

# UNAIDS

## **An Evaluation of the contribution of the UNAIDS Joint Programme to strengthening HIV and Primary Health Care outcomes**

*Country case studies*

Indonesia



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## Abbreviations and acronyms

AIDS	acquired immuno-deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
BAPPENAS	ministry of national planning and development
BPJS	national social security administrator; social security ( <i>kesehatan</i> ) and healthcare ( <i>ketenagakerjaan</i> )
CCM	(Global Fund) country coordinating mechanism
CLM	community-led monitoring
CLO	community-led organisation
COVID-19	coronavirus disease
CSE	comprehensive sexuality education
CSO	civil society organisation
DFAT	Australian government department of foreign affairs and trade
DHO	district health office
EHG	Euro Health Group
EID	early infant diagnosis
EpiC	USAID/PEPFAR meeting targets and maintaining epidemic control project
FGD	focus group discussion
GBV	gender-based violence
GDP	gross domestic product
HIV	human immuno-deficiency virus
ILO	International Labour Organization
JKN	Indonesian national health insurance
Kader	community health worker
KII	key informant interview
KP	key population
MMD	multi-month dispensing
MoH	ministry of health
MSM	men who have sex with men
PEPFAR	(US) President's Emergency Plan for Aids Relief
PHC	primary health care
PHO	provincial health office
PLHIV	people living with HIV/AIDS
PMTCT/EMTCT	prevention of mother-to-child transmission/elimination of mother-to-child transmission
Posyandu	health posts
PR	(Global Fund) principle recipient
PrEP	pre-exposure prophylaxis
Puskesmas	primary health centres
RPJMN	National Mid-term Development Plan
RSSH	resilient and sustainable systems for health
SATUSEHAT	national health data system
SDG	sustainable development goals
SDG3 GAP	the global action plan for healthy lives and well-being for all

SIHA 2.1	national HIV data system
SPM	minimum standards for services
STI	sexually transmitted infection
TB	tuberculosis
UBRAF	unified budget results and accountability framework
UHC	universal health coverage
UHC-P	UHC partnership
UNAIDS	Joint United Nations Programme on HIV/Aids
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children’s Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
USAID	United States Agency for International Development
VAW	violence against women
WHO	World Health Organization
JUNTA	Joint UN Team on AIDS
UN	United Nations



## Glossary of key terms

Term	Definition
<b>Communities</b>	Groups of people that may or may not be spatially connected, but who share common interests, concerns or identities. These communities could be local, national or international, with specific or broad interest <sup>a</sup>
<b>Community-led (AIDS) responses</b>	Actions and strategies that seek to improve the health and human rights of their constituencies, specifically informed and implemented by and for communities themselves and the organizations, groups and networks that represent them <sup>b</sup>
<b>Community engagement</b>	A process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes <sup>c</sup>
<b>Comprehensive HIV services</b>	Services provided across a continuum that addresses the prevention, testing, treatment, and care needs for people living with and affected by HIV. This may include combination HIV prevention, HIV testing, antiretroviral therapy (ART), management of co-morbidities and coinfections (e.g., tuberculosis (TB), sexually transmitted infections (STIs), viral hepatitis, cervical cancer, non-communicable diseases (NCDs), mental health conditions, etc.), and specific services and interventions for key and other populations (e.g., pre-exposure prophylaxis, harm reduction, condoms, lubricant).
<b>Comprehensiveness of care</b>	The extent to which the spectrum of care and range of available resources responds to the full range of health needs of a given community. Comprehensive care encompasses health promotion and prevention interventions, as well as diagnosis and treatment or referral and palliation. It includes chronic or long-term home care and, in some models, social services <sup>d</sup>
<b>Differentiated service delivery</b>	An approach that simplifies and adapts HIV services to better serve the needs of people living with HIV/AIDS (PLHIV) and to optimize the available resources in health systems <sup>e</sup>
<b>Empowerment</b>	The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or an increase in the ability to self-manage illnesses. <sup>d</sup>
<b>Essential public health functions</b>	The spectrum of competences and actions that are required to reach the central objective of public health — improving the health of populations. This document focuses on the core or vertical functions: health protection, health promotion, disease prevention, surveillance and response, and emergency preparedness. <sup>d</sup>
<b>Health system</b>	All organizations, people, and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, family caregivers; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; and occupational health and safety legislation. The WHO health system framework identifies six health system "building blocks": leadership and governance, health financing, health workforce, health services, health information systems, and medical products, vaccines, and technologies <sup>f</sup>
<b>Health benefits packages</b>	The type and scope of health services that a purchaser buys from providers on behalf of its beneficiaries. <sup>d</sup>
<b>Integrated health services</b>	The management and delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease

Term	Definition
	management, rehabilitation and palliative care services through the different functions, activities, and sites of care within the health system. <sup>d</sup>
<b>Interlinkages</b>	Joined or connected, with the parts that are joined often having an effect on each other
<b>Key populations (KPs)/ vulnerability</b>	<p>KPs are groups that have a high risk and disproportionate burden of HIV in all epidemic settings. They frequently face legal and social challenges that increase their vulnerability to HIV, including barriers to accessing HIV prevention, treatment and other health and social services. KPs include gay men and other men who have sex with men, sex workers, transgender people and people who inject drugs.</p> <p>Vulnerability refers to unequal opportunities, social exclusion, unemployment or precarious employment (and other social, cultural, political, legal and economic factors) that make a person more susceptible to HIV infection and developing AIDS. The factors underlying vulnerability may reduce the ability of individuals and communities to avoid HIV risk, and they may be outside of their control. These factors may include lack of the knowledge and skills required to protect oneself and others; limited accessibility, quality and coverage of services; and restrictive societal factors, such as human rights violations, punitive laws or harmful social and cultural norms (including practices, beliefs and laws that stigmatize and disempower certain populations). These factors, alone or in combination, may create or exacerbate individual and collective vulnerability to HIV.<sup>e</sup></p>
<b>Multisectoral action on health</b>	Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, which address social, economic and environmental determinants of health and associated commercial factors or improve health and well-being. <sup>d</sup>
<b>People-centred care</b>	An approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care. <sup>d</sup>
<b>Person-centred care</b>	Care approaches and practices in which the person is seen as a whole, with many levels of needs and goals, the needs being derived from their personal social determinants of health. <sup>d</sup>
<b>Primary care</b>	A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care. <sup>d</sup>
<b>Primary health care</b>	A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities. <sup>d</sup>
<b>Primary health care-oriented systems</b>	Health system organized and operated to guarantee the right to the highest attainable level of health as the main goal, while maximizing equity and solidarity. A primary health care-oriented health system is composed of a core set of structural and functional elements that support achieving universal coverage and access to services that are acceptable to the population and equity enhancing. <sup>d</sup>
<b>Service package</b>	A list of prioritized interventions and services across the continuum of care that should be made available to all individuals in a defined population. It may be endorsed by the government at national or subnational levels or agreed by actors where care is by a non-State actor <sup>d</sup>

Term	Definition
<b>Synergy</b>	The interaction of elements that when combined produce a total effect that is greater than the sum of the individual elements
<b>Universal Health Coverage</b>	Ensured access for all people to needed promotive, preventive, resuscitative, curative, rehabilitative, and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship. <sup>d</sup>
<b>Vertical programmes</b>	Health programmes focused on people and populations with specific (single) health conditions. <sup>d</sup>

## Sources for glossary:

- a) Community engagement: a health promotion guide for universal health coverage in the hands of the people. Geneva: World Health Organization; 2020
- b) Community-led AIDS responses: final report based on the recommendations of the multistakeholder task team [Internet]. UNAIDS; 2022 [cited 2023 Apr 29]. Available from: <https://www.unaids.org/en/resources/documents/2022/MTT-community-led-responses>
- c) WHO community engagement framework for quality, people-centred and resilient health services. Geneva: World Health Organization; 2017
- d) Operational Framework for Primary Health Care. Geneva: World Health Organization and UNICEF; 2020
- e) Updated recommendations on service delivery for the treatment and care of people living with HIV. Geneva: World Health Organization; 2019
- f) Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. [Internet]. World Health Organization; 2007 [cited 2023 Apr 7]. Available from: <https://www.who.int/publications/i/item/everybody-s-business---strengthening-health-systems-to-improve-health-outcomes>
- g) UNAIDS terminology guidelines, 2015. [https://www.unaids.org/sites/default/files/media\\_asset/2015\\_terminology\\_guidelines\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf)

# Executive summary

## Introduction

The purpose of this case study was to generate evidence and learnings from the different ways in which the UNAIDS Joint Programme has supported countries to leverage PHC and HIV linkages across various contexts. The case study used a mixed methods approach combining qualitative and quantitative methods for data collection and analysis. An initial document and data review was supplemented by primary data collection through key informant interviews and focus group discussions with key stakeholders. Altogether, 13 key informant interviews and 17 focus group discussions were conducted, through which a total of 148 key stakeholders shared their experiences.

Indonesia is facing the persisting presence of communicable diseases as well as the rise of non-communicable diseases. As of 2022, an estimated 540 000 adults and children in Indonesia were living with HIV, with a national prevalence of 0.3%, while the prevalence among key populations ranges from 2% to 25%. Despite a low prevalence of HIV, Indonesia is not on track to reach the global 95-95-95 targets by 2030. The National Mid-term Development Plan (RPJMN 2020-2024) emphasizes the improvement of health services towards Universal Health Coverage (UHC), especially by strengthening primary health care (PHC) services and encouraging promotive and preventive efforts supported by innovation and technology. The health sector is reforming the health system through six pillars of Indonesia's health transformation, with the first pillar being PHC. External partners, including the Global Fund, USAID-PEPFAR, are strategically shifting towards PHC and health systems strengthening.

## Key findings

The evaluation found examples of Joint UN Team on AIDS or individual Cosponsor efforts related to applying the PHC approach to HIV responses since 2020. These included: WHO support to deliver integrated surveillance, testing, and treatment for HIV and STIs; UNICEF has led JUNTA efforts to support integrating triple elimination (HIV/AIDS, syphilis, and hepatitis B) into the overall life cycle strategy; UNFPA has been engaging through activities related to gender-based violence and out-of-school comprehensive sexuality education; UNAIDS has employed PHC approaches by coordinating Joint UN Team on AIDS efforts to engage the community in the HIV response, advocating for multisectoral actions and policies, and reducing human rights barriers to accessing health care at primary care sites for vulnerable populations. The Joint UN team on AIDS has also made efforts to increase the sustainability of the community response through capacity building for civil society organizations and social contracting pilots.

The evaluation found that despite these activities, the aim of leveraging PHC and HIV integration and interlinkages is not explicitly described within the 2021-2025 Joint Programme Strategy in Indonesia, nor are they monitored as an objective, and there is a lack of conceptual clarity about what integration of HIV and other services and integration of HIV within broader health system would look like and how to achieve it. Furthermore, collaboration between the Joint UN Team on AIDS, national government, and external actors working with HIV has been challenging since the disbandment of the National AIDS Commission in 2016 and stakeholders see the UNAIDS Cosponsors as separate and working in silos, which is a barrier to coordinated efforts on PHC and HIV integration and interlinkages.

Achievements and opportunities in leveraging HIV investments and approaches to strengthen broader health outcomes thus far have been rooted in the strong approach to community engagement in the HIV response. Multiple initiatives to maintain testing and adherence to HIV treatment were developed at the national and sub-national level during the COVID-19 pandemic and, if adopted and sustained, these approaches could contribute to improving broader health outcomes.

There is also a potential for lessons learned from stigma and human rights-related HIV programming to reduce stigma associated with key populations and PLHIV in general, as well as other diseases and populations in primary care settings.

The evaluation found that some key populations have limited access to primary care facilities due to structural barriers as well as stigma and discrimination. Health care systems and level of access in Indonesia further vary by location due to the decentralized system, requiring the use of sub-national data for a contextualised approach to HIV/PHC integration.

The evaluation identified potential enablers (e.g. the upcoming PHC transformation of Indonesia's health care system) and barriers to integrating HIV and PHC that need to be addressed (e.g., existing weaknesses in the health care system; disjointed data systems; insufficient protection of human rights for key populations; and a current lack of public-private partnerships).

There are opportunities for further alignment of UN activities, for joint advocacy for the integration of HIV with PHC through ongoing national integration efforts under the government's health transformation initiative and furthering multisectoral collaborations to strengthen interlinkages of HIV and PHC. The Joint UN Team on AIDS was described as being uniquely positioned to convene with different stakeholders, both internal and external (including the government, civil society, and development agencies), for the purpose of coordination and joint advocacy. While capacity was high at the country offices, many stakeholders discussed concerns about limited resourcing to carry out joint activities as UBRAF funding continues to decrease.

## Conclusions and considerations on the way forward

The Joint Programme in Indonesia does not yet have an overarching strategy regarding the integration of HIV and PHC, but there have been activities and achievements with linkages to broader PHC aspects. While some consideration has been given to the integration of HIV responses and that of other communicable diseases and key resources accessed by PLHIV with strong community engagement, the approach is currently lacking attention to multisectoral action and the integration of services with a life-course perspective. The recent health transformation initiative, with PHC as the first pillar, presents an opportunity for early advocacy from the Joint UN Team on AIDS to ensure that HIV is integrated into programming across the life course, including training units for community health workers, school- and work-based health education, and integration of laboratories and data systems.

The HIV response in Indonesia employed unique approaches to community engagement and reducing stigma that could be utilised to strengthen broader health outcomes. There is also room for further collaboration and multisectoral coordination between the members of the Joint UN Team on AIDS with partners (government and external donors) to improve HIV outcomes. The evaluation noted ongoing initiatives to explore the sustainability of community engagement through social contracting and capacity-building and an increased need for advocacy to ensure the sustainability of the national response to HIV through increased domestic funding and the inclusion of HIV prevention, testing, and treatment in UHC packages.

The following presents considerations for the Joint UN Team on AIDS in relation to leveraging HIV and PHC intersections:

- Develop an evidence-based joint strategy for the integration of HIV with PHC, considering what can and cannot be integrated in this context. This is critical and, if produced in a timely manner, can be used for joint advocacy for the inclusion of HIV modules in the government's new approach to PHC.
- Improve multisectoral action and policy - detailed in the joint strategy for the integration of HIV and PHC, and establishment of inter-agency platforms.
- Enhance sustainable community engagement, including scaled-up piloting of social contracting and generation of data to outline benefits and risks.
- Foster political commitment for addressing needs of key populations.
- Intensify coordination and leadership within the Joint UN Team on AIDS and strengthen coordination efforts with government and external donor partners.

# 1. Introduction and context

## 1.1. Purpose and scope of country case studies

This case study contributes to a global evaluation to identify opportunities and imperatives for the work of the UNAIDS Joint Programme (Joint Programme)<sup>1</sup> in relation to the intersections and integration of HIV and primary health care (PHC) in the future. The evaluation is primarily designed for learning and planning purposes. The main objective is to conduct a forward-looking process evaluation that identifies opportunities for the Joint Programme to strengthen HIV and PHC integration and linkages, and to assess what the Joint Programme has achieved since 2020 in relation to these aspects. The purpose of carrying out country case studies was to generate evidence from the different ways in which the Joint Programme has supported countries to leverage PHC and HIV linkages across various contexts.

Four countries were selected for the country case studies: Angola, Botswana, Indonesia, and Pakistan. The selection was based on criteria including relevance of the evaluation topic for UNAIDS country offices, the UN Joint Programme and country governments, geographic diversity, and a diversity in HIV epidemiology and health system contexts.

## 1.2. Approach/methods/limitations

**Approach and methods** – The case studies used a multi-methods approach, in which an initial document and data review was supplemented by primary data collection through key informant interviews (KIIs) and focus group discussions (FGDs). In Indonesia, primary data collection took place during the period 17-24 July 2023 with key stakeholders at national and provincial levels (Jakarta, Banten, and Surabaya).

Key stakeholders were purposely selected to take part in KIIs and FGDs. Interviewees represented United Nations (UN) organizations, government, multi and bilateral organizations, civil society and community-led organizations, and health facility staff (semi-private and public sector). In addition to conducting extensive interviews with national level agencies in Jakarta, the evaluation team visited provincial/district health offices and PHC centres in Jakarta, Tangerang, and Surabaya, which are a sample of the districts where the Joint UN Team on AIDS (JUNTA) has had ongoing activities.

