Peer Support*).

The limited number of psychosocial assistance services (*Peer Educators*) as one of the causes of ODHI in Kendari City has not all started treatment. The number and capacity of peer companions (*community supporters*) are not adequate to accompany patients emotionally post-diagnosis to the mental adjustment phase. The root of this problem highlights that the process

of a person accepting their HIV-AIDS status, deciding to start treatment, and surviving therapy for life, is not just a medical-clinical process, but also a heavy psychosocial process. At this point, *peer educators/peer support workers*, i.e. other ODHIV who have undergone treatment and are trained to accompany new ODHIV play a crucial role. When the number of distributions, or the capacity of peer companions, is still very limited, new people with HIV are losing the most effective figure to convince them that living with HIV-AIDS and undergoing treatment is possible and reasonable.

This reinforces the picture that the increase in case findings is not balanced by the strengthening of the assistance system. The Head of the Kendari City Health Office himself emphasized that this issue is not only a health issue, but has become a development issue that requires the collaboration of the government, NGOs, professional organizations, and the community, an implicit recognition that community-based handling capacity (including *peer support*) still needs to be strengthened institutionally, not left to depend on voluntary initiatives alone.

Confidentiality Guarantee in Health Facilities Has Not Been Maximized.

Confidentiality guarantees in Health Service Facilities (*fasyankes*) have not been maximized, as one of the causes of ODHIV in Kendari City has not all started treatment. There is no adequate separate/private counseling room available in several health facilities, so there are concerns that the patient's health status is known by other visitors.

This is in line with the finding that many HIV-AIDS cases in Kendari City come from key population groups at risk of sex workers, injecting drug users, transvestites, nightlife venues (HTM) and productive age groups (such as men and women, which have penetrated junior high, high school and university students) with high work mobility, a group that is structurally more vulnerable to cost and access barriers than the general population.

The Causes of the Post-Test Referral and Counseling System Are Not Strong

The capacity of PDP (Care, Support, and Treatment) Counselors is Not Evenly Distributed.

Training for health workers on Test and Treat persuasion counseling techniques is not periodical in Kendari City, so the delivery of information on the importance of ARV is not comprehensive. If the previous root of the problem (the referral system and post-test counseling) highlighted the bridge between the test point and the PDP point, then the root of this problem highlights the quality of human resources at the end of the recipient, namely the counselor who is in charge of the PDP service itself, where ODHIV will undergo lifelong treatment. The PDP counselor plays a role far beyond just explaining how to take medication, building long-term compliance, dealing with psychological side effects, detecting signs of withdrawal from medication early, and being the main trusted figure of ODHIV throughout the treatment period. When the capacity of these counselors is uneven, both in terms of number, competence, and distribution between health facilities, the quality of medical assistance becomes unequal depending on where the patient happens to get services.

There is no digital-based integrated referral system yet.

Monitoring (*tracking*) the status of the sustainability of referrals from the discovery health facility (*screening*) to the PDP health facility still uses conventional recording, so that patients are vulnerable to loss *to follow-up*, as one of the causes of ODHIV in Kendari City has not all started treatment. The root of this problem highlights that the referral process from the test point to the PDP point in Kendari City still relies on the manual mechanism of physical referral letters, oral communication between officers, or separate register book records in each health facility without a single digital platform that connects all HIV-AIDS service points in real-time.

Without this kind of system, there is no automated way to know if a referred patient has actually arrived and been enrolled at the destination facility, when, and under what conditions.

This condition is relevant to the trend of increasing HIV-AIDS cases that continue to occur in Kendari City, where the increase in the volume of cases without being accompanied by the strengthening of the digital tracking system makes the potential for lost cases between test points and treatment points to be greater from year to year.