KIIs were conducted using a semi-structured interview guide with a predetermined set of questions. Informants in the FGDs were asked to reflect on the questions asked by the interviewer, provide comments, listen to what others in the group had to say and react to their observations. The interview guide/FGD guide is available in Annex 1. Altogether, 13 KIIs (some with multiple participants) and 17 FGDs were conducted, through which a total of 148 key stakeholders shared their experiences.

Data from KIIs and FGDs were recorded in notes, analysed, and organized according to evaluation themes and content. The evaluation relied on triangulation both across and within categories of data sources. Coding all qualitative data and populating the evaluation evidence matrix by sub-question and evaluation question supported the triangulation process.

**Scope** – The temporal scope of the case study was January 2020 to end of July 2023. The evaluation team assessed the contribution, role, and activities of the Joint Programme at the country level, focusing on the UNAIDS Secretariat and four Cosponsors (WHO, UNICEF, UNFPA and the World Bank) in line with the terms of reference.

**Limitations** – The country case study was restricted by time and scope. It was only possible to conduct KIIs/FGDs with national organizations based in Jakarta, with limited visits to primary care facilities supported by JUNTA and partners in Jakarta, Surabaya, and surrounding areas. Therefore, the evaluation team was unable to collect subnational data about HIV and PHC integration, noting

<sup>1</sup> The UN Joint Programme on AIDS includes the UNAIDS Secretariat and 11 UN agencies who work on HIV known as ‘Cosponsors’.



that it may vary due to decentralisation, geographic distribution of the HIV epidemic, the programmatic response, and donor support between provinces and districts. However, during the limited timeframe of the case study, evaluators were able to gather information from critical national actors in the HIV and PHC response.

In addition, at the time of data collection in July 2023, the Indonesian government was in the process of reforming its health care system through a PHC approach, and the impacts are not yet known. The Omnibus Health Bill passed in June 2023 has PHC as the first pillar of its Health Transformation Initiative, which will likely lead to numerous changes in the way that health care in Indonesia is delivered (see Section 2.2.1), as well as providing the opportunity for HIV and PHC integration and interlinkages. Due to the recency of this approach, findings regarding potential collaborations and opportunities are future oriented and based on evidence of integration efforts in recent years (2020-now).

Interpretation of the report findings should take into consideration these limitations. However, despite these limitations, the country case study identified important learnings, opportunities, and gaps which can inform the future direction of UNAIDS support for HIV and PHC integration and interlinkages in Indonesia.

## 2. Introduction to the Indonesian national PHC and HIV context

Indonesia is the world's fourth most populous country, with over 270 million<sup>2</sup> living across an archipelago of 17 000 islands located in Southeast Asia.<sup>3</sup> The country has a diverse population of over 300 ethnic groups with distinct language and cultures spread over 38 provinces and 514 cities/districts.<sup>4</sup>

Indonesia has the sixteenth largest economy in the world by nominal gross domestic product (GDP), with a GDP of 1.32 trillion (4 788.0 per capita).<sup>5</sup> On 1 July 2023, Indonesia's financing status to upper middle-income<sup>6</sup> after being downgraded to lower middle-income country in 2020 as consequence of the COVID-19 pandemic. The economy is growing rapidly, with a rate of annual GDP growth at 5.3% in 2022.<sup>7</sup> Despite this growth, inequality remains high, not only between urban and rural settings but also between the western and eastern region of the country.

The average life expectancy of men and women in Indonesia is 62 years and 65.7 years, respectively. Indonesia has experienced a demographic dividend since 2015 with the peak period expected to occur in the period 2020-2035. According to the National Statistical Bureau, the population pyramid is currently in the expansive category, indicating that most of Indonesia's population is still relatively young. This period for advancement in economic and social development – including poverty alleviation and greater productivity – is the basis for the National Mid-term Development Plan (RPJMN) 2020-2024 and the National Long Term Development Plan 2025-2045.

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<sup>2</sup> According to the Ministry of Home Affairs, the total population of Indonesia on 31 December 2021 was 273,879,750 people consisting of 138,303,472 male residents and 135,576,278 female residents: <https://dukcapil.kemendagri.go.id/page/read/7/data-kependudukan>

<sup>3</sup> World Bank. Data: Indonesia. 2023. (<https://data.worldbank.org/country/ID>, accessed 12 July).

<sup>4</sup> Ministry of Health. National Action Plan HIV and STI Prevention and Control Program 2024-2026. 2023.

<sup>5</sup> Ibid.

<sup>6</sup> The World Bank notes that Indonesia's per capita gross national income (GNI) is US\$ 4 580 in 2022, up 9.8% from the previous year of US\$ 4 170. (<https://openknowledge.worldbank.org/server/api/core/bitstreams/e276a12e-4a4c-4429-812f-fd14f77337c5/content>).

<sup>7</sup> Ibid.

## 2.1. Overview of health context

### 2.1.1. Key health data

The Ministry of Health (MoH) Directorate of Public Health has highlighted Indonesia's triple disease burden that consists of: (1) new emerging and re-emerging diseases such as COVID-19, (2) communicable diseases<sup>8</sup> that have not been well managed or controlled, and (3) non-communicable diseases that continue to rise. The rise of leading risk factors for death and disability in Indonesia, including high systolic blood pressure, tobacco use, dietary risks, high fasting plasma glucose, and high body mass index, aggravated the impact of COVID-19, with the country experiencing more than 6 million cases and 160 000 deaths between January 2020 and August 2023.<sup>9,10</sup>

### 2.1.2. Progress on sustainable development goals (SGD) SDG3 targets (except SDG3.6 and 3.9)

Although maternal deaths have decreased – the maternal mortality ratio declined from 298.6 deaths per 100 000 live births in 2000 to 172.9 deaths per 100 000 live births in 2020 – maternal mortality is still high.<sup>11</sup> From 2000 to 2021, the mortality rate for children under 5 years of age reduced from 52.2 to 22.2 deaths per 1 000 live births, and the infant mortality rate reduced from 41.0 to 18.9 deaths per 1 000 live births.<sup>12</sup>

As described in Section 2.1.1, Indonesia is facing the persisting presence of communicable diseases as well as the rise of non-communicable diseases contributing to death and disability. The risk of dying between the ages of 30 and 70 from cardiovascular disease, cancer, diabetes, or chronic respiratory disease was 24.8% in 2020 (only slightly lower than 25.6% in 2000).<sup>13</sup> While rates are declining, the risk of dying from communicable diseases is still pertinent: malaria, respiratory diseases/TB, and HIV are still among the top 20 leading causes of death, respectively comprising 0.037%, 4.48%, and 0.33% of total deaths in Indonesia in 2019 (see Figure 1).

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<sup>8</sup> On 16 November 2022, Minister of Health, Ir. Budi Gunadi Sadikin, CHFC, CLU at the International Conference on Tropical Medicine 2022, emphasized that "Indonesia is not free of communicable infectious diseases, such as malaria, TB and HIV... This is why we must have a strong health innovation system to fight the spread of infectious diseases. COVID-19 teaches us that every country must have the capacity to prevent, detect and respond to various threats that come."

<sup>9</sup> Ibid.

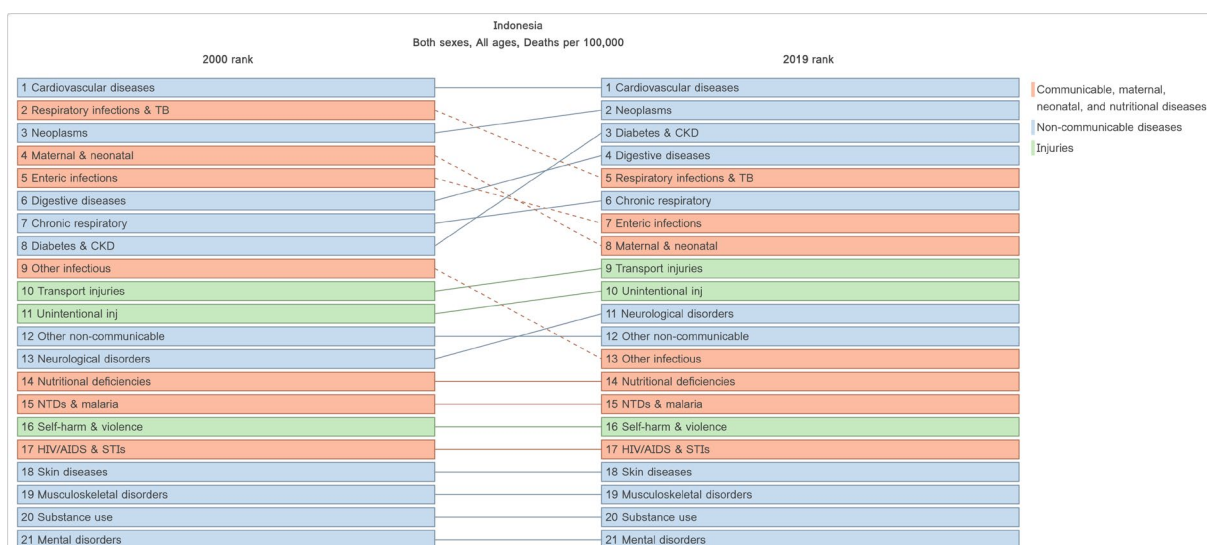
<sup>10</sup> World Health Organization. COVID-19: Indonesia Situation. ([Indonesia: WHO Coronavirus Disease \(COVID-19\) Dashboard With Vaccination Data](#) | [WHO Coronavirus \(COVID-19\) Dashboard With Vaccination Data](#), accessed 28 August 2023).

<sup>11</sup> United Nations Indonesia. Sustainable Development Goal 3. 2023. ([Sustainable Development Goal 3: Good Health and Well-being | United Nations in Indonesia](#), accessed 28 August 2023).

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.



**Figure 1: Leading causes of death in Indonesia (2009 and 2019)<sup>14</sup>**

Meanwhile, a greater proportion of the population has access to affordable healthcare. The universal health coverage (UHC) service coverage index has increased from 29.0 in 2000 to 55.0 in 2021.<sup>15</sup> The population is spending less of their total household income on health, with 2.0% spending above 10% and above 0.3% spending above 25%.<sup>16</sup>

## 2.2. National PHC policy (by July 2023) and programmatic response and challenges

### 2.2.1. Current health sector strategic plan, UHC roadmap and PHC strategy

The recent COVID-19 pandemic demonstrated that health is essential to social and economic development. The health sector targets in the National Development Long Term Plan 2025-2045 include: increasing health status and quality of life, increasing life expectancy to 75.5 years, reducing HIV/AIDS, TB, and non-communicable diseases; eliminating malaria in all districts/cities, and reducing stunting in children under five to 5%.<sup>17</sup>

The RPJMN 2020-2024<sup>18</sup> emphasizes the improvement of health services towards UHC, especially by strengthening PHC services and encouraging promotive and preventive efforts supported by innovation and technology. The health sector is reforming the health system through the six pillars of Indonesia's health transformation. These pillars are:

1. Transformation of primary services through the revitalization of community (primary) health centres (Puskesmas) and integrated health posts (Posyandu) to provide promotive and preventive efforts for all cycles of life;
2. Referral service transformation for handling stroke, cancer, and kidney disease through a uniform distribution of specialty health care services;

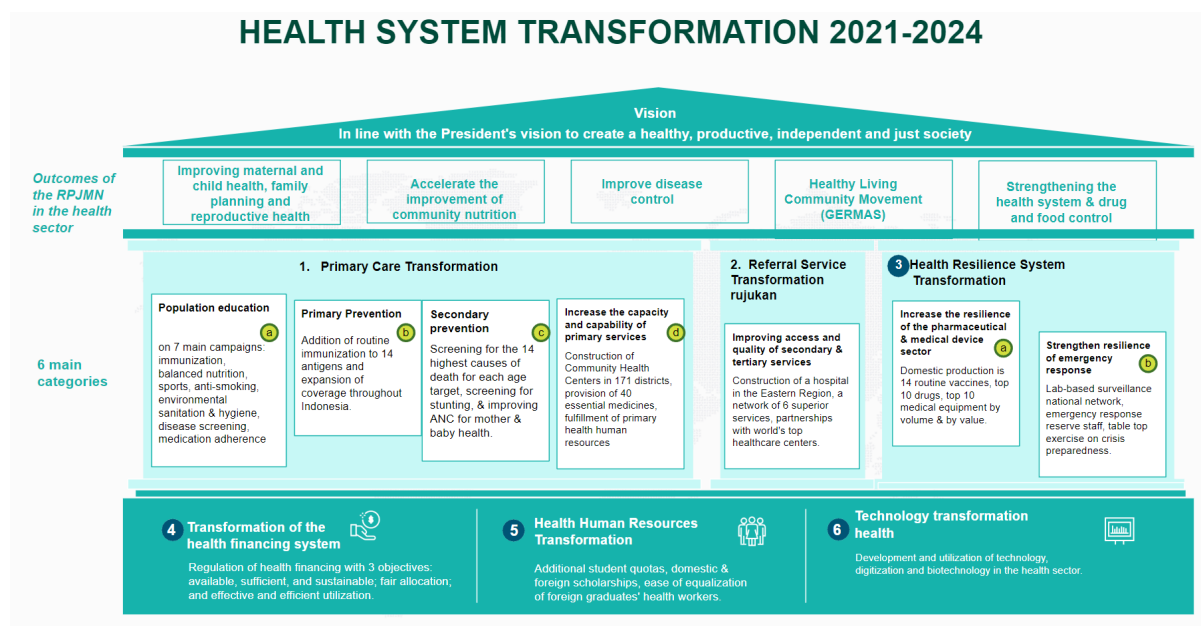
<sup>14</sup> IHME. GBD Compare. <https://vizhub.healthdata.org/gbd-compare/#0>; accessed 12 October 2023.

<sup>15</sup> United Nations Indonesia. Sustainable Development Goal 3. 2023. ([Sustainable Development Goal 3: Good Health and Well-being | United Nations in Indonesia](#), accessed 28 August 2023).

<sup>16</sup> Ibid.

<sup>17</sup> Indonesian Government. National Long-Term Development Plan (RPJPN 2025-2045). 2023.

<sup>18</sup> Ministry of Health. PERATURAN MENTERI KESEHATAN REPUBLIK INDONESIA NOMOR 13 TAHUN 2022. 2022. ([https://e-renggar.kemkes.go.id/file\\_performance/1-131313-1tahunan-502.pdf](https://e-renggar.kemkes.go.id/file_performance/1-131313-1tahunan-502.pdf)).

**Figure 2: Health system transformation 2021-2024**

- Transformation of health system resilience by ensuring the availability of medicines, vaccines, locally made diagnostic tools, and backup health workers;
- Transformation of the health financing system to support the process of revamping the health offices' budgets;
- Transformation of human resources for health to meet a target doctor-to-population ratio of 1:1 000. Currently, in Indonesia, there is one doctor for every 2 700 people; and
- Transformation of health technologies by developing and implementing a health technology platform that can be used to digitally record patients' medical history in all health service facilities.

In its efforts to expand UHC, the government of Indonesia has published the Presidential Instruction (IN PRES) Number 1 of 2022 concerning Optimizing the Implementation of the National Health Insurance Program, which mandates the National Social Security for Health (BPJS) and the synergising of ministries/agencies and all regional governments at the provincial and district/city levels to ensure that all residents are protected in the National Health Insurance Program (JKN). The RPJMN 2020-2024 targets a participation of 98%. JKN covers 90.3% of Indonesia's population, of which 60.39% of JKN participants are included in the JKN Contribution Assistance Beneficiary Programme.<sup>19</sup> 319 districts/cities in 16 provinces have reached 95% coverage.<sup>20</sup>

### 2.2.2. Leadership and responsibilities for delivering PHC at all levels

Indonesia has a decentralized governance structure. Provinces and cities/districts are responsible for providing public services including health. The central government (through the MoH) provides health-related guidance, procedures, and standards, while implementation is the responsibility of provincial health offices (PHOs) and district/city health offices (DHOs) and delivered by public facilities at district (hospitals and district health offices) and community level (Puskesmas/primary

<sup>19</sup> Annur CM. Ada 27.659 Fasilitas JKN BPJS Kesehatan hingga Awal 2023, Terbanyak Puskesmas. Databoks. February 2023. (<https://databoks.katadata.co.id/datapublish/2023/02/24/ada-27659-fasilitas-jkn-bpjs-kesehatan-hingga-awal-2023-terbanyak-puskesmas#:~:text=Per%2031%20Januari%202023%2C%20BPJS,mencapai%2049%2C67%20juta%20jiwa>).