Administrative Procedures and Inter-Service Referral Flows Are Still Convolutd

Administrative procedures and inter-service referral flows are still convoluted as one of the causes of ODHIV in Kendari City that not all have started treatment. There is no Fast-Track Standard Operating Procedure (SOP) that allows patients to complete files and initial supporting laboratory examinations directly on the same day (*same-day initiation*). The root of this problem highlights that although HIV-AIDS testing and treatment services are substantially available, administrative procedures to move from one service point to another are actually an obstacle in itself. This includes layered requirements, for example, having to bring certain population documents, BPJS/JKN cards, a letter of introduction from the home facility, or a tiered referral form according to the BPJS tiered referral system, as well as bureaucratic flows that patients must go through before they can actually be served at the destination facility.

Causes of Accessibility Barriers and Transportation Costs

Geographical Disparity and Distribution of PDP Services Are Not Even.

The burden of patient transportation costs to come periodically to health services, especially for ODHIV from vulnerable groups or low economies. The location of health facilities providing PDP/ARV services is still centralized in the city center or the main referral hospital, so that ODHIV from the suburbs must travel long distances.

Geographical disparity and the distribution of PDP services are not evenly **distributed**, as one of the causes of ODHIV in Kendari City which continues to increase. The root of this problem highlights that HIV-HIV Treatment, Support, and Treatment (PDP) services in Kendari City are not physically distributed evenly throughout the city, but are concentrated in a handful of referral facilities appointed by the government, namely health centers and hospitals as HIV-AIDS screening and treatment services.

As a result, the distance and travel time to medical services differ greatly depending on where a person lives, creating a structural-spatial access gap, rather than just an individual travel cost.

Kendari City as a city with an area that stretches from several coastal to inland villages, this kind of geographical disparity is very likely to occur, especially for sub-districts that are far from the city center where the main referral hospital is located. The trend of increasing ODHIV cases that continues to occur without the expansion of service points risks widening the gap in access between regions from year to year.

There is no operational assistance scheme/transportation subsidy for vulnerable groups.

There has been no special budget allocation (either from the APBD, Non-Physical DAK, or partnerships/NGOs) to subsidize the cost of ODHIV travel from poor families/vulnerable groups. The lack of an operational assistance scheme/transportation subsidy scheme for vulnerable groups is one of the causes of ODHIV in Kendari City that not all have started treatment. The root of this problem highlights the regional financing policy side, although ARV drugs are provided free of charge by the government, there is no official assistance scheme (from the APBD, CSR funds, coordinated, or partnerships with institutionalized NGOs) that specifically subsidizes the transportation or operational costs of ODHIV visits from vulnerable groups to PDP facilities. This is a logical continuation of the root of the problem (accessibility barriers and transportation costs) that have been discussed earlier, if the root of the problem explains the symptoms (patients have difficulty in costs), then the root of this problem explains why the symptom has never been addressed, this is because there is indeed a lack of financing policy instruments from the APBD designed for this problem.

In the situation of a trend of cases that continues to increase every year in Kendari City, the absence of this kind of subsidy scheme risks increasing the number of ODHIV who fail to

start or continue treatment precisely because of the actual reason that the budget efficiency is relatively small compared to the health costs that must be borne by the state if the patient experiences drug resistance due to discontinuation of therapy.

The decentralized drug courier/pick-up service system is not yet running.

The decentralized courier/drug collection service system has not been running, as one of the causes of ODHIV in Kendari City has not all started/continued treatment. The innovation of community-based ARV distribution networks or integrated delivery services (*mobile clinics/special courier delivery*) has not been utilized to bring access to medicines closer to the patient's domicile. The root of this problem highlights that Kendari City does not have *an ARV home delivery/courier system* delivery mechanism or a decentralized drug collection point that allows ODHIV, especially those whose conditions are clinically stable, to access monthly routine drugs without always having to come directly to PDP facilities, health centers and hospitals where drug screening and collection are carried out. Unlike some regions that have implemented *differentiated service delivery* (DSD) schemes such as drug couriers, community drug collection lockers, or distribution points at partner pharmacies, Kendari City still fully relies on the conventional face-to-face visit model for each drug collection cycle.