<sup>20</sup> Ibid.



For HIV, the current SPM (2019) specifies that local governments are responsible for funding community-based outreach, HIV screening,<sup>22</sup> and consumables. Specifically, local governments are required to fund and provide HIV education and screening for KPs who are at risk of contracting HIV at least once per year.<sup>23</sup> However, city/district governments set their own annual HIV screening targets and have no legal obligation to achieve specific targets.

The HIV response is led by the HIV/sexually transmitted infections (STI) working group (*Tim Kerja*) under the Directorate of Communicable Diseases at the MoH. The 2016 Presidential Regulation dictates that authorities and functions held by the National AIDS Commission's Secretariat<sup>24,25</sup> are divided between the MoH and the coordinating Ministry of Human Development and Culture, with MoH being responsible for strategy and regulation while the latter is responsible for hosting coordinating forums. At sub-national level, the PHOs and DHOs have their own HIV/STI sub-division under the communicable diseases' directorate. The PHO's functions include formulating technical policies, management of the health sector within the province, and evaluation and reporting. The DHO provides guidance and technical support to Primary Health Centres and other health units at district/city level.

### 2.2.3. Community structures and engagement

The current health system transformation puts patients and community at the centre through a participatory approach and community-based interventions. The role of communities affected by HIV increased significantly as the National AIDS Commission intensified engagement with networks of KPs and people living with HIV (PLHIV). There are also many civil society organisations (CSOs) engaged on health issues in Indonesia, which play an important role in promoting awareness, prevention, policy advocacy, and working in partnership with government on monitoring and evaluation.

Community health workers – known as kader – are part of the health system at village level.<sup>26</sup> Kader are volunteers or community-based workers supporting health and social development activities in the community.<sup>27</sup> Community health workers or kader have been part of the HIV/AIDS response since the early 2000s, when local AIDS Commission engaged volunteers for promotion, education and engaging local communities on HIV. This was strengthened by the Regulation of the Minister of

<sup>22</sup> For risk populations groups, comprising of: 1. Pregnant women, namely every woman who is pregnant.

2. TB patients, namely patients who are proven to be infected with TB and are receiving TB-related services

3. Sexually Transmitted Infection (STI) patients, namely patients who are proven to be infected with an STI other than HIV and are receiving STI-related services

4. Sex worker, namely someone who has sexual relations with other people as a main or additional source of livelihood, with certain compensation in the form of money, goods or services

5. Men who have sex with men (MSM), namely men who have had sex with other men, once, occasionally or regularly whatever their sexual orientation (heterosexual, homosexual or bisexual)

6. Transgender, namely people who have a gender identity or gender expression that is different from the gender or sex assigned at birth, sometimes also called transsexual.

7. Injecting drug users (IDUs), namely people who are proven to have a history of using narcotics and/or other injectable addictive substances.

<sup>23</sup> Ministry of Health. KEPUTUSAN MENTERI KESEHATAN REPUBLIK INDONESIA NOMOR HK.01.07/MENKES/90/2019. 2019. ([https://siha.kemkes.go.id/portal/files\\_upload/PNPK\\_HIV\\_Kop\\_Garuda\\_1.pdf](https://siha.kemkes.go.id/portal/files_upload/PNPK_HIV_Kop_Garuda_1.pdf)).

<sup>24</sup> Since 2006, the National AIDS Commission, managed by a Secretariat led and governed the HIV and AIDS response, coordinated the multisectoral response while MoH focused on the technical aspect of the response. The National AIDS Commission was dissolved before the last review in 2017 based on the 2106 Presidential Regulation.

<sup>25</sup> Presidential Regulation. Perubahan Atas Peraturan Presiden Nomor 75 Tahun 2006 Tentang Komisi Penanggulangan Aids Nasional. 2016. ([PERPRES No. 124 Tahun 2016 \(bpk.go.id\)](http://perpres.go.id/PERPRES.No.124.Tahun.2016)).

<sup>26</sup> Kompak. Funds Interplay in Public Health Centres (Puskesmas). December 2017.

([https://sikompak.bappenas.go.id/pustaka/view/231/en/2017\\_Funds%20Interplay%20in%20Public%20Health%20Centres%20Puskesmas.pdf](https://sikompak.bappenas.go.id/pustaka/view/231/en/2017_Funds%20Interplay%20in%20Public%20Health%20Centres%20Puskesmas.pdf)).

<sup>27</sup> *Kader* or *cadre* are volunteers deriving from the Family Welfare Movement (PKK) from the 1970s to support mostly promotive activities in health and nutrition at village level through the Posyandu. From the mid 1980s, MoH used Posyandu as entry point for family planning program, increase infant's health (measurement of weight, height, providing nutrition), counseling on child growth and support MoH for immunization. These volunteers work in coordination and supervised by the local Puskesmas. They may do home visits and report to the local public clinic for required follow up.

Home Affair No. 20/2007 concerning general guidelines for the establishment of HIV/AIDS management and community empowerment commissions in the framework of handling HIV and AIDS at subnational level. Kaders are essential in remote areas where there are no CSOs working on HIV, as they support the Puskesmas to assess the local community, find new cases in their localities, and carry out mobile clinic activities. They become an extension of the Puskesmas at community level. Where CSOs and community-led organisations (CLOs) are operating, they also fill this role.

In 2006 the MoH introduced the Vigilant Village (*desa/kampung siaga*) concept<sup>28</sup>, which aims to create basic health care access through Village Health Posts (*Poskesdes*) with an emphasis on community empowerment, participation, resilience, and using community resources to identify and tackle local health issues. *Poskesdes*, especially in rural areas or remote places such as in islands where a Puskesmas is not available, provide support for HIV testing through mobile clinics led by the local public health centre.

#### **2.2.4. Role of private sector**

The Indonesian health system has a mixture of public and private providers and financing. There are a range of private providers, including networks of hospitals and clinics managed by manufacturers' corporate social responsibility programmes, not-for-profit and charitable organizations, for-profit providers, and individual doctors and midwives who engage in dual practice (i.e. have a private clinic as well as a public facility role).<sup>29</sup> Public insurance (JKN) covers private clinics and hospitals through a case-based reimbursement scheme, where public and private hospitals are paid with the same rate by BPJS Health (*Kesehatan*).

The 2021 National Economic Survey indicated that more than two-thirds of outpatients are more likely to access private health services, as they are perceived to be closer and more accessible to communities.<sup>30</sup> This extends to pregnant women, who are likely to access private practices but unlikely to undergo HIV testing, with a longitudinal study published in 2019 reporting that only 52% of pregnant women referred by private midwives to clinics were tested for HIV.<sup>31</sup> MoH in Indonesia is planning to expand services through private providers in the next Global Fund Funding Request 2024-2026 through the development of a district-based Public Private Community Partnership network engaging public, private, and community sectors.

#### **2.2.5. Health systems and service delivery challenges and social inequities affecting access to health services**

Access to health services for KPs is becoming increasingly challenging due to a strict legal environment. The Parliament has ratified the revised Penal Code, Law No.1/2023, taking effect in January 2026, and is planning to revise the Narcotics Law 35/2009. The Penal Code has criminalised:

- the display of contraceptives to minors by anyone other than “authorised persons”
- extramarital sexual relationships
- same-sex relationships.

In addition, local regulations further criminalise transgender individuals.<sup>32</sup> Increasing legal barriers and corresponding stigma are a barrier to accessing health services for KP members.

<sup>28</sup> Decree of the Minister of Health Number 564/Menkes/SK/VIII/2006 concerning guidelines for implementing the development of *Desa Siaga*

<sup>29</sup> World Health Organization. The Republic of Indonesia Health System Review. WHO Indonesia. 2017.

<sup>30</sup> Susenas. 2021 National Economics Survey. 2021.

<sup>31</sup> Wulandari LPL, Lubis DSM, Widarini P, Widyanthini DN, Wirawan IMA, Wirawan DN. HIV testing uptake among pregnant women attending private midwife clinics: challenges of scaling up universal HIV testing at the private sectors in Indonesia. *Int J Health Plan Manage.* 2019 Oct;34(4):1399-1407. doi: 10.1002/hpm.2807. Epub 2019 May 23. PMID: 31120151.

<sup>32</sup> An example is the Bogor City Sexual Deviation Regulation, gender minority groups feel threatened “there will be legitimacy of persecution,” BBC News Indonesia, <https://www.bbc.com/indonesia/indonesia-60886391>

In addition, gender-based vulnerabilities are a barrier to seeking health services. There has been an increase in HIV cases amongst women who are not members of KPs. The 2020 annual report of the National Commission on Violence Against Women (*Komnas Perempuan*) documented a spike in cases of violence against women living with HIV from 4 cases in 2019 to 23 in 2020.<sup>33</sup> The 2021 Annual report from the National Commission on VAW (*Komnas HAM*) reported violence took form of physical and sexual, psychological and financial violence.<sup>34</sup> The report added that HIV/AIDS positive status has increased women's vulnerabilities due to gender-related power imbalances, poverty, and stigma around HIV status. The report identified 441 regional regulations that discriminate against women, resulting in their criminalization and limiting their autonomy over their bodies and expression.<sup>35</sup>

In addition, access to health services varies by region. The MoH Health Profile Report 2021 notes that there are 10 292 Puskesmas in Indonesia, consisting of 4 201 inpatient Puskesmas and 6 091 non-inpatient Puskesmas.<sup>36</sup> Although the number has increased from 9 767 in 2016, the distribution is uneven. West Papua is recorded as having the lowest national ratio of Puskesmas per sub-district, at only 0.29. DKI Jakarta has the highest national ratio of Puskesmas per sub-district, at 7.16.<sup>37</sup>

## 2.3. Overview of the national HIV epidemic and response

### 2.3.1. Key epidemiological data

As of 2022, an estimated 540 000 adults and children in Indonesia were living with HIV, with a national prevalence of 0.3% and incidence rate of 0.15 per 1 000 population among adults aged 15-49 years old.<sup>38</sup> Provincial prevalence ranges from 0.1% to over 2%.<sup>39</sup> In the former Papua and West Papua (now split into six provinces), there is a low-level generalised epidemic, with the prevalence in non-KPs at 1.8%.<sup>40</sup> In KPs, which are most affected by HIV in Indonesia, prevalence ranges from 2.2% to 25.3% (see Table 1).

**Table 1: HIV prevalence amongst KPs<sup>41</sup>**

Population	Non-Papua	Papua
Men who have sex with men	21.90%	-
Female sex workers	2.20%	15.92%
Transgender women	12.70%	-
People who inject drugs	14.70%	-
Male sex workers	25.27%	-

<sup>33</sup> Komnas Perempuan. Annual Report. 2020.

<sup>34</sup> <https://komnasperempuan.go.id/download-file/816>

<sup>35</sup> Ibid.

<sup>36</sup> Ministry of Health. Health Profile Report. 2021.

<sup>37</sup> Ibid.

<sup>38</sup> UNAIDS. Indonesia Country Factsheet. 2022. <https://www.unaids.org/en/regionscountries/countries/indonesia>; accessed 9 October 2023.

<sup>39</sup> Ibid.

<sup>40</sup> Ibid.

<sup>41</sup> Review Team (Ministry of Health, UNAIDS, WHO, et al.). Joint Review of the National HIV and STI Control Program 2020-2022. Ministry of Health. June 2023; 43.



### 2.3.2. Progress against 95-95-95 targets

Indonesia is not on track to reach 95-95-95 by 2030. The most recent cascade data shows that 79% of PLHIV know their status, 33% of PLHIV are on antiretroviral treatment (ART), and 6% of PLHIV on treatment have achieved viral suppression (see Figure 4). This varies by KP group (see Table 2), with sex workers having the lowest rates of status awareness and ART coverage.

Figure 4: Treatment cascade for PLHIV<sup>42</sup>

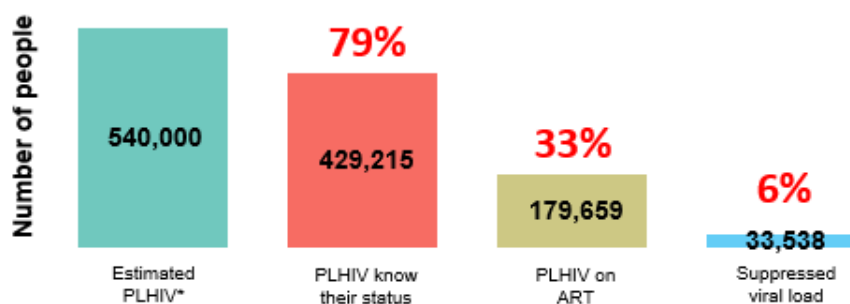
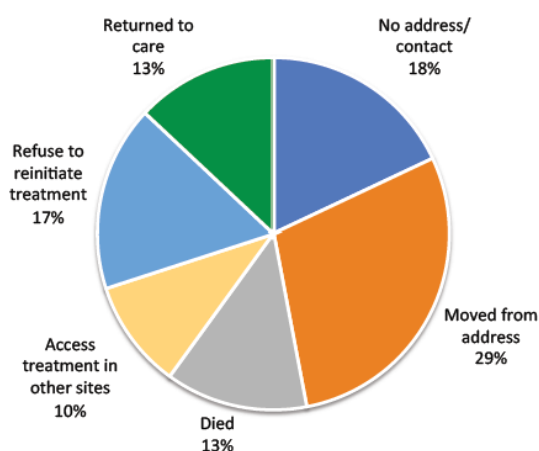


Table 2: KP cascade data<sup>43</sup>

Population	Testing and status awareness	ART coverage
Men who have sex with men	55.5%	37.9%
Sex workers	38.6%	22.4%
Transgender people	65%	34.4%
People who inject drugs	57.2	-
Male sex workers	25.27%	-

Although access to testing has increased in recent years, loss to follow-up and poor retention on ART (see Figure 5), as well as limited resources for viral load testing, are barriers to reaching the 95-95-95 targets.

Figure 5: PLHIV loss to follow-up<sup>44</sup>



<sup>42</sup> UNAIDS Indonesia

<sup>43</sup> UNAIDS. Indonesia Country Factsheet. 2022. <https://www.unaids.org/en/regionscountries/countries/indonesia>; accessed 9 October 2023.

<sup>44</sup> Review Team (Ministry of Health, UNAIDS, WHO, et al.). Joint Review of the National HIV and STI Control Program 2020-2022. Ministry of Health. June 2023; 54.

Linkage from testing to treatment and care is also weak, with only 28% of pregnant women living with HIV and 34% of TB patients with HIV receiving ART in 2022.<sup>45</sup>

### **2.3.3. The aims and strategic orientation of the HIV and STI prevention and control national action plan**

Indonesia's 2020-2024 HIV and STI Prevention and Control National Action Plan aims to decrease HIV incidence from 24 to 18 per 100 000 population members over 15 years of age by 2024,<sup>46</sup> and the 2024-2026 National Action Plan aims to further decrease the incidence to 8 per 100 000 population members by 2026.<sup>47</sup>

In 2022, MoH released Regulation No. 23 of 2022 on the Prevention and Control of HIV, AIDS, and STIs to achieve the target of ending AIDS by 2030 through the fast track 95-95-95 approach.<sup>48</sup> There are six acceleration strategies, namely:

1. **Strategy 1:** Strengthening the commitment of ministries/institutions, provinces, and districts/cities;
2. **Strategy 2:** Improving and expanding community access to comprehensive and quality screening, diagnosis, and treatment of HIV, AIDS, and STIs;
3. **Strategy 3:** Intensifying health promotion activities, prevention of transmission, surveillance, and handling of HIV, AIDS, and STI cases;
4. **Strategy 4:** Strengthening the improvement and development of partnerships and the involvement of cross-sectoral, private, community/organization, society, and related stakeholders;
5. **Strategy 5:** Improving policy studies and development that support HIV, AIDS, and STI control programmes; and
6. **Strategy 6:** Strengthening program management through monitoring, evaluation, and follow-up.