Based on the description of the problem as explained above, priority calculation is carried out using the *Failure Mode and Effects Analysis* (FMEA) method. This method measures priority using the *Risk Priority Number* (RPN), which is the result of 3 (three) factors on a scale of 1-10, where the root of the problem with the highest RPN value is the factor that requires policy improvement or evaluation of the most urgent item control as shown in Table 5.

Table 5. Priority Calculation The root cause of ODHIV that is found to have not all started treatment (*test and treat*) has not been optimal.

Yes	The Root of the Problem	Severity (S)	Occurrence (O)	Detection (D)	Total Value (S x W x D)
1.	Internal/External Stigma and Discrimination				
	There is No Systematic Anti-Stigma Regulation/Education in the Community	9	9	8	648
	Limitations of Psychosocial Assistance Services (<i>Peer Educator/Peer</i>)	7	8	9	504
	Confidentiality Guarantee at Health Facilities Has Not Been Maximized	7	7	7	343
	The Causes of the Post-Test Referral and Counseling System Are Not Strong				
2.	The Capacity of PDP Counselors (Care, Support, and Treatment) Is Not Evenly Distributed	9	8	8	576
	There is no integrated referral system yet	9	7	7	441
	Digital-Based				
3.	Administrative Procedures and Inter-Service Referral Flows Are Still Convolutd	7	6	7	294

Problem Statement

Based on the analysis of the root of the problem and the calculation of priorities as explained above, including considerations with the dominant causative factors, the focus of the problem is as follows.

1. The main problem is that ODHIV that has not been found to have all started ODHIV treatment (*test* and *treat*) is not optimal
2. The root of the level 1 problem is the absence of systematic anti-stigma regulations/education in the community
3. The root of the Level 2 problem is the Uneven Capacity of the PDP (Care, Support, and Treatment) Counselor.

Based on the root of the problem, the problem statement in this *policy paper* is that ODHIV is found to have not all started ODHIV treatment (*Test* and *Treat* is not optimal) caused by the absence of systematic Anti-Stigma regulations/education in the community, due to not being supported by the capacity of PDP (Care, Support, and Treatment) counselors are not evenly distributed, so that ODHIV patients are reluctant to start treatment with *Antiretroviral* (ARV) which has an impact on the increase in HIV-AIDS cases in Kendari City.

RESULTS AND DISCUSSION

Concepts/Theories about HIV-AIDS

HIV-AIDS is still a global health problem that requires special attention, especially in terms of prevention and treatment. People with HIV-AIDS (ODHIV) who undergo Antiretroviral therapy (AVR) need a good understanding of treatment and how to maintain quality of life. In addition, the key populations of HIV/AIDS are commercial sex workers, injecting narcotics users, men who have sex with men (LSL), and transgender/transgender women have a high risk of contracting HIV-AIDS, so education about prevention is very necessary.

In Indonesia, as in Kendari City, stigma and discrimination against ODHIV are still a major obstacle in efforts to prevent and handle HIV-AIDS. Many individuals are reluctant to take an HIV-AIDS test because they are afraid of the consequences, even though this detection is very important for more effective treatment, and there is even rejection of treatment. This is in the opinion (Geibel *et al.*, 2017) stigma and discrimination are the biggest obstacles in HIV-AIDS prevention and control efforts. Stigma comes from the mind of individuals who are afraid if they are near HIV (WU, *et al.*, 2015). The emergence of stigma and discrimination can be caused by a lack of community involvement in any HIV-AIDS prevention and control efforts and a lack of appropriate information about HIV-AIDS, especially in the mechanism of HIV-AIDS transmission (Andersson *et al.*, 2020; Martiana *et al.*, 2019 in Nursalam, *et al.*, 2022). Furthermore, according to Nyblade *et al.*, (2021) who stated that community stigma has a considerable influence, not only affecting citizens but also health workers.

Experts look at the concept of HIV-AIDS from various angles, but these definitions basically refer to similar meanings. The Ministry of Health of the Republic of Indonesia (2016), in its HIV Information Pocket Book, defines HIV as an abbreviation for *Human Immunodeficiency Virus*, which is a virus that weakens and attacks the human body's defense system so that the body is susceptible to various diseases. AIDS, an abbreviation for *Acquired Immunodeficiency Syndrome*, refers to a set of symptoms of disease due to decreased immunity caused by HIV, (Anonymous, 2016).

According to Panjaitan, (2028) *Acquired Immunodeficiency Syndrome* (AIDS) is a set of symptoms or diseases caused by decreased immunity due to HIV virus infection that has the family retroviridae.

Squirt *et al.*, (2018), in Salbila Isal & Usiono, (2023) defines HIV as a virus that damages human immunity and lowers or eliminates immunity, so that sufferers are susceptible to other infections.

Furthermore, HIV is a type of retrovirus that has a sheath and consists of two copies of a single-stranded RNA genome. The virus targets cells that express CD4 proteins, including T lymphocytes, monocytes, macrophages, dendritic cells, Langerhans cells, and microglia cells, eventually triggering the death of these cells and significantly lowering immunity in infected individuals. HIV is the cause of AIDS, the final stage of HIV infection (JR & V, 2023 in Franda Sinaga, Harda Afrit (2025); Mariam, 2020).

From some of the concepts above, the author concludes that HIV infects the cells and immune system of the human body, then kills those cells thereby lowering the body's immunity. The immune system becomes deficient when it is no longer able to fight infections and diseases. People with HIV-AIDS endure this infection for life, even though proper treatment allows them to act like a healthy person.

HIV-AIDS transmission occurs through sexual contact, blood transfusions, the use of joint syringes, and transmission from mother to child during childbirth or breastfeeding. Nationally, the HIV epidemic is compound, transmission is concentrated in high-risk populations such as injecting narcotics users, male sex workers (LSL), sex workers, and transvestites. LSL cases in Southeast Sulawesi Province are the highest concentrated in Kendari City, with 1,721 cases in 2025 and 2,348 in 2026. This case has penetrated the younger generation, junior high school and high school students, to university students, so parents and teachers and lecturers need to closely supervise students through HIV-AIDS health education. This is in accordance with the opinion of Mulyaningsih, (2017) who stated that HIV-AIDS health education aims to increase public awareness and understanding of HIV risks and how to protect themselves. These programs include information on condom use, HIV testing, and other risk reduction.

In the second quarter of 2026 alone, 171 new cases of HIV-AIDS were recorded. Health center and referral hospital officers in Kendari City found this case through their preparedness and the expansion of *Voluntary Counseling and Testing* (VCT) and *Provider-Initiated Testing and Counseling* (PITC) services.

The development of the discovery of HIV-AIDS cases in Kendari City over the past five years is presented in the following Table 6:

Table 6. Development of HIV-AIDS Case Discovery in Kendari City.

No.	Faskes	Bum il	IM S	WP S	LS L	WB P	TB C	Wari a	Pelangga n PS	Pasanga n Risti	Pasanga n ODHIV	Anak ODHI V	Cati n	Popula si Umum
1	Kemaraya	1	0	0	25	0	2	1	0	0	1	0	0	0
2	Lepo- Lepo	0	0	2	34	0	0	2	0	0	1	0	0	1
3	Perumnas	0	0	0	5	0	0	0	0	0	0	0	0	0
4	Poasia RSUD	0	0	0	5	0	0	0	0	0	0	0	0	0
5	Kota Kendari RSU	1	0	7	32	0	4	0	0	2	1	1	0	0
6	Bahteram as	4	0	0	15	0	4	0	0	0	1	3	0	9
7	RS Santa Anna	1	0	0	3	0	0	0	0	0	2	0	0	1

No.	Faskes	Bum il	IM S	WP S	LS L	WB P	TB C	Wari a	Pelangga n PS	Pasanga n Risti	Pasanga n ODHIV	Anak ODHI V	Cati n	Popula si Umum
Jumla h		7	0	9	119	0	10	3	0	2	6	4	0	11

Source : Kendari City Health Office, 2026

*) Number of Cases until May 2026

Table 6 shows that HIV-AIDS cases in Kendari City until August 2026 amounted to 171 cases. HIV-AIDS that loses contact with treatment services, or *loss to follow up* (LTFU), causes difficulties for health workers to know their whereabouts. This is in line with the findings of Ramadhan & Ahmad (2026) found that 62% of cases of ARV treatment LTFU in Kendari City come from three factors other than loss of contact, namely the patient's fear of revealing their health status to the work or family environment, geographical constraints, and financial constraints for patients from outside Kendari City.