## **2.4. HIV and PHC interlinkages**

Puskesmas act as a PHC focal point (see Section 2.2.2), under which there are sub-district health centers (Pustu), mobile health centers (Pusling), practicing doctors and practicing midwives. At the village level, primary care services are extended through Polindes, Poskesdes, Posyandu, early childhood education (PAUD), and toddler family development (BKB). The implementation of the SPM for health in 2008 established grounds for the integration of HIV services into primary care through referrals, epidemiology and prevention, health promotion, and community empowerment.<sup>49</sup>

Primary care facilities provide key access to HIV testing and treatment in Indonesia. Access to HIV testing services is available in 98% of districts/cities, and 88% of Puskesmas able to provide HIV testing.<sup>50</sup> In addition, the number of HIV treatment services tripled from 1 000 in 2019 to 2 989 in 2022.<sup>51</sup> Two-thirds of these services are in Puskesmas, increasing from being available in 500 Puskesmas in 2019 to 2,000 Puskesmas in 2021.<sup>52</sup> 187 districts and cities (36.4%) have comprehensive service facilities, defined as the availability of, at a minimum, HIV testing, STI

<sup>45</sup> Review Team (Ministry of Health, UNAIDS, WHO, et al.). Joint Review of the National HIV and STI Control Program 2020-2022. Ministry of Health. June 2023; 51.

<sup>46</sup> Ministry of Health. National Action Plan: HIV and STI Prevention and Control Programme 2020-2024. Ministry of Health. 2020.

<sup>47</sup> Ministry of Health. National Action Plan: HIV and STI Prevention and Control Programme 2024-2026. Ministry of Health. 2023.

<sup>48</sup> Ministry of Health. MoH Regulation No. 23\_2022 on HIV, AIDS and STIs. 2022.

<sup>49</sup> Hatt L, Cico A, Chee G, Ergo A, Fuad A, Gigli S, et al. RAPID ANALYTICAL REVIEW AND ASSESSMENT OF HEALTH SYSTEMS OPPORTUNITIES AND GAPS IN INDONESIA. Abt Associates Inc. 2015.

<sup>50</sup> Review Team (Ministry of Health, UNAIDS, WHO, et al.). Joint Review of the National HIV and STI Control Program 2020-2022. Ministry of Health. June 2023.

<sup>51</sup> Ibid.

<sup>52</sup> Ibid.



services, care, support and treatment, and EMTCT services.<sup>53</sup> HIV providers are required to report through the SIHA 2.1 (HIV/AIDS Information System) application on HIV testing services, STI services, care, support and treatment, EMTCT, early infant diagnosis (EID), and viral load testing.

#### 2.4.1. Access to HIV services for KPs

According to the 2018 Integrated Biological and Behavioural Surveillance (IBBS) survey, the majority of MSM, transgender women, and female sex workers access HIV testing through the PHC system (Puskesmas), followed by mobile VCT services (see Table 3). This varies by KP, with female sex workers most likely to access testing through mobile VCT services (39.9%), and MSM more likely than other KP groups to seek testing services at a private clinic or hospital (8.4% and 7.1%, respectively).

**Table 3: Access to testing for KPs<sup>54</sup>**

KP	MSM	Transgender Women	Female sex workers
Puskesmas	67%	66.2%	33.7%
VCT Mobile	11.9%	22.2%	39.9%
Private Clinic	8.4%	0.5%	4.1%
Hospital	7.1%	3.8%	3.7%
Other	5.6%	7.3%	18.6%

While Puskesmas are increasingly able to provide treatment services (see Section 2.4), hospitals and the private sector also play a key role in treatment of PLHIV. From an analysis of 2018 JKN claims data, Setiawan et al. (2022) reported that 81% of HIV patients who first seek care at the primary care level are referred to hospitals for treatment (13% being private hospitals).<sup>55</sup> Most cases treated at hospitals were delivered at an outpatient department with no comorbidities or complications; however, there are not clear guidelines for “down referral” of stable patients. Furthermore, of HIV patients receiving ART through JKN (public insurance), 22% receive treatment at the primary care level and 78% at hospitals.<sup>56</sup>

In addition, pregnant women are known to seek services from private midwives and hospitals, which may serve as a barrier to promotion of EMTCT through testing and treatment. A longitudinal study published in 2019 revealed that only 52% of pregnant women referred by private midwives to VCT clinics underwent HIV testing.<sup>57</sup>

#### 2.4.2. Current financing for HIV and inclusion of HIV services in UHC and health insurance

Financing for health services at primary care level comes from National Insurance (monthly capitation funds by JKN sourcing from BPJS Health (*Kesehatan*), sub-national public funds (*APBD*) from district government, and fees charged to service users. This funding covers the salaries of health workers, operating costs, infrastructure, public health programmes, and medical supplies.

<sup>53</sup> Ibid.

<sup>54</sup> Ministry of Health. National Action Plan: HIV and STI Prevention and Control Programme 2024-2026. Ministry of Health. 2023.

<sup>55</sup> Setiawan E, Nurjannah N, Kormaryani K, Nugraha RR, Thabrany H, Purwaningrum F & Sarnianto P. Utilization patterns of healthcare facility and estimated expenditure of PLHIV care under the Indonesian National Health Insurance Scheme in 2018. *BMC Health Services Research*. 2022; 22 (97). <https://doi.org/10.1186/s12913-021-07434-9>

<sup>56</sup> Ibid.

<sup>57</sup> Wulandari LPL, Lubis DSM, Widarini P, Widyantini DN, Wirawan IMA, Wirawan DN. HIV testing uptake among pregnant women attending private midwife clinics: challenges of scaling up universal HIV testing at the private sectors in Indonesia. *Int J Health Plann Manage*. 2019 Oct;34(4):1399-1407. doi: 10.1002/hpm.2807. Epub 2019 May 23. PMID: 31120151.

For HIV, the National Insurance provided by BPJS Kesehatan covers the costs of HIV treatment and treatment of opportunistic infections, as well as supporting laboratory examinations and CD4 examinations and viral load tests. Antiretroviral (ARV) drugs are provided by the government and given free of charge.

Health expenditure as a proportion of GDP is low in Indonesia. In 2020, health expenditure was 3.41% of GDP, which was an increase from 2.9% in 2019,<sup>58</sup> but this is amongst the lowest in the region. While the health sector in Indonesia is largely funded by domestic financing, this is not the case for HIV where 28.8% of funding comes from external donors.<sup>59</sup>

The most recent National Health Account (2020 – 2021) reported that out of the USD 120 million HIV/AIDS programme, 75% was contributed by the national government, 5% from local governments, and 20% from donors and the private sector.<sup>60,61</sup> The NASA 2020 report noted the doubling of domestic spending on HIV and STI programmes in 2019-2020 compared to 2010-2011; in 2020, approximately 53% of the total budget for HIV was from domestic sources.<sup>62</sup> While ARV is provided through domestic budget, prevention, care and support, innovative approaches such as district-based mentoring and pre-exposure prophylaxis (PrEP), which are primarily working within the PHC system, remain funded by international organisations such as the Global Fund.

## 3. UNAIDS Joint Programme in Indonesia

### 3.1. UNAIDS Joint Programme strategic direction, priorities and plans

The Indonesia Joint Programme Strategy (2021-2025) is structured around the strategic priorities in the Global AIDS Strategy and is aligned with national documents including the RPJMN 2020-2024, 2020-2024 National Action Plan for the prevention and control of HIV, AIDS and STIs, and 2021-2025 UN Strategic Development Cooperation Framework.

The strategy outlines joint areas of effort and indicators to:

- maximize equitable and equal access to HIV services and solutions
- break down barriers to achieving HIV outcomes
- fully resource and sustain efficient HIV responses and integrate into systems for health, social protection, humanitarian settings, and pandemic responses.

### 3.2. Overview of JUNTA – UNAIDS cosponsor activities and funding

The JUNTA in Indonesia currently consists of the UNAIDS Secretariat and nine UNAIDS Cosponsors: UNICEF, UNFPA, UN Women, UNHCR, ILO, UNODC, UNDP, WHO and the World Bank. These agencies are funded through Unified Budget Results and Accountability Framework (UBRAF) core, non-core funds, and country envelope.

Annex 4 presents an overview of main activities and the level of funding of the UNAIDS Secretariat and Cosponsors since 2020. Of note is the lack of language and specific focus around support to PHC and UHC, although it is implied through efforts jointly targeting the integration of HIV into services for STIs, TB, sexual reproductive health and rights, antenatal care (ANC), comprehensive sexuality education (CSE), and GBV, as well as through activities related to social protection, inclusion, and community empowerment. The World Bank no longer has HIV-related activities in Indonesia, does

<sup>58</sup> World Bank. Current health expenditure (% of GDP). 7 April 2023.

(<https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ID>).

<sup>59</sup> Magnani RJ, Harimurti P, Pambudi ES, Pei Lyn MC, Hafez R, Samudra RR, Munira SL, Najib I. Transitioning from Donor-Funded Health Programs in Indonesia: Issues and Priorities. The World Bank. 30 December 2017.

<sup>60</sup> NHA report on ATM, MoH 2023

<sup>61</sup> Community and private funding contributions are not accounted for in this figure.

<sup>62</sup> National AIDS Spending Assessment 2020.

not receive UBRAF funding, and does not regularly attend JUNTA meetings. However, they are still included in the JPS 2021-2025 due to their work within ensuring adequate financing for essential health care and intervention, including advocacy for the inclusion of HIV services in the JKN benefit package and supply-side financing.

### 3.3. Key partners

#### 3.3.1. Government partners

The JUNTA collaborates primarily with the MoH, which is responsible for coordinating all policies and standard operating procedures for HIV/AIDS and STI screening services, treatment, care and support for PLHIV.<sup>63</sup> Other ministries are engaged by individual UNAIDS Cosponsors, such as ILO with the Ministry of Manpower,<sup>64</sup> UNFPA with the Ministry of Family Planning (BKKBN), and UN Women with the Ministry of Women Empowerment and Child Protection.<sup>65</sup>

While involved to a lesser extent, the Joint Programme Strategy also highlights other ministries with which UNAIDS engages in advocacy:<sup>66</sup>

- Ministry of National Planning and Development (BAPPENAS), which coordinates budget allocation related to the prevention and control of HIV/AIDS and STIs;<sup>67</sup>
- Ministry of Finance, which runs a national community coordination platform;<sup>68</sup> and
- Ministry of Home Affairs, which provides guidance and supervision to provincial, district, and city governments to integrate HIV/AIDS indicators into regional development planning documents and to allocate sufficient budgeting.

#### 3.3.2. External partners

The major international development partners working with the JUNTA in Indonesia are the Global Fund, USAID-PEPFAR, and the Australian Government Department of Foreign Affairs and Trade (DFAT).

USAID-PEPFAR budgeted US\$ 700 000 to support UNAIDS in 2022 and US\$ 500 000 in 2023.<sup>69</sup> This funding has supported technical assistance to improve the capacity of national stakeholders to use strategic information effectively in support of HIV treatment acceleration, to integrate PrEP and community-based HIV self-testing into HIV national policy and programming for scaled implementation, to enhance the capacity of community implementers to access, implement and manage KP programme grants, and support for community-led monitoring and advocacy at national and sub-national levels to advocate for the improvement of service deliveries to achieve treatment acceleration.<sup>70</sup>

DFAT's budget allocation to support the HIV response in Indonesia was US\$ 831 899 in 2022<sup>71</sup> and US\$ 389 674 in 2023. Activities funded include PrEP service assessments, CSO capacity building including through support of social contracting, support for community-led monitoring (CLM), development of guidance for private providers engagement on PrEP and social contracting on HIV, anti-discrimination advocacy, supporting community mentorship in five provinces, platform to

<sup>63</sup> DFAT. DFAT Workplan 2023. 2 March 2023.

<sup>64</sup> Joint United Nations Programme on HIV and AIDS (UNAIDS). Indonesia's Joint Programme Strategy (JPS) 2021-2025. 31; 2021.

<sup>65</sup> UNAIDS. Stakeholder Mapping, Joint UN Programme on HIV and AIDS (Joint Team). 5 May 2023.

<sup>66</sup> Joint United Nations Programme on HIV and AIDS (UNAIDS). Indonesia's Joint Programme Strategy (JPS) 2021-2025. 23; 2021

<sup>67</sup> Ministry of Health. National Action Plan: HIV and STI Prevention and Control 2024-2026.

<sup>68</sup> UNAIDS. Stakeholder Mapping, Joint UN Programme on HIV and AIDS (Joint Team). 5 May 2023.

<sup>69</sup> USAID. Scope of Work for Directed Activities under UNAIDS Grant Agreement. April 2022.

<sup>70</sup> Ibid.

<sup>71</sup> DFAT. DFAT Workplan 2021-2023. n.d.

spearhead community action to eliminate vertical transmission, engagement of sub-national community stakeholders in Tanah Papua, and young KP demand creation.<sup>72</sup>

The Global Fund provides a substantial amount of support in Indonesia, with the most recently submitted funding request for US\$ 100 201 509 for 2024-2026.<sup>73</sup> The principal recipients (PR) are the MoH (PR1), Yayasan Spiritia (PR2), and Indonesia AIDS Coalition (PR2).<sup>74</sup> In 100 priority districts and 78 KP districts, the Global Fund funding supports PHC centres (Puskesmas), expansion of treatment, care and support, differentiated HIV testing services, prevention packages (including condoms, communications and outreach, community empowerment, PrEP, opioid substitution therapy, and needle and syringe programmes) for KPs, strengthening of integrated TB and HIV services, sensitisation of health care providers, and public-private community partnerships.

## 4. Findings

### 4.1. EQ1: To what extent is there conceptual clarity and internal coherence within the UNAIDS Joint Programme and external coherence with other actors in relation to leveraging HIV and PHC integration and linkages?

#### SUMMARY OF FINDINGS – EQ1

- The Joint Programme has individual activities linking HIV prevention, testing, and treatment to that of comorbidities and coinfections, but the aim of integration is not explicitly described within the 2021-2025 Joint Programme Strategy and monitored as an objective.
- There is consensus by key stakeholders on the potential benefits of strengthening the alignment of HIV and PHC, but there is a lack of conceptual clarity about what this would look like and how to achieve it.
- Stakeholders see the UNAIDS Cosponsors as separate and working in silos, which is seen as a barrier to coordinated efforts on PHC and HIV.
- There are opportunities for further alignment of UN activities, both within HIV and outside of HIV, for increased interlinkages of HIV and PHC.
- There is an opportunity for joint advocacy for the integration of HIV with PHC through ongoing national integration efforts under the government's health transformation initiative.
- Collaboration between JUNTA, national government, and external actors working with HIV has been challenging since the disbandment of the National AIDS Commission in 2016.
- While JUNTA primarily works with the MoH, there are potential opportunities for further multisectoral collaborations to strengthen interlinkages of HIV and PHC.
- External partners, including the Global Fund, DFAT, and USAID-PEPFAR, are strategically shifting towards PHC and health systems strengthening.

<sup>72</sup> Ibid.

<sup>73</sup> The Global Fund. Funding Request Form, Allocation Period 2023-2025. 20 March 2023.

<sup>74</sup> Ibid.

#### **4.1.1. What does the Joint Programme aim to achieve through strengthening HIV and PHC alignment, integration, and interlinkages? To what extent is there conceptual clarity?**

**Finding 1.1: The Joint Programme has individual activities linking HIV prevention, testing, and treatment to that of comorbidities and coinfections, but the aim of integration is not explicitly described within the 2021-2025 Joint Programme Strategy and monitored as an objective.** Health systems strengthening, PHC, and UHC are not explicitly mentioned within the strategy. Ongoing Joint Programme activities linked to PHC since 2020 are project-based and owned by individual organizations, focusing on linking HIV prevention, testing, and treatment activities with other activities within their mandates. For example:<sup>75</sup>

- UNFPA: out-of-school CSE and female sex worker programming
- UNICEF: ANC and STIs (hepatitis and syphilis through triple elimination)
- WHO: STIs and TB
- UNAIDS, UNFPA, and UN Women: GBV.

Linkages to PHC are also evident through community engagement and social protection initiatives, e.g., the joint ILO and UNAIDS initiative to increase access to national ID cards and employment insurance for transgender individuals.