Subsequently, HIV-AIDS cases based on screening results by health centers and hospitals are dominated by productive age, namely between 15 – $\geq$ 50 years old. This is in accordance with the opinion of Sudikno (2010), in Salbila Isal & Usiono (2023) explained that the high number of AIDS cases in the age group of 20 to 29 years indicates that many of them have been exposed to HIV since adolescence, at the age of 15 to 24 years. Limited access to HIV-AIDS information for adolescents encourages this pattern of transmission.

In Kendari City, male sex workers (LSL) dominate this case and have penetrated junior and senior high school students, students, they are a productive age group that is an asset of the nation, the number of LSL cases will reach 1,721 in 2026. Based on interviews conducted by Kendari City Health Officers with LSL perpetrators, they revealed their reason, that the sexual sensation of fellow men that they feel goes beyond sexual relations with women, and sex with men eliminates the fear of pregnancy.

Current Regulations/Policies

Based on the analysis and discussion in the previous chapter, there are several regulations/policies that are currently in force as follows:

1. Law of the Republic of Indonesia Number 17 of 2023 concerning Health, which integrates regulations regarding prevention, treatment, and legal protection for People With HIV-AIDS (ODHIV).
2. Presidential Regulation of the Republic of Indonesia Number 124 of 2016 concerning Amendments to Presidential Regulation Number 75 of 2006 concerning the National AIDS Control Commission.
3. Regulation of the Minister of Home Affairs Number 20 of 2007 concerning General Guidelines for the Establishment of AIDS Control Commissions and empowering the community in the context of HIV and AIDS Control in the Regions. In the intensive, comprehensive and integrated management of HIV-AIDS in the regions, it is necessary to establish an AIDS Control Commission in the provinces and districts/cities as well as carry out community empowerment. The objectives of this Regulation according to Article 3 of Permendagri Number 20 of 2027 are (a) to reduce to eliminate new infections of HIV-AIDS and STIs, (b) to reduce to eliminate recording and deaths caused by circumstances related to HIV-AIDS and STIs, (c) to eliminate stigmatization and discrimination against people infected with HIV-AIDS and STIs, (d) to improve the health status of people infected with HIV-AIDS and STIs, and (e) to reduce the economic and social impact of HIV-AIDS and STIs on individuals, families and communities.
4. Regulation of the Minister of Health of the Republic of Indonesia Number 23 of 2022 concerning the Prevention of Human Immunodeficiency Virus, Acquired

Immunodeficiency syndrome and Sexually Transmitted Infections. In this context, it is still a health problem that has an impact on the quality of human resources which can cause various socio-economic problems, so countermeasures are needed. In order to carry out the control of *Human Immunodeficiency Virus* (HIV) and *Acquired Immunodeficiency syndrome* (AIDS) Sexually Transmitted Infections (STIs), cross-sector and community support is needed to achieve the elimination of *Human Immunodeficiency Virus* (HIV) and *Acquired Immunodeficiency syndrome* (AIDS) Sexually Transmitted Infections (STIs).

5. Kendari City Regional Regulation Number 7 of 2017 concerning Infectious Disease Control.
6. Kendari City Regional Regulation Number 19 of 2014 concerning HIV and AIDS Control. In this Regional Regulation, the transmission of the HIV-AIDS virus in Kendari City is increasing regardless of social status, as well as regional boundaries, and even there has been a significant increase in number from time to time so that optimal management is required, so it needs to be carried out comprehensively, integrated, sustainable and harmonious by the local government in all stakeholders by involving various sectors for the prevention, transmission, treatment and support and treatment of people with HIV-AIDS in order to improve the degree of public health.

Policy Options

Policy Objectives and Objectives

Referring to the problem statement that has been formulated in Chapter I, namely ODHIV which is found to have not all started treatment (*Test* and *Treat* is not optimal) which stems from the absence of systematic anti-stigma regulations/education in the community and the uneven capacity of Care, Support, and Treatment (PDP) counselors, the policy options in this chapter are formulated to directly answer the two root problems. The policy objectives formulated are as follows:

"Accelerating ODHIV found in Kendari City to initiate Antiretroviral (ARV) treatment through strengthening systematic anti-stigma regulations/education in the community and equitable distribution of the capacity of Care, Support, and Treatment (PDP) counselors, to support the achievement of the 95-95-95 target and the elimination of AIDS as a public health threat by 2030."

In order to operationalize these objectives, the following policy objectives are formulated:

1. An increasing proportion of newly discovered ODHIV and starting ARV treatment in less than 7 (seven) days after being declared reactive/positive, towards the national target of 95%;
2. The availability of local regulations (Mayor Regulations) and anti-stigma and anti-discrimination public education programs against ODHIV that are implemented in a systematic, scheduled, and sustainable manner;
3. Increase and evenly distribute the number, competence, and distribution of trained PDP counselors in all health facilities (health centers and referral hospitals) providing HIV-AIDS services in Kendari City;
4. Decreased patient contact loss rate during the transition from diagnosis to treatment (*loss to follow-up/LTFU on linkage to care*).

Policy Alternative Assessment Criteria

To choose the most appropriate policy alternative, the *Multi-Criteria Decision Analysis* (MCDA) approach is used with five assessment criteria that are relevant to the context of the authority of the Kendari City Government, the limitation of regional resources, and the urgency of the problem as described in Chapter I and Chapter II above. The five criteria and their weights are presented in the following Table 7.

Table 7. Criteria and Weights of Policy Alternative Assessments

Yes	Criteria	Operational Definition	Weight
1.	Effectiveness	To what extent are the alternatives able to solve the root of the main problem (stigma/education and capacity of PDP counselors) directly.	30%
2.	Budget Efficiency	The fairness of the APBD/DAK burden needed compared to the benefits obtained.	20%
3.	Administrative and Institutional Eligibility	Conformity with the authority of the City Government, the availability of a legal umbrella, and the readiness of implementing institutions (Health Office, Regional KPA, health facilities).	20%
4.	Stakeholder Support	The level of acceptance and support from related OPDs, DPRD, health facilities, the ODHI community, and development partners (NGOs/donor partners).	15%
5.	Speed of Impact	The time span it takes for alternatives to start showing results against the increase in the number of starts for HIV treatment.	15%

Source: Data Analysis Results in Processing, Year 2026

Identification and Description of Policy Alternatives

Based on the root of the problem and the criteria above, four alternative policies are formulated as follows.

Alternative 1: Maintain a Business as Usual Policy

This alternative continues the implementation of Kendari City Regional Regulation Number 7 of 2017 concerning Infectious Disease Control and Kendari City Regional Regulation Number 19 of 2014 concerning HIV and AIDS Control as it is, without the addition of derivative regulations, systematic anti-stigma education programs, or strengthening the capacity of PDP counselors in particular.

Advantages: it does not require additional budgets or new political/administrative processes, and is easiest to implement because it only continues the running program.

Disadvantages: does not address the root of the stigma and limitations of PDP counselors directly, so that the trend of increasing HIV-AIDS cases in Kendari City (Table 1.1) has the potential to continue and the achievement of the 95-95-95 indicator in Southeast Sulawesi (Table 1.4) will remain far from the target.

Alternative 2: Strengthening HIV-AIDS Anti-Stigma Regulations and Education Systematically

This alternative focuses on the preparation of the Mayor's Regulation on the Prevention of Stigma and Discrimination against ODHIV as an implementing regulation of Regional Regulation Number 19 of 2014, accompanied by scheduled and sustainable public education programs (HIV-AIDS literacy campaigns in schools, workplaces, and places of worship), as well as strengthening *peer educator* networks as identified in the root of problems 1a1 and 1a2 in Chapter I.