**Finding 1.2: There is consensus by key stakeholders on the potential benefits of strengthening the alignment of HIV and PHC, but there is a lack of conceptual clarity about what this would look like and how to achieve it.**

Despite identifying some barriers and risks (Findings 2.8-2.12), KIs in the JUNTA were generally in agreement that there are benefits of leveraging the interlinkages of HIV and PHC in Indonesia, especially in the context of the recent health transformation initiative. Informants supported the concept of integration of HIV and PHC, primarily of HIV services into primary care, for the following reasons:

- increased access for KPs and PLHIV to services for co-morbidities along the lifespan, such as communicable diseases, non-communicable diseases, and mental health services; and
- perceived sustainability of HIV testing and treatment in light of decreasing donor funding.

“[The concept of PHC and integration] comes with clear polarization, even within the agencies.”  
JUNTA KI

It was also acknowledged that there may not be a shared understanding between and within UNAIDS Cosponsors regarding the concept of integration and what it would look like in operationalisation. There was an identified need to consider what can and cannot be integrated through strong sub-national data and advocacy from the JUNTA. One KI identified the conversations about integration of HIV and PHC thus far as “theoretical” and “based in Geneva,”<sup>76</sup> without concrete guidance at the country level.

#### **4.1.2. To what extent are relevant goals, plans, strategies, and activities harmonised and aligned internally within the Joint Programme at country levels?**

**Finding 1.3: Stakeholders see the UNAIDS Cosponsors as separate and working in silos, which is seen as a barrier to coordinated efforts on PHC and HIV.**

<sup>75</sup> UNAIDS. JPMS extracts 2020-2023. Accessed June 2023.

<sup>76</sup> JUNTA KI

Both JUNTA and external partner KIs identified limitations to the alignment of strategies and activities between the UNAIDS Cosponsors, in general and in relation to HIV and PHC. Internal stakeholders identified that each Cosponsor works within their mandate, with interlinkages and collaborations primarily limited to joint projects financed by UBRAF or external sources. External stakeholders also saw the organizations as individual units working within their areas as opposed to a cross-cutting collaboration, describing the UNAIDS Cosponsors as “separate” and “disaggregated.”

“The work is very diverse, and it is challenge for us to work together on issues because the division of labour has limited us. For example, it leads to the division of KPs. It creates another sector.”

JUNTA KI

This was primarily seen as a challenge for advocacy, where efforts are not seen as being coordinated or streamlined and this is exacerbated by UNAIDS Cosponsors working with separate ministries. Multiple government stakeholders expressed a desire to

hear a joint voice from the JUNTA as opposed to separate agencies with seemingly different agendas. The health sector transformation offers an opportunity for the JUNTA to work as one and to provide joint guidance for the strategic integration of HIV.

**Finding 1.4: There are opportunities for further alignment of UN activities, both within HIV and outside of HIV, for increased interlinkages of HIV and PHC.** UNAIDS Cosponsors have overlapping mandates and areas of responsibility in the Division of Labour, e.g., UN Women, UNDP and UNAIDS Secretariat are working on human rights, and UNDP, WHO and UNICEF are working on supply chain management. Stakeholders identified that these overlapping mandates create the potential for further knowledge sharing and partnerships, both for technical and advocacy purposes.

In addition, the work of UNAIDS Cosponsors in areas outside of HIV may present opportunities to leverage interlinkages. Examples include the broader PHC strengthening activities of WHO and UNICEF, including those under the UHC Partnership (UHC-P) and the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), e.g., the recent UHC-P support for the development of an integrated service delivery model at the PHC level, a countrywide assessment of PHC-level service readiness, assessment of minimum service standards at the PHC level, and strengthening the health information system for PHC-related health infrastructure, facility, and equipment.<sup>77</sup> In addition, the World Bank’s lending for strengthening the PHC response to TB, incentivising primary care providers (public and private) to notify cases using existing mechanisms under the BPJS provider payment system, and making the TB information system interoperable with the national health data system (SATUSEHAT). This project arose from concerns about the sustainability of TB financing, which may also be relevant for HIV.<sup>78, 79</sup> Exploring potential interlinkages between HIV and ongoing UNAIDS cosponsor initiatives outside of the JUNTA activities could expose further opportunities to leverage the interlinkages of HIV and related programmes and strengthen the multisectoral nature of the HIV response.

Furthermore, the UNSDCF may provide a platform for UN partnerships and coordination to leverage the interlinkages of HIV and PHC, as well as for coordinating efforts towards addressing relevant barriers to accessing PHC for PLHIV and KPs in Indonesia. UHC/PHC is not included in the current UNSDCF 2021-2025. However, reducing stigma and discrimination against PLHIV is mentioned under the “leave no one behind” platform. The first outcome is: “people living in Indonesia, especially those at risk of being left furthest behind, are empowered to fulfil their human development potential as members of a pluralistic, tolerant, inclusive, and just society, free of gender and all other forms of discrimination.”<sup>80</sup> It elaborates that UN initiatives in Indonesia will seek to work with people who are marginalised through stigma and discrimination, specifically mentioning PLHIV and those who

<sup>77</sup> World Health Organization. Universal Health Coverage Partnership annual report 2021. 2023; 15.

<sup>78</sup> Ministry of Health. National Action Plan HIV and STI Prevention and Control Programme 2024-2026. 2023.

<sup>79</sup> Magnani RJ, Harimurti P, Pambudi ES, Pei Lyn MC, Hafez R, Samudra RR, Munira SL, Najib I. Transitioning from Donor-Funded Health Programs in Indonesia: Issues and Priorities. The World Bank. 30 December 2017.

<sup>80</sup> United Nations Indonesia. United Nations Sustainable Development Cooperation Framework 2021-2025. April 2020.



experience discrimination on the basis of their sexual orientation. It states that this should be done through upstream policy advice and technical support to the national government and ministries and engagement with providers of downstream services, including civil society and community-based organizations, front-line service providers, and the private sector. The UNSDCF 2021-2025 and upcoming UNSDCF 2026-2030 could be leveraged for UN collaboration beyond the JUNTA to collectively work towards social protection of KPs and PLHIV and inclusive access to services through a PHC approach. With the planned evaluation of UNSDCF in 2021-2025, there is also an opportunity to consider the inclusion of PHC/UHC in the objectives of the upcoming framework.

#### **4.1.3. How does the Joint Programme’s work on HIV and PHC integration and linkages complement and harmonise with the efforts of national governments and external actors?**

**Finding 1.5: There is an opportunity for joint advocacy for the integration of HIV with PHC through ongoing national integration efforts under the government’s health transformation initiative.** The Indonesian government is currently shifting from a vertical, disease-focused approach to a PHC approach, with key changes that include:

- Integrated primary care services with a life course, person-centred approach, including integration of laboratories and data systems at the national and local/district levels (by the Digital Transformation Office and Pusdatin);
- Multisectoral policy and action with the involvement of several ministries in initiatives, e.g., school- and work-based health education; and
- Increased community engagement through training courses for volunteer community health workers (*kaders*) based on “buckets” of care.

MoH stakeholders identified limited UN engagement regarding the integration of HIV initiatives thus far but expressed a willingness to receive assistance from the JUNTA to do so, e.g., through the development of an HIV module for the training of *kaders* and through the integration of HIV into school and work-based education programmes. The MoH is building a “vehicle” for PHC and is open to input about specific content and initiatives related to HIV prevention, screening, support, and treatment.

Other stakeholders highlighted the risk that HIV could get “lost” in the PHC transformation if UNAIDS is not engaged in early advocacy, particularly in the current context of decreasing national attention to HIV. However, as of now there is an opportunity in that the incidence of HIV is still an indicator in the Medium-Term Development Plan 2020-2024<sup>81</sup> and included in the SPM.

**Finding 1.6: Collaboration between the Joint Programme, national government, and external actors working with HIV has been challenging since the disbandment of the National AIDS Commission in 2016.** The subsequent absence of a governmental coordinating platform was identified as a key barrier to JUNTA’s coherence with external partners on HIV and PHC integration. When the National AIDS Commission was disbanded, roles were redistributed, with the Ministry of Human Development and Culture responsible for coordinating the prevention and control of HIV/AIDS across all sectors and levels, and the MoH playing a technical role in the response.<sup>82</sup> However, KIs from national ministries, UN organizations, and external donors stated that there are still challenges with this approach, and that there is a lack of clarity about responsibilities for coordination of the national HIV response in Indonesia.

Many stakeholders identified the role of the Global Fund Country Coordinating Mechanism (CCM) as the key mediator and multisectoral coordinator for HIV in Indonesia, bringing together 25 members from government and donors. The CCM Technical Working Group on HIV has a broader membership consisting of 50 people, including development partners, CSOs, government, and the private sector.

<sup>81</sup> Ministry of Health. Permenkes No. 21/2020 concerning the Strategic Plan of the MoH 2020-2024. 2020.

<sup>82</sup> Ministry of Health. National Action Plan HIV and STI Prevention and Control Programme 2024-2026.

It is viewed as facilitating strong communication with the government and taking on roles beyond the usual scope of work, e.g., the Technical Working Group provides advice to CSOs on implementation of programmes. However, it does not have legal authority and its sustainability is linked to ongoing Global Fund support.

This lack of multisectoral coordination may have contributed to the relative lack of attention to HIV at the national level. One key ministry stakeholder noted that they are not getting strong messages about HIV, compared to other health issues such as TB and stunting (see Box 1). While there are key variations in the burden of disease, histories, and associated stigma between HIV, TB, and stunting, “lessons learned” may contribute to more successful inclusion of HIV in national programming, including PHC, are the importance of strong coordination, leadership, and multisectoral advocacy.

**Box 1: Lessons learned from the national responses to stunting and TB**

Government stakeholders identified stunting and TB as examples of health issues that have elicited strong political focus and action. While it is not possible to directly compare diseases with different epidemiology, histories, and associated stigma, some “lessons learned” were identified:

- **Stunting** has had a strong central coordination mechanism with a steering committee and technical team, a reporting mechanism to the President, and internal advocacy. This was seen as a success, with strong results and a clear focus (“23 cross-sectoral ministries are now talking about stunting”).
- **TB** lacks a central coordinating mechanism but was still seen as a stronger programme than that of HIV due to the existence of special programmes at the Ministry level.

There was a call for the JUNTA to utilise their convening power to strengthen joint coordination and advocacy with the national government and external actors on HIV and PHC integration. The siloed working of the current JUNTA and separate engagement with select ministries (see Finding 1.1) were seen as a barrier to this engagement. However, the presence of a strong UNAIDS Secretariat country office was recognized as an advantage: “[other international donors] work in the sky, but UNAIDS works in Indonesia.” However, the need for strong leadership on integration of HIV and PHC was also identified, with one KI saying, “the one who makes the car move is the driver,” regarding engagement with the government and other relevant organizations.

**Finding 1.7: While JUNTA primarily works with the MoH, there are potential opportunities for further multisectoral collaborations to strengthen interlinkages of HIV and PHC and address broader determinants of health.** Multisectoral collaboration is inherent to PHC but is limited in the current work of the JUNTA, which works primarily with the MoH. Other ministries are engaged by individual UNAIDS Cosponsors. The 2024-2026 National Action Plan for the HIV Prevention and Control Programme identified several national ministries with roles related to HIV (and more broadly, PHC), alongside others identified through this evaluation (see Box 2), which the JUNTA could engage with more to advocate for HIV, social protection of KP, and broader health system strengthening.<sup>83</sup> As Indonesia shifts to a whole-of-government approach to PHC, KIs identified the increasing relevance of engaging in ministries involved in broader health determinants. As described in Box 1, one of the reasons why the approach to stunting was effective was due to the number of different ministries who had it on their agenda.

<sup>83</sup> Ministry of Health. National Action Plan HIV and STI Prevention and Control Programme 2024-2026. 2023.



**Box 2: Ministries with roles related to HIV**

- **Ministry of Coordination for Human Development and Culture** – coordination of roles in the prevention and control of HIV/AIDS nationally at all cross-sectoral levels
- **Ministry of National Planning and Development (Bappenas)** – cross-sectoral planning to ensure sufficient national budget allocation related to the prevention and control of HIV/AIDS
- **Ministry of Home Affairs** – guidance and supervision for provincial/district/city government officials to allocate sufficient budget for the prevention and control of HIV/AIDS
- **Ministry of Health** – formulation of policies, regulations, and standard operating materials, research, preparing health supplies, ensuring health financing, and developing human resources for the prevention and control of HIV/AIDS, as well as integrating HIV/AIDS into other health efforts
- **Ministry of Foreign Affairs** – access to HIV/AIDS services for Indonesian citizens who are abroad
- **Ministry of Manpower** – policies on HIV/AIDS and implementation in workplaces, including for migrant and foreign workers, and occupational training for KP members
- **Ministry of Communication and Information Technology** – policies and implementation of HIV/AIDS programme campaigns via traditional and online mass media
- **Ministry of Education, Culture, Research, and Technology** – policies on inclusion of HIV/AIDS in general, primary, secondary, and higher education curricula, research funding prioritisation for topics related to HIV/AIDS prevention, control, and epidemiology, and communication channels from research results to implementation
- **Ministry of Religious Affairs** – policies related to prevention and control of HIV/AIDS and prevention of stigma and discrimination in religious institutions and inclusion of HIV/AIDS prevention in pre-marital preparations
- **Ministry of Village, Development of Disadvantaged Regions, and Transmigration** – policy and monitoring and evaluation mechanisms for the use of village funds for the prevention and control of HIV/AIDS
- **Ministry of Social Affairs**; policy instruments to ensure social rehabilitation activities for KPs and PLHIV and financing policies to support access to HIV/AIDS testing and treatment for poor and destitute families
- **Ministry of Transportation** – promotion of HIV/AIDS prevention and control in public transportation facilities
- **National Population and Family Planning Board (BKKBN)** – information, education, and communication about HIV/AIDS prevention and distribution of condoms for family planning
- **Centre on Health Systems, Health Resources, Financing and Decentralisation, Global Health and Health Technology (BKBK)** – health development policy recommendations
- **Ministry of Women Empowerment and Child Protection** – prevention of VAW for women living with HIV/AIDS and integrated HIV/AIDS services for women who experienced GBV.

While the HIV response varies at the sub-national level due to the decentralized governance system, there are multiple examples of multisectoral collaborations at the provincial and district levels that offer learning opportunities for other provinces and districts. For example, in districts visited by the evaluation team, the DHO was collaborating with non-health sectors such as education for school-based reproductive health education, social affairs for home renovation programmes, and tourism for mobile testing in crowded areas.

**Finding 1.8: External partners in Indonesia, including the Global Fund, DFAT, and USAID-PEPFAR, are strategically shifting towards PHC and health systems strengthening.** The JUNTA works closely with external partners, including the Global Fund, DFAT, and USAID-PEPFAR, who are increasingly

shifting away from vertical disease programmes towards supporting PHC and broader health systems strengthening. In accordance with the Global Fund's new Strategy 2023-2028,<sup>84</sup> the most recent Global Fund funding request in Indonesia includes activities related to broader resilient and sustainable systems for health (RSSH). Proposed RSSH activities to support integration of HIV and PHC in the context of Indonesia's ongoing health system transformation initiative, i.e., technical assistance for the integration of the national HIV data information system (SIHA 2.1) into the national health data ecosystem (SATUSEHAT), increasing capacity of CSOs and awareness of social contracting mechanisms, strengthening the public health laboratory system, and strengthening data management capacity.<sup>85</sup>

In addition, USAID is reportedly shifting their focus towards PHC, internationally and in Indonesia.<sup>86</sup> USAID has recently announced the inclusion of Indonesia in the Primary Impact Initiative, which aims to accelerate progress in PHC through creating linkages between ongoing USAID programmes and initiatives, health workforce investments, engagement of civil society, and coordination to deliver PHC services.<sup>87</sup> In Indonesia, this will build upon USAID's existing connections with district-level Puskesmas and Posyandus. DFAT also reported that they are beginning to work with PHC and linkages of HIV with broader health systems strengthening initiatives, including programming regarding health security and digitalisation of information systems.