Advantages: directly answer the root of the level 1 problem (the absence of systematic anti-stigma regulations/education), has the potential to encourage greater openness of HIV status so as to accelerate the initiation of treatment, and is in line with the goal of Permendagri Number 20 of 2007 to eliminate stigmatization and discrimination against ODHIV.

Disadvantages: changes in behavior and social norms take a relatively long time to see results, and have not answered the barriers in terms of service capacity (PDP counselors) which are the root of level 2 problems.

Alternative 3: Strengthening and Equitable Capacity of PDP Counselors

This alternative focuses on tiered training and certification of PDP counselors, increasing the number of trained counselors in health facilities that are still lacking,

implementing uniform post-test counseling service standards, and providing incentives for counselors serving in health facilities in suburban areas, as identified in root problem 1b1 in Chapter I.

Advantages: directly strengthen the chain of counseling and post-test referrals which have been a weak point (*linkage to care*), and can be implemented through the technical authority of the Health Office without the need for new legal products.

Disadvantages: require a sustainable training and incentive budget, and have not addressed the root of the stigma problem at the community level which is the main cause of the reluctance of ODHIV to access services in the first place.

Alternative 4: Integrated Policy on Strengthening Anti-Stigma and Capacity of PDP Counselors

This alternative combines alternative 2 and alternative 3 simultaneously and mutually reinforcing (anti-stigma regulation/education combined with strengthening the capacity of PDP counselors), supported by strengthening one-stop *service* (OSS) and integrating referral data into the HIV-AIDS Information System (SIHA) which is an application from the Ministry of Health as a supporting instrument, thus answering the two main root problems that have been determined in the problem statement in Chapter I at once.

Advantages: it is most comprehensive because it intervenes at the root of level 1 and level 2 problems simultaneously, so it has the potential to have a greater and more sustainable impact on the acceleration of ODHIV treatment than a single alternative.

Disadvantages: requires more complex coordination across OPDs (Bappeda, Health Office, Social Service, Regional KPA), larger budget, and time to prepare regulations and training that needs to be carefully planned.

Assessment and Comparison of Policy Alternatives

The four policy alternatives were then assessed quantitatively using five criteria in Table 8, with a score scale of 1 (very low) to 5 (very high). The results of the assessment are presented in Table 8 below.

Table 8. Results of Assessment and Comparison of Policy Alternatives (MCDA)

Criteria	Weight	Alt. 1 BAU	Alt. 2 Regulation/Education	Alt. 3 Counselor Capacity	Alt. 4 Integrated
Effectiveness	30%	2	4	4	5
Budget Efficiency	20%	5	3	3	2
Administrative/Institutional Eligibility	20%	5	4	4	3
Stakeholder Support	15%	3	4	4	4
Speed of Impact	15%	2	3	3	4
Weighted Total Score	100%	3,35	3,65	3,65	3,70
Ratings	-	4	2 (equivalent)	2 (equivalent)	1

Source: Data Analysis Results in Processing, Year 2026

The results of the assessment in Table 8 show that alternative 1 (*business as usual*) obtained the lowest score (3.35) because it did not provide additional interventions to the root of the problem, so the risk of the sustainability of the trend of increasing HIV-AIDS cases in Kendari City remained high. Alternative 2 and alternative 3 obtained an equivalent score (3.65) because each only answered one of the two root problems identified in Chapter I (problem statement), namely anti-stigma regulation/education on the one hand, and the capacity of PDP counselors on the other. Alternative 4 (integrated policy) obtained the highest score (3.70) because it provided the greatest effectiveness and speed of impact through simultaneous interventions on both root problems, although it required relatively higher costs and institutional complexity than the other alternatives.

Recommended Policies

Based on the results of the assessment in Table 8, the policy recommended in this *policy paper* is **Alternative 4, namely the Integrated Policy "Strengthening Anti-Stigma Regulation/Education and the Capacity of PDP Counselors"**, with the consideration that this alternative most consistently answers the problem statement in Chapter I in its entirety, namely ODHIV which is found to have not all started treatment caused either by the absence of systematic anti-stigma regulations/education, as well as by the uneven capacity of PDP counselors. This selected policy includes four main components as follows:

- 1. Strengthening Anti-Stigma Regulations and Education.** The preparation of the Mayor's Regulation on the Prevention of Stigma and Discrimination against ODHIV as an implementing regulation of Regional Regulation Number 19 of 2014, accompanied by scheduled and continuous public education campaigns in schools, workplaces, and communities, as well as strengthening peer mentoring networks (*Peer Educator*).
- 2. Strengthening and Equitable Capacity of PDP Counselors.** Tiered training and certification of PDP counselors, addition and equitable distribution of trained counselors to all health facilities (including suburban areas), and the establishment of post-test counseling service standards.
- 3. Strengthening Integrated Services (*One Stop Service*).** Integration of screening, counseling, and treatment initiation services in a single point of service on the same day (*Same-day initiation*) to cut down on procedural barriers and inter-service referrals.
- 4. Information and Monitoring System Support.** Strengthening reporting and integration of referral data into the HIV-AIDS Information System (SIHA) to reduce the risk of patients losing contact (*loss to follow-up*) between the screening test point and the treatment point.

With this integrated approach, it is hoped that the proportion of ODHIV who immediately start ARV treatment will increase significantly, stigma and discrimination against HIV in Kendari City will be reduced, and the achievement of the 95-95-95 indicator in Southeast Sulawesi Province (Table 1.4) will be closer to the set target.

CONCLUSION

Based on the analysis and discussion presented in Chapters I and II, several conclusions can be drawn. 1) HIV/AIDS cases in Kendari City have shown an increasing trend over the past six years (Table 1), while the achievement of HIV/AIDS elimination indicators in Southeast Sulawesi Province, including HIV screening coverage (77.80%), initiation of antiretroviral (ARV) treatment among newly diagnosed people living with HIV (PLHIV) (61.52%), and viral load suppression (52.04%), remains below the UNAIDS 95–95–95 targets (Table 1.4), despite the enactment of Regional Regulation No. 7 of 2017 and Regional Regulation No. 19 of 2014 concerning infectious disease and HIV/AIDS control. 2) The results of problem prioritization using the Urgency, Seriousness, and Growth (USG) method identified the failure to initiate treatment among all newly diagnosed PLHIV as the most pressing issue, indicating suboptimal implementation of the Test and Treat approach. This issue received the highest priority score (63) among the seven identified problems. 3) Root cause analysis using Failure Mode and Effects Analysis (FMEA) identified two priority contributing factors based on their Risk Priority Number (RPN) scores: the absence of systematic anti-stigma regulations and community education programs (RPN = 648), representing the primary root cause, and disparities in the competencies of HIV care, support, and treatment (*Perawatan, Dukungan, dan Pengobatan [PDP]*) counselors (RPN = 576), representing the secondary root cause. 4) The formulated problem statement highlights that not all newly diagnosed PLHIV initiate antiretroviral therapy (ART), reflecting suboptimal implementation of the Test and Treat approach. This situation is associated with the absence of systematic anti-stigma regulations and community education programs, compounded by disparities in PDP counselor

competencies. These factors may discourage PLHIV from initiating ART, potentially contributing to ongoing HIV transmission and the increasing number of reported HIV/AIDS cases in Kendari City. 5) Among the four policy alternatives evaluated using Multi-Criteria Decision Analysis (MCDA) (Table 8), Alternative 4, an integrated policy entitled "Strengthening Anti-Stigma Regulations, Community Education, and PDP Counselor Capacity," emerged as the preferred option, achieving the highest overall score (3.70). This alternative was prioritized because it simultaneously addresses both identified root causes and received the highest assessment scores for effectiveness and speed of impact.

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