These shifts in strategic focus and corresponding activities could be a potential opportunity for alignment with Joint Programme advocacy and activities. These agencies are already engaged by the JUNTA, as evident in the engagement of UNAIDS in preparation of the Global Fund Funding Request (2024-2026, submitted in 2023) and direct support from USAID-PEPFAR and DFAT to UNAIDS. Examples of supported JUNTA activities related to HIV and PHC include:

- CLM and community-based monitoring and feedback (CBMF) mechanisms led by UNAIDS, UN Women and UNDP are being used to generate data on stigma and discrimination for monitoring and documenting access to HIV services, quality of services, and human rights violations. With support from USAID, DFAT, and the Global Fund, the CLM feedback mechanism has already been implemented in 23 districts and used to conduct policy dialogues in 7 cities.<sup>88</sup>
- With the support of the Global Fund and DFAT, UNAIDS has a pilot project supporting 35 CSOs in six districts to increase their capacity to advocate for and access social contracting. As part of the pilot, CLO alliances have been created in each of the six districts to link government stakeholders and community organisations, as well as create a learning network between districts. This has strengthened relationships with the local government, with lobby and advocacy processes resulting in increased budget allocation for community-led responses in two cities.

The increasing focus of external partners on PHC provides further opportunities for JUNTA to leverage interlinkages of PHC and HIV.

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<sup>84</sup> The Global Fund. Information Note: Resilient and Sustainable Systems for Health (RSSH). July 2022. ([core\\_resilientsustainable-systems-for-health\\_infonote\\_en.pdf \(theglobalfund.org\)](https://www.theglobalfund.org/en/core-resilientsustainable-systems-for-health-infonote-en.pdf)).

<sup>85</sup> The Global Fund. Indonesia Funding Request Form 2024-2026. 2023

<sup>86</sup> USAID. Primary Health Care. 2023. ([Primary Health Care | Global Health | Health Systems and Innovation | U.S. Agency for International Development \(usaid.gov\)](https://www.usaid.gov/our-work/primary-health-care), accessed 29 August 2023).

<sup>87</sup> Ibid.

<sup>88</sup> UNAIDS Indonesia. The UN Joint Programme contribution to strengthening HIV and Primary Health Care (PHC) outcomes: interlinkages and integration. June 2023.

## 4.2. EQ2: To what extent is the Joint Programme applying the PHC approach to HIV responses and what are the achievements and lessons learned?

### SUMMARY OF FINDINGS – EQ2

- Under the Joint Programme, WHO has supported the MoH's capacity to deliver integrated surveillance, testing, and treatment for HIV and STIs through the development of guidelines and technical assistance.
- UNICEF has led JUNTA efforts to support the MoH in integrating triple elimination (HIV/AIDS, syphilis, and hepatitis B) into the overall life cycle strategy.
- Through the Joint Programme, UNFPA has been engaging with the integration of HIV into sexual and reproductive health and rights with engagement of community networks through activities related to gender-based violence and out-of-school comprehensive sexuality education.
- UNAIDS has employed PHC approaches by coordinating JUNTA efforts to engage the community in the HIV response, advocating for multisectoral actions and policies, and reducing human rights barriers to accessing health care at primary care sites for vulnerable populations.
- The Joint Programme has made efforts to increase the sustainability of the community response through capacity building for civil society organizations and social contracting pilots.
- A potential enabler is the upcoming transformation of Indonesia's health care system to a PHC approach.
- Existing weaknesses in the health care system (e.g., in supply chain management and access to certain laboratory services) pose challenges to the integration of HIV.
- Insufficient protection of human rights has led to challenges in accessing KP and prevention initiatives.
- While HIV and broader health information systems are strong, Kis identified a need for more advocacy regarding HIV-PHC interlinkages and integration using strategic data.
- A current lack of public-private partnerships is seen as a barrier to integration of services for HIV into PHC

### 4.2.1. What has been achieved since 2020 in terms of applying a PHC approach to HIV responses?

**Finding 2.1: Under the Joint Programme, WHO has supported the MoH's capacity to deliver integrated surveillance, testing, and treatment for HIV and STIs through the development of guidelines and technical assistance.** WHO has supported integrated prevention and control of HIV and STIs at the primary care (Puskesmas) level through guideline and policy development, strengthening of laboratories and protocols, and advocacy for the integration of STI screening and management into other programmes (including HIV).

WHO- led JUNTA activities since 2020 that have applied a PHC approach to HIV responses have included:

- guidelines for integrated STI and HIV surveillance and testing
- advocacy for the integration of STI screening and management into ANC, family planning services, and HIV prevention programmes
- broader health systems strengthening through the strengthening of laboratories and quality assurance mechanisms
- comprehensive prevention strategies for STIs

- guidelines and policies for the monitoring of care for PLHIV at Puskesmas, including the management of opportunistic infections and psychosocial support
- integrated access to and demand generation for PrEP as prevention (with UNAIDS)
- support of multi-month dispensing to increase access to ARVs (with UNDP and UNAIDS).

Lessons learned during implementation include the need to:

- expand beyond HIV to work with programmes that increase the number of people tested, treated, and monitored for TB and STIs
- consider the impacts of decentralisation on programme implementation and advocacy
- look beyond “test and treat” to address prevention
- have a JUNTA leadership role in advocacy to remove barriers to access to HIV testing and treatment, addressing issues of stigma and discrimination
- work as a collective Joint UN Team.

**Finding 2.2: UNICEF has led Joint Team efforts to support the MoH in integrating triple elimination (HIV/AIDS, syphilis, and hepatitis B) into the overall life cycle strategy.** In line with the national government’s new approach, UNICEF has been providing guidance to the Ministry regarding the integration of triple elimination into the overall life cycle, where testing, treatment, and care are incorporated accordingly into the appropriate life stage for mothers, newborns, children, adolescents, adults of reproductive age, and elderly individuals. UNICEF is also supporting the MoH to strengthen the data reporting and recording system. Activities are also relying on community engagement through CSOs and peer mentors. The overall prevention of maternal to child transmission (PMTCT) agenda and corresponding activities are carried out in collaboration with UNAIDS Cosponsors including WHO, UNFPA, UNAIDS, and UNHCR.

UNICEF-led JUNTA projects since 2020 that have applied a PHC approach to HIV responses have included:

- support to the MoH to strengthen PMTCT through triple elimination (testing for HIV/AIDS, syphilis, and hepatitis B) (with WHO, UNFPA, UNAIDS, and UNHCR)
- maintaining elimination of maternal to child transmission (EMTCT) programming through an integrated approach for health services during COVID-19, working with health programmes throughout the UNICEF office (e.g., health systems strengthening, child health, immunization, maternal and neonatal health)
- working with community volunteers as peer mentors to increase ARV treatment adherence for pregnant women living with HIV and early infant detection testing.

**Lessons learned during implementation include the need to:**

- employ strong advocacy, engagement, and collaboration and national and sub-national levels to maintain the EMTCT programme
- integrate with maternal and child health programmes to leverage support despite limited human and financial resources
- collaborate across sectors with professional associations, the private sector, CSOs, and other UN agencies that support other components of EMTCT
- work jointly towards common goals described in the JPS 2021-2025 and ensure support is integrated
- ensure that work is aligned with and strengthening the health system transformation agenda.

**Finding 2.3: Through the Joint Programme, UNFPA has been engaging with the integration of HIV into sexual and reproductive health and rights with engagement of community networks through activities related to GBV and out-of-school comprehensive sexuality education.** UNFPA integrates HIV into broader sexual and reproductive rights programmes through partnering with community networks for implementation, including the Indonesia AIDS Coalition, Indonesia Positive Network

(JIP), Inti Muda Indonesia (national young KP network), and PKBI DKI Jakarta. UNFPA also engages with UNAIDS Cosponsors such as UNAIDS, UNICEF, and UNDP to carry out work related to HIV integration through PMTCT advocacy, CSE, and GBV.

UNFPA-led JUNTA projects since 2020 that have applied a PHC approach to HIV responses have included:

- increased awareness of reproductive health and HIV services for young KP members through out-of-school CSE (with UNAIDS and UNICEF)
- supporting women living with HIV on PMTCT advocacy (with WHO, UNICEF, UNAIDS, and UNHCR)
- social marketing of condoms
- strengthening prevention programmes for female sex workers
- capacity-building for CSOs and training of community leaders (with JUNTA); and
- integration of HIV into GBV services through, e.g., training and cash-based vouchers (in partnership with UN Women and UNAIDS).

**Lessons learned during implementation include the need to:**

- initiate and/or maintain collaborations and sharing of responsibilities with implementing and strategic partners in light of decreased funding for HIV
- coordinate between JUNTA partners based on agreed priorities and the UN division of labour
- increase advocacy to promote condoms as a dual protection method
- collaborate with national stakeholders to fill the gap in the national HIV response.

**Finding 2.4: UNAIDS has employed PHC approaches by coordinating Joint Team efforts to engage the community in the HIV response, advocating for multisectoral actions and policies, and reducing human rights barriers to accessing health care for vulnerable populations.** UNAIDS has put considerable effort into partnerships with and capacity building for many CSOs, in collaboration with UNAIDS Cosponsors including UNDP, UNFPA, UN Women, UNODC, and ILO. The Secretariat is also working with UN Women and UNDP to remove legal barriers to accessing health care for KPs. In addition, UNAIDS is implementing initiatives to ensure the sustainability of the HIV response, e.g., piloting social contracting mechanisms.

UNAIDS-led JUNTA projects since 2020 that have applied a PHC approach to HIV responses have included:

- support for CLM (with UNDP)
- social contracting pilot project
- technical assistance to develop a roadmap towards sustainability of HIV response, including multisectoral response and leadership
- advocacy to remove legal barriers to HIV programmes, especially the Penal Code Bill, and for the promotion of legal protection of the rights of PLHIV and KPs through the enactment of a comprehensive anti-discrimination legislation
- community engagement on PMTCT (with WHO, UNICEF, UNAIDS, and UNHCR)
- implementation of HIV self-testing (with WHO, UNFPA, UNICEF, and UNHCR)
- outreach to young KP members through social media campaigns (with UNFPA)
- technical assistance for updating strategic information.

**Lessons learned during implementation include the need to:**

- secure political and programmatic endorsement from the Global Fund Technical Working Group-HIV and the MoH National AIDS programme for smooth project implementation
- hold regular meetings with partners to harmonize work

- importance of political advocacy at the national and sub-national levels (e.g., to create a favourable environment for the introduction of PrEP)
- importance of including CSE in public education curriculum to prevent HIV transmission in adolescent girls
- employ bold actions to eliminate legal barriers against the HIV and AIDS response.

#### **4.2.2. What is the Joint Programme doing to build political commitment for sustainable HIV financing in the context of PHC?**

##### **Finding 2.5: As Indonesia's economy continues to grow and the sustainability of HIV financing is uncertain, the Joint UN Team may need to be involved in further efforts for advocacy and planning.**

It is expected that donor funding for HIV will begin to decrease over the coming years. Some elements of the HIV response are more dependent upon donor support than others. For example, support for procurement, distribution, and demand generation for public sector condoms for KPs is supported by the Global Fund due to restrictions around the use of public sector condoms for purposes other than family planning.<sup>89, 90</sup> In addition, support to CSOs that are integral to the HIV response, implementing initiatives such as outreach, peer mentoring, and decreasing loss to follow-up, has been dependent upon donor support from the Global Fund.<sup>91</sup> Multiple JUNTA stakeholders also identified concerns about sustainability of financing for UN activities in the context of decreasing UBRAF funding. Interviewees suggested that potential approaches to maintain HIV gains and sustain programming included integration into PHC and increased interlinkages with other services, as well as increased collaboration to streamline efforts between UNAIDS Cosponsors.

The 2021-2025 Joint Programme Strategy has an output related to a fully funded HIV response. Related UNAIDS Secretariat activities include: technical assistance to produce strategic information on HIV (including an HIV National AIDS Spending Assessment, HIV Projection and Investment Case Analysis, Sustainability Index Dashboard, etc.) to guide the roadmap toward sustainability of the HIV response; technical assistance to mobilise a multisectoral response and leadership for a fully funded national and sub-national AIDS control programme; and technical assistance for pilot implementation of social contracting in six cities/districts and capacity building for CSOs in 26 priority cities/districts to improve capacity for grant and programme management.

However, UNAIDS Cosponsors have had limited engagement on the issue of sustainable HIV financing and KIs suggested that further work is needed by the Joint Team to identify strategies and action plans for when donor funding begins to decrease. Moving forward, it is expected that the JUNTA will need to intensify efforts around transition planning and to advocate for increased domestic funding for HIV at the national and sub-national level. This was identified as a priority by the 2020-2022 Joint HIV/STI Programme Review<sup>92</sup> and subsequently reflected in the 2024-2026 National Action Plan for HIV Prevention and Control.<sup>93</sup>

Interviewees also identified the importance of a broader health system strengthening approach, ensuring financial support for general service delivery as well as programmes to ensure the sustainability of the HIV response. Increased coverage of KPs and PLHIV may be explored through the inclusion of testing and treatment in the national social insurance scheme (JKN) and expansion of public-private partnerships,<sup>94</sup> as the technical package for JKN currently only covers opportunistic infections with limited coverage of private hospitals and clinics.

<sup>89</sup> The Global Fund. Funding Request Form, Allocation Period 2024-2026. 2023.

<sup>90</sup> UNAIDS. Comprehensive Condom Programming in Indonesia. 2019.

<sup>91</sup> Magnani RJ, Harimurti P, Pambudi ES, Pei Lyn MC, Hafez R, Samudra RR, Munira SL, Najib I. Transitioning from Donor-Funded Health Programmes in Indonesia: Issues and Priorities. The World Bank. 30 December 2017.

<sup>92</sup> Ministry of Health. Joint Review, National HIV and STI Control Programme in Indonesia, 2020-2022. 2023.

<sup>93</sup> Ministry of Health. National Action Plan: HIV and STI Prevention and Control, 2024-2026. 2023.

<sup>94</sup> Magnani RJ, Harimurti P, Pambudi ES, Pei Lyn MC, Hafez R, Samudra RR, Munira SL, Najib I. Transitioning from Donor-Funded Health Programmes in Indonesia: Issues and Priorities. The World Bank. 90; 30 December 2017.



**Finding 2.6: The Joint Programme has made efforts to increase the sustainability of the community response through capacity building for civil society and community-led organizations and social contracting pilots.** Stakeholders at the national and sub-national levels identified civil society involvement as an integral component of the HIV programme in Indonesia. Joint Team organizations have been involved in capacity building for CSOs. For example, UN Women, UNFPA, UNDP and UNAIDS have provided technical assistance to Global Fund principal recipients. UNAIDS has particularly been involved with CSOs in Indonesia, with a large network of CSO implementing partners and recent capacity-building and social contracting initiatives. However, civil society informants highlighted concerns about their engagement in multiple JUNTA pilot projects, including recruiting community members, as these are short term, have an uncertain future and may change in scope and target population if they are eventually adopted by other organizations.

Civil society KIs also expressed concern about the sustainability of their programming, given their reliance on donor support, and about the community members who are financially dependent on employment as community health workers.

The JUNTA is currently exploring social contracting as a mechanism for sustainable financing of CSOs and CLOs. The government has a legal mechanism for social contracting, with four types being implemented (see Box 3).<sup>95</sup> With the support of the Global Fund, UNAIDS has an ongoing pilot of Type III in six districts, supporting

35 CSOs to increase their capacity to advocate for and access social contracting. As part of the pilot, CLO alliances have been created in each of the six districts to link government stakeholders and community organizations, as well as create a learning network between districts. This has strengthened relationships with the local government, with lobby and advocacy processes resulting in increased budget allocation for community-led responses through social contracting in two cities.<sup>96, 97</sup> This pilot was proposed to be scaled up in 100 priority Global Fund districts in the 2024-2026 Funding Request. While this could be a step towards sustainability, stakeholders highlighted: the need to raise awareness of social contracting and build capacity for financial management and marketing amongst CLOs and CSOs; the limited experience of the health system of Indonesia in working with CSOs and knowledge of the CSO landscape; and concerns that CSOs may lose autonomy and the ability to work freely with KPs that are criminalised if they are contracted by the government. Knowledge generated by the UNAIDS pilot may identify some of these concerns and potential mitigations.

### **Box 3: Types of social contracting in Indonesia**

- Type I: In-house management, planned, implemented, and supervised by the government institutions responsible for the budget;
- Type II: In-house management, planned and supervised by the government institutions responsible for the budget and carried out by other national/regional government bodies;
- Type III: In-house management, planned and supervised by the government institutions responsible for the budget and implemented by external organizations; and
- Type IV: In-house management planned by the government institutions responsible for the budget and/or based on community organization proposals, and implemented and supervised by community groups.

<sup>95</sup> Balai Diklat Keuangan Makassar. Definsi dan Tipe Swakelola. Kementerian Keuangan. 26 October 2021.

(<https://bppk.kemenkeu.go.id/balai-diklat-keuangan-makassar/artikel/definisi-dan-tipe-swakelola-481542#:~:text=pelaksana%20Swakelola%3B%20atau-.Tipe%20IV%20yaitu%20Swakelola%20yang%20direncanakan%20oleh%20Kementerian%2FLembaga%2FPerangkat,oleh%20Kelompok%20Masyarakat%20pelaksana%20Swakelola>).

<sup>96</sup> Semarang City and Denpasar City

<sup>97</sup> UNAIDS Indonesia. UN Joint Team Programme on HIV and AIDS Activity Report 2022. May 2023.

### 4.2.3. What are the main enablers and barriers to integrating HIV into PHC in various contexts? How is the Joint Programme addressing these at country level?

**Finding 2.7: A potential enabler is the upcoming transformation of Indonesia’s health care system to a PHC approach.** As described in Finding 1.5, KIs identified early opportunities for early engagement with the MoH to integrate HIV programming throughout the life course through the following components of the health transformation initiative:

- Integrated primary care services with a life course, person-centred approach, including integration of laboratories and data systems at the national and local/district levels (by the Digital Transformation Office and Pusdatin);
- Multisectoral policy and action with the involvement of several ministries in initiatives, i.e., school- and work-based health education; and
- Increased community engagement through training courses for volunteer community health workers (*kaders*) based on “buckets” of care.

There is, however, a need to identify which elements of HIV services would be appropriate to integrate with PHC and define the best approaches to do so in a sustainable manner, e.g., by ensuring that public funding is funnelled to CSOs.

**Finding 2.8: Existing weaknesses in the health care system (e.g., in supply chain management and access to certain laboratory services) pose continuous challenges to effective HIV response and service delivery.** For example, rates of viral load testing are low due to delays in procuring reagents, lack of storage for specimens, limited testing capacity and quotas for tests in some health facilities, and equipment not working.<sup>98</sup> In addition, there have been issues with supply chain management for ARVs leading to over- or under-stocking. The 2020-2022 Joint National HIV and STI Control Programme review highlighted a need to strengthen the logistics system to ensure uninterrupted supply of commodities and strengthen the capacity of district and provincial health programme managers.

The strength of PHC systems and the implementation of the national HIV programme also vary by location due to the decentralised health system and dependence upon local government priorities and budgeting, as well as differences in the availability of health care workers. Health care access also varies, depending on Puskesmas coverage, as discussed earlier in this report. This variation also affects the HIV response. While 187 priority districts have comprehensive service facilities, defined as the availability of HIV testing, STI services, HIV care, support, and treatment services, and EMTCT services, only 37 districts offer early infant detection and viral load tests.<sup>99</sup>

The Joint Team is working to address some of these barriers, with UNDP, WHO, and UNICEF providing support for supply chain management and WHO involved in guideline generation, technical assistance, and the strengthening of district mentoring for broader health systems and logistics strengthening.

**Finding 2.9: Insufficient protection of human rights and stigma have led to challenges in key populations’ access to testing, treatment, and prevention initiatives.** Indonesia has a number of laws that affect provision of and access to HIV services for KPs, including the criminalisation of sex workers, people who use drugs, and extramarital sex.<sup>100</sup> While there are no national laws penalising *waria* (transgender women), local byelaws targeting “immoral behaviours” have been used to arrest *waria*, as well as other marginalised groups.<sup>101</sup> The Penal Code has become more prohibitive over the years, with the increased application of a range of laws against MSM and transgender people, as well as unlawful crackdowns and raids targeting gatherings of lesbian, gay, bisexual, and transgender

<sup>98</sup> Ministry of Health. Joint Review, National HIV and STI Control Programme in Indonesia, 2020-2022. 55; 2023.

<sup>99</sup> Ministry of Health. Joint Review, National HIV and STI Control Programme in Indonesia, 2020-2022. 50; 2023.

<sup>100</sup> UNAIDS. The State of HIV Prevention in Indonesia. October 2021. [Indonesia-1.pdf \(unaids.org\)](#).

<sup>101</sup> UNAIDS. Legal and policy trends impacting people living with HIV and KPs in Asia and the Pacific, 2014-2019. 2021. [Legal and policy trends impacting people living with HIV and key populations in Asia and the Pacific 2014–2019 \(unaids.org\)](#)



people by the police and religious groups.<sup>102</sup> The lack of protection of the rights of KPs has contributed to stigma and fear, which deter these populations from seeking health care.

There are also laws that undermine HIV prevention, which was identified as a weakness in Indonesia's HIV response. The ability to provide CSE is limited,<sup>103</sup> with the UN focusing on out-of-school initiatives. Recent revisions to the Penal Code also threaten the future of CSE by prohibiting the display and promotion of contraceptives, including condoms, to minors. In addition, as of 2008, condoms distributed by the public sector are only to be used for family planning.

**Finding 2.10: While HIV and broader health information systems are strong, key informants identified a need for more advocacy regarding HIV-PHC interlinkages and integration using strategic data.** This was identified as key to potential integration of HIV into PHC. HIV in Indonesia has a specific context and epidemiology, with the localisation of the epidemic in KPs and a generalised epidemic in Papua and West Papua. While there is ongoing national HIV and KP mapping data which is analysed and used by the MoH, sub-national health offices sometimes lack the resources to do so. There are ongoing JUNTA projects to address this gap; for example, UNAIDS provides technical assistance in 14 districts in the Greater Jakarta area to do sub-national treatment cascade analyses, which they then discuss at stakeholder meetings. There is an opportunity to expand these efforts, as KIs at Puskesmas identified a desire to have more training regarding data analysis and strategic use.

KIs noted that integration of HIV into PHC requires a national strategy guided by robust national and sub-national data, and this is an area where the Joint Programme could contribute through continued technical assistance. KIs also identified a need for stronger advocacy and dissemination of analysed data.

**Finding 2.11: Health information systems are separate for HIV-related reporting, leading to a high workload for clinicians inputting data.** Clinicians interviewed estimated spending one and a half hours inputting data every day, working with approximately 20-30 data systems in total. This includes national systems as well as reporting systems for donor-funded programmes.

There are national plans to integrate the current patient registration system for HIV (SIHA 2.1) into the health data ecosystem (SATUSEHAT)<sup>104</sup> in the upcoming years, under the government's new initiative.<sup>105, 106</sup>

Previously, the health information systems for various diseases (e.g., TB, non-communicable diseases) had been separate. The Joint Programme has had limited involvement in this integration, although UNODC has been involved in linking the Prison Health Information System contributing information on HIV, TB, and hepatitis C programmes to SATUSEHAT.

KIs identified benefits in linking information about PLHIV with broader health data, e.g., through disaggregation of data by HIV status and facilitating strategic management of national and sub-national inventory, concerns have been raised about data security, which must be considered in the context of stigma and criminalisation experienced by PLHIV and KPs in Indonesia.

**Finding 2.12: A current lack of public-private partnerships is seen as a barrier to integration of services for HIV with PHC.** While Puskesmas are commonly used for HIV testing and treatment (see Section 2.4.8), KIs reported that many PLHIV and KPs use private clinics, community clinics, or private hospitals for services because of fear of disclosure of status and stigma in local public clinics.

“Clinic services stop at 14.30, and then we input data for an hour and a half.”  
Puskesmas KI

<sup>102</sup> Ibid.

<sup>103</sup> UNDP. Assessing Human Rights and Gender in HIV/AIDS Prevention and Care in Indonesia. 2021.

<sup>104</sup> SATUSEHAT is an integrated health platform that links health systems and integrates health data, providing publicly accessible dashboards of MoH health information to support monitoring, data management, policy development, and data-based decision making.

<sup>105</sup> Ministry of Health. National Action Plan HIV Prevention and Control Programme 2024-2026. 2023.

<sup>106</sup> The Global Fund. Indonesia Funding Request Form 2024-2026. 2023

However, there are differences in service standards and subsequent access to HIV testing and treatment. Limited integration of the private sector with the national HIV data system (SIHA 2.1), the lack of downstream referrals, and limited partnerships of CSOs/CLOs with the private sector have been identified as barriers to achieving and monitoring progress towards the 95-95-95 targets. Some public-private partnerships are supported by the Global Fund at the district level to enable testing (e.g., through samples sent to Puskesmas) and sharing of coverage data, which was described as an enabler to integration.

#### 4.3. EQ3: To what extent is the Joint Programme using investments, infrastructure, innovations, and lessons learned from the HIV response, including adaptations during the COVID-19 pandemic, to improve broader health outcomes?

##### SUMMARY OF FINDINGS- EQ3

- Achievements and opportunities in leveraging HIV investments and approaches to strengthen broader health outcomes thus far have been rooted in the strong approach to community engagement in the HIV response.
- There is a potential for lessons learned from stigma and human rights-related HIV programming to reduce stigma associated with KPs and PLHIV in general, as well as other diseases and populations in primary care settings; and
- Multiple initiatives to maintain testing and adherence to HIV treatment were developed at the national and sub-national level during the COVID-19 pandemic and, if adopted and sustained, these approaches could contribute to improving broader health outcomes.

##### **4.3.1. To what extent is the Joint Programme leveraging HIV investments, knowledge, infrastructure, approaches, and innovative models developed by the HIV response to strengthen broader health outcomes? Are there any untapped opportunities?**

**Finding 3.1: Achievements and opportunities in leveraging HIV investments and approaches to strengthen broader health outcomes thus far have been rooted in the strong approach to community engagement in the HIV response.** Achievements from Joint Programme activities thus far have been limited to the spin-off effects of increasing community engagement. For example, community organizations engaged by the Joint UN Team have been influential in connecting KP members and PLHIV to health services in general, driving rights-based programmes and policies, and strengthening government accountability for health and development through CLM.

KIs noted that the health system in Indonesia has limited experience in working with CSOs and could learn from the HIV response. Health programme managers are viewed as risk-averse and unaware of the civil society landscape, and CSOs lack access to information about government programmes as well as capacity for financial management and marketing. There is an opportunity to use lessons learned from years of strong community engagement in the HIV response to strengthen broader health outcomes, including through the scaling up of social contracting and capacity-building initiatives for wider civil society.

**Finding 3.2: There is a potential for lessons learned from stigma and human rights related HIV programming to reduce stigma associated with KPs and PLHIV in general, as well as other diseases and populations in primary care settings.**

KIs highlighted the benefits of the community-led approach to countering stigma towards PLHIV in Indonesia and its potential application to other stigmatised diseases and populations. Joint Team efforts that have contributed to these efforts include:

- CLM (UNAIDS and UNDP)
- advocacy for anti-discrimination legislation and the removal of legal barriers (UN Women and UNAIDS)
- increasing access to Indonesian identity cards for transgender people (ILO)
- community sensitisation and generating awareness (UNAIDS).

While these have focused on HIV, there have likely been spin-off effects from removing legal and social barriers to health care access and more broadly, reducing socioeconomic barriers for marginalized populations. Lessons learned from these efforts could also inform the response to other stigmatised diseases and groups of people.

#### **4.3.2. To what extent is the Joint Programme using and promoting wider adoption of adaptations in service delivery developed in response to COVID-19 to improve broader health outcomes?**

**Finding 3.3: Multiple initiatives to maintain testing and treatment adherence were developed at the national and sub-national level during the COVID-19 pandemic and, if adopted and sustained, these approaches could contribute to improving broader health outcomes.** During the pandemic, access to testing and treatment was sustained through HIV self-testing initiatives, multi-month dispensing, telemedicine and other initiatives at national and sub-national levels. Lessons learned from these adaptations in service delivery to meet the needs of populations who could not come to clinics may be more widely applicable for other health issues and other populations.

Joint Programme initiatives during COVID-19 included the following:

- WHO, UNAIDS, and UNDP support to the MoH to introduce multi-month dispensing: three months of ART can now be dispensed to patients in 320 facilities in 111 districts, depending on district and case considerations<sup>107, 108</sup>
- WHO, UNAIDS, and UNDP worked with the MoH to develop guidelines and a comprehensive platform for HIV treatment through telemedicine;<sup>109</sup> and
- UNAIDS has been working on self-testing pilots among MSM, female sex workers and transgender women, leading to an increase in testing uptake of 25%, and has scaled up the initiative in partnership with WHO, UNHCR, UNFPA, and UNICEF.<sup>110, 111</sup>

<sup>107</sup> Ministry of Health. Joint Review, National HIV and STI Control Programme in Indonesia, 2020-2022. 53; 2023.

<sup>108</sup> Joint United Nations Programme on HIV and AIDS (UNAIDS). Indonesia's Joint Programme Strategy (JPS) 2021-2025. 2021.

<sup>109</sup> Joint United Nations Programme on HIV and AIDS (UNAIDS). Indonesia's Joint Programme Strategy (JPS) 2021-2025; 2021.

<sup>110</sup> Ministry of Health. Joint Review, National HIV and STI Control Programme in Indonesia, 2020-2022. 73; 2023.

<sup>111</sup> Joint United Nations Programme on HIV and AIDS (UNAIDS). Indonesia's Joint Programme Strategy (JPS) 2021-2025. 2021.

#### 4.4. EQ4: To what extent does the Joint Programme ensure that equity, gender, and human rights issues, including the needs of KPs, are sufficiently addressed when leveraging HIV and PHC interlinkages and integration?

##### SUMMARY OF FINDINGS- EQ4

- While training and compensation for volunteer community health workers is a central part of the upcoming health transformation, the HIV response in Indonesia still relies upon civil society and community-led organizations to reach certain KP groups.
- Some KPs have limited access to primary care facilities due to structural barriers as well as stigma and discrimination.
- Health care systems and level of access in Indonesia vary by location due to the decentralized system, requiring the use of sub-national data for a contextualised approach to HIV/PHC integration. The JUNTA is supporting Indonesia to ensure stigma- and discrimination-free services for PLHIV and vulnerable and KPs through community-led monitoring initiatives and advocacy.
- Given the context of persistent stigma and discrimination against people living with HIV and vulnerable and KPs in Indonesia, there is a need for more high-level advocacy by the Joint UN Team.
- The JUNTA has primarily supported the integration of HIV into testing systems for co-infections (e.g., TB and STIs) and services accessed by KPs (e.g., ANC and GBV), but integration of management of co-morbidities experienced by ageing PLHIV and with broader health and non-health related sectors have been limited.

##### 4.4.1. Which locations and population groups are potentially benefitting or being left behind?

**Finding 4.1: While training and compensation for volunteer community health workers is a central part of the upcoming health transformation, the HIV response in Indonesia still relies upon CLOs and CSOs to reach certain KP groups.** Stakeholders believed that community health workers (“*kaders*”) could reach out to certain populations, such as women living with HIV including those who are pregnant, to further PMTCT efforts, they may be less able to reach KPs. Reaching MSM, female sex workers, people who use drugs, and transgender individuals will still require outreach via CSOs. CSOs are used in numerous ways to link PLHIV to treatment through outreach including peer mentorship, inviting people to return to treatment to decrease loss to follow-up, and accompanying PLHIV and KP members to primary care facilities. More broadly, they work with the JUNTA on a number of advocacy, accountability (through community-based monitoring framework and CLM), demand generation, and community mobilisation initiatives. While the education of *kaders* in HIV prevention and control was thought to be useful and an opportunity for further outreach, KIs resoundingly thought that CSOs were still necessary to ensure that key and marginalised population groups are able to access primary care.

**Finding 4.2: Some KPs have limited access to primary care facilities due to structural barriers as well as stigma and discrimination.** MSM, female sex workers, and transgender women were identified by stakeholders as being at risk of being unable to access HIV services if they are fully integrated into primary care facilities. Under the upcoming health transformation initiative, a national ID will be essential for accessing services and linking data through SATUSEHAT. ILO has recently worked on a social protection initiative to increase access to national ID cards for transgender women, but there is still work to be done.

In addition, prisoners and migrants have limited access to health services. There are reportedly less than 180 prisons with official permits to deliver health services within the prison. Refugees and asylum seekers do not have national ID cards and are not included in the national health insurance which limit them to have access to the primary, secondary, and tertiary health services. The Joint Team is using UBRAF funding to address these issues.

Even with legal access, as described in Finding 2.9, PLHIV and KPs may feel uncomfortable accessing services in primary care facilities due to stigma and fear of disclosure. CSO stakeholders reported that many PLHIV opt to go to tertiary facilities instead.

“During access to treatment, [MSM and transgender women] were told to repent by getting married, some were told by doctors to recite the Koran so that they would realize that they were wrong.”  
CSO KI

**Finding 4.3: Health care systems and level of access in Indonesia vary by location due to the decentralized system, requiring the use of sub-national data for a contextualised approach to HIV/PHC integration.** As described in Finding 2.8, districts are responsible for budgeting and the level of financing and health resources vary. For example, the city of Jakarta has a higher rate of coverage by Puskesmas than Papua and West Papua. The HIV epidemic also differs depending on the district and the size of KPs. In Papua and West Papua, there is a low-level generalised epidemic with different resource needs and considerations. Stakeholders urged the Joint UN Team to take a data-driven approach to integration in this context to determine where and how integration of services is feasible and appropriate.

#### ***4.4.2. How is the Joint Programme supporting countries to ensuring stigma and discrimination free services for PLHIV and vulnerable and KPs in all service delivery settings, including primary care?***

**Finding 4.4: The JUNTA is supporting Indonesia to ensure stigma- and discrimination-free services for PLHIV and vulnerable and KPs through community-led monitoring initiatives and advocacy.** The JUNTA is taking a leading role on the collection of strategic information regarding stigma and discrimination facing PLHIV and KPs in primary care settings. This is being done through partnerships with networks of PLHIV and KPs. CLM and community-based monitoring framework mechanisms led by UNAIDS, UN Women and UNDP are being used to generate data on stigma and discrimination for monitoring and documenting access to HIV services, quality of services, and human rights violations. With support from USAID, DFAT, and the Global Fund, the CLM feedback mechanism has already been implemented in 23 districts and used to conduct policy dialogues in 7 cities.<sup>112</sup> UN Women, ILO and UNAIDS are also supporting the Stigma Index.

In addition, UNAIDS is coordinating and convening partners to advocate for elimination of HIV-related stigma and discrimination, especially in the context of the new revised Penal Code and is providing TA to the National Commission on Human Rights.

**Finding 4.5: Given the context of stigma and discrimination against people living with HIV and vulnerable and KPs in Indonesia, multiple stakeholders have seen a need for more high-level advocacy from the JUNTA.** They primarily highlighted the need for the Joint UN Team to speak with a unified voice with strong multisectoral advocacy under the “leave no one behind” umbrella, and specifically to raise issues facing PLHIV and KPs in the context of increased criminalisation and stigma. While UNAIDS was identified as a key coordinator for this advocacy, multiple internal and external stakeholders said it is important to have a collective and aligned voice on the issues facing PLHIV from the whole Joint Team. Stakeholders also identified the need for advocacy at sub-national levels: “advocacy made by the UN team is mostly in Jakarta, but the issues are not just in Jakarta.”

<sup>112</sup> UNAIDS Indonesia. The UN Joint Programme contribution to strengthening HIV and Primary Health Care (PHC) outcomes: interlinkages and integration. June 2023.

#### 4.4.3. *To what extent is the Joint Programme supporting countries to integrate HIV into systems for health and other sectors appropriately in different epidemic and health systems contexts?*

**Finding 4.6: The JUNTA has primarily supported the integration of HIV with other communicable diseases (e.g., TB and STIs) and services accessed by KPs (e.g., ANC and GBV), but integrated management of comorbidities experienced by ageing PLHIV and with non-health related sectors has been limited.** There is still limited integration of HIV with long-term treatment further along the life-course, including mental health and non-communicable diseases. The health transformation agenda provides an opportunity to consider issues affecting PLHIV along the life course and how to integrate services, multisectoral action and policy, and community engagement for long-term care and treatment outside of the standard “test and treat” programming. While this integration is happening in some cases at the district level, it does not yet have broader national engagement.

In addition, integration of HIV into PHC has primarily been on a medical basis. There has been limited engagement in addressing potential socioeconomic impacts of HIV/AIDS, such as food insecurity and unemployment. Work related to social protection has been limited; ILO has some projects in these areas, including promotion of the right to work of PLHIV and increasing access to national ID cards, which could complement a broader strategy.

#### 4.5. EQ5: What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages and to what extent is the Joint Programme sufficiently resourced to pursue this?

##### SUMMARY OF FINDINGS- EQ5

- The added value of the Joint Programme in Indonesia is that it enables each agency to contribute its strengths to create a holistic package to support the national HIV response.
- The JUNTA was also described as being uniquely positioned to convene with different stakeholders, both internal and external (including the government, civil society, and development agencies), for the purpose of coordination and joint advocacy.
- While capacity was high at the country offices, many stakeholders discussed concerns about limited resourcing to carry out joint activities as UBRAF funding continues to decrease.

#### 4.5.1. *What is the added value of the Joint Programme in terms of leveraging HIV and PHC interlinkages? (Joint Programme ways of working, collaboration, synergies, and comparative advantages)?*

**Finding 5.1: Key informants identified that the added value of the Joint Programme in Indonesia is that it enables each agency to contribute its strengths to create a holistic package of support for the national HIV response.** JUNTA KIs primarily described the strength of the Joint Programme as each organization’s ability to complement each other based on the agreed division of labour to fill gaps in the national HIV response. KIs also suggested that leveraging each organisation’s mandate and comparative strengths could be beneficial for the agenda of HIV and PHC integration.

Stakeholders at the national and sub-national levels also identified clear strengths in the technical work and support provided by the JUNTA as well as the comparative advantages of each UNAIDS cosponsor. However, KIs also identified that to leverage HIV and PHC interlinkages, reduce the risk of duplication, and strengthen advocacy efforts, the joint programme needs to act more cohesively (see Finding 1.3).

**Finding 5.2: The JUNTA was also described as being uniquely positioned to convene with different stakeholders, both internal and external (including the government, civil society, and development agencies), for the purpose of coordination and joint advocacy.** KIs highlighted multiple advantages



to the UN's involvement in joint advocacy due to their global and national presence and role in generating high-level guidance and strategic data. However, as described in Finding 1.3, this is not actualised to its full potential. KIs identified the need to synergise work for advocacy and to appear as a singular voice on key issues affecting PLHIV, KPs, and PHC.

#### **4.5.2. To what extent does the Joint Programme have the necessary skills and resources to contribute to strengthening HIV and PHC integration and linkages?**

**Finding 5.2: While capacity was high at the country offices, many stakeholders discussed concerns about limited resourcing to carry out joint activities as UBRAF funding continues to decrease.**

JUNTA KIs described this as a barrier to starting new initiatives in the coming years, as they have “a lot of challenges, and not a lot of UBRAF funding.”<sup>113</sup> Aside from UBRAF, the Global Fund had previously provided WHO, UNFPA and UN Women with funding for technical assistance, but they are reportedly limiting technical assistance provided by UN institutions going forward. UNAIDS Cosponsors work with different donors to mobilise their own funding but are concerned about sustainability.

This was described as a key consideration when considering introduction of programming around the integration of PHC and HIV, as some KIs were concerned about financial constraints. Others suggested that increased coordination between UNAIDS Cosponsors as well as leveraging interlinkages of HIV and related programmes could maximize the use of limited resources. However, this is an area that requires more exploration and mapping by the JUNTA.

## 5. Conclusions and considerations going forward

### 5.1. Summary of conclusions

- **The Joint UN Team on AIDS in Indonesia does not yet have an overarching strategy regarding the integration of HIV and PHC, but there have been activities and achievements with linkages to broader PHC.** The 2021-2025 Joint Programme Strategy does not explicitly address PHC or have associated indicators, and there is a lack of overall conceptual clarity about the Joint Team's agenda on the integration of HIV and primary care/PHC in Indonesia. However, there are activities related to the integration of HIV services into testing and treatment for co-infections such as hepatitis B and syphilis through triple elimination and TB, and broader connected services such as sexual and reproductive health and rights, antenatal care, gender-based violence, and CSE. In addition, the Joint UN Team is highly involved in community engagement in the HIV response.
- **There is room for further collaboration and multisectoral coordination between the members of the Joint UN Team on AIDS with partners (the government and external donors).** Stakeholders described a lack of coordination between UNAIDS and its Cosponsors, with a need for further alignment of related activities and joint multisectoral advocacy. External stakeholders also identified a desire to engage with the Joint UN Team on AIDS as a unit, both in general and in relation to integration of HIV and PHC, as UNAIDS Cosponsors were seen as working in silos with separate projects related to their mandates. There is a gap left by the dissolution of the National AIDS Commission in 2016, but there are opportunities for the Joint UN Team to leverage existing mechanisms, such as the Global Fund CCM, for cross-sector coordination. There are also opportunities for further engagement outside of the usual HIV partners through information sharing about UNAIDS cosponsor projects that are not explicitly related to HIV or funded by the UBRAF. In addition, there are numerous ministries outside of the MoH that could be convened for multisectoral HIV advocacy.

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<sup>113</sup> JUNTA KI



- **The PHC health transformation initiative of the Indonesian government presents key opportunities for early engagement and advocacy for the inclusion of HIV.** The recent health transformation initiative, with PHC as the first pillar, presents an opportunity for early advocacy from the Joint UN Team to ensure that HIV is integrated into programming across the life course, including training units for community health workers, school- and work-based health education, and integration of laboratories and data systems. Stakeholders expressed concerns that HIV would be lost in this transformation without strong advocacy.
- **While some consideration has been given to the integration of HIV control and that of other communicable diseases and key resources accessed by PLHIV with strong community engagement, the approach is currently lacking multisectoral action and the integration of issues along the lifespan.** Integration of HIV has primarily been through packaging with related coinfections and services for increased access to testing and treatment. There is a lack of attention to co-morbidities faced by PLHIV across their lifespan, particularly in relation to mental health and issues facing ageing PLHIV, such as non-communicable diseases and opportunistic infections. In addition, there is a lack of integration of HIV with non-medical sectors to address socioeconomic issues faced by PLHIV, such as potential barriers to employment, food insecurity, etc.
- **Sustainability of the HIV response is a key issue impacting potential integration of HIV with PHC as Indonesia begins to transition from some sources of donor support.** There is an increased need for advocacy to ensure the sustainability of the national response to HIV through increased domestic funding and the inclusion of HIV prevention (through PrEP), testing, and treatment in UHC packages. There are ongoing initiatives to explore the sustainability of community engagement through social contracting and capacity-building, but many CSOs are still unaware of this mechanism and/or have concerns regarding their autonomy when relying upon government funding. In the context of limited resources, there may also be a need to leverage HIV and PHC financing.
- **There are barriers and considerations related to the integration of HIV within PHC, including weaknesses in the health care system, insufficient protection of human rights, access for key and vulnerable populations, disjointed data systems, the need for an evidence-based strategy, and engagement of private partnerships.** There is a need to map and strategically address these barriers and issues through programming and advocacy when integrating HIV into PHC, as well as to consider what can and cannot be integrated.
- **The HIV response in Indonesia employed unique approaches to community engagement and reducing stigma that could be utilised to strengthen broader health outcomes.** These achievements were identified by stakeholders as potential learning opportunities for other diseases as well as to strengthen health outcomes more broadly.
- **The Joint Programme has a comparative advantage in leveraging each UNAIDS cosponsor's strengths to contribute a holistic effort to fill gaps in the national HIV response.** These strengths can be built upon through increased coordination and streamlining of activities, as well as connections with non-HIV and non-UBRAF-related activities.

## 5.2. Considerations for strengthening the Joint Programme contributions to alignment and integration

The following presents a summary of considerations for the Joint Programme moving forward.

### Strategy to inform the integration of HIV within primary care

**There is a need to develop an evidence-based joint UN Team on AIDS strategy for the integration of HIV with PHC, considering what can and cannot be integrated in this context.** This is critical and, if produced in a timely manner, can be used for joint advocacy for the inclusion of HIV modules in the government's new approach to PHC. This should address key concerns around integration of HIV into PHC, including:

- considerations of the current status of HIV and PHC in Indonesia, including decentralisation and diverse geographic and epidemiological contexts
- social protection and inclusion of KPs and PLHIV
- the sustainability of HIV funding
- data privacy
- the role of the private sector
- plans for sustained engagement of civil society organizations
- the diverse needs of PLHIV throughout their lifespans
- stigma and discrimination facing KPs and PLHIV.

The strategy should include specific objectives related to integration (to the extent it is deemed appropriate in this context) that are reported upon by JUNTA.

### Improve multisectoral action and policy

**The Joint UN Team on AIDS's approach to multisectoral action and policy should be detailed in the joint strategy for the integration of HIV and PHC, considering the roles and responsibilities of UNAIDS Cosponsors, ministries, and external partners in the broader landscape of PHC and determinants of health.** This should detail the Joint UN Team's position in the landscape of health actors in Indonesia, as well as plans for engagement and advocacy targeting a broad spectrum of multisectoral actors. This should also consider the ongoing health transformation, as well as the strategic goals and activities of external actors in PHC.

**Further alignment of PHC agendas and opportunities for linking HIV programming with non-HIV sectors and activities should be explored further through the establishment of inter-agency platforms.** These forums should aim to generate opportunities for linkages of HIV with other programmes related to health and broader determinants of health, and the establishment of multi-sectoral policies and actions. This may include:

- Inclusion of a platform in Joint UN Team meetings to discuss organizational activities that are not directly related to HIV, such as other disease programmes and broader health systems strengthening activities, to identify potential opportunities for integration; and
- Regularly convening inter-agency forums on integration of HIV and PHC, including representatives from ministries and external development partners working in PHC and with broader determinants of health, such as education and social welfare.

## Enhance sustainable community engagement

### **Continue and scale up efforts to ensure the sustainability of community engagement mechanisms.**

This may include (but is not limited to):

- Joint UN Team support in creating HIV-related modules to integrate into ongoing training of *kaders* led by the MoH;
- Continuation of joint efforts for capacity-building in national and local CSOs working with KPs and PLHIV;
- Scaled-up piloting of social contracting and generation of data to outline benefits and risks; and
- Creation of sustainability plans with CSOs receiving funding from Joint UN Team members, including plans for the sustainability of ongoing pilots.

## Foster political commitment for addressing needs of KPs

**There is an urgent need for strong multisectoral advocacy to keep HIV and particularly issues facing KPs on the political agenda amid the health transformation initiative.** This may be spearheaded by UNAIDS as a coordinating body but should come from the Joint UN Team as a collective unit. This engagement should also involve the range of ministries involved in HIV beyond the MoH, as well as engagement at the sub-national level through the Ministry of Home Affairs and Ministry of Villages. Stronger advocacy for the rights of KPs and PLHIV should come from the Joint UN Team, as well as with the support of the UN Country Team through inclusion in UNSCDF.

## Intensify coordination and leadership within the Joint UN Team on AIDS

**Strong leadership is needed to further the agenda of HIV and PHC interlinkages and integration, spearheaded by UNAIDS with support from UNAIDS Cosponsors.** Clear leadership was described as a key lesson from the responses to TB and stunting, which have greater government backing. PHC and HIV convergent actions should be a regular talking point on the agenda of meetings within the Joint UN Team as well as in multisectoral meetings. Through these platforms, key achievements, challenges, and opportunities may also be discussed and addressed jointly.

**There is further a need for the Joint UN Team to intensify coordination efforts with government and external donor partners.** The Joint UN Team should bolster efforts to bring together multisectoral partners in an open forum for advocacy and coordination purposes, potentially tapping into the wide membership of the Global Fund's CCM and HIV Technical Working Group. This can be done through an inter-agency meeting focused applying the PHC approach to HIV responses, where the Joint UN Team can share their strategy and goals as well as align with that of external partners.

**Increased coordination and alignment of the Joint UN Team.** Joint UN Team meetings should occur more frequently, e.g., monthly, to discuss and align activities in general, including those that are not directly related to HIV or funded by UBRAF. This should involve:

- alignment of joint activities towards a common goal
- potential for linkages of HIV and ongoing programming
- coordination of advocacy-related activities.

## Annexes

### Annex 1 – Key informant interview guide

Note: the following guide is tailored to the Joint Team, we also developed tailored guides targeting the following categories of key informants:

- Global Fund, PEPFAR, BMGF, USAID, international NGOs etc.
- Government Ministry/central staff
- Facility staff/Service providers (government and or private/NGO)
- Community led/based organizations, KP groups
- Academic/research organizations

#### **Country case studies - Key Informants Interview Guides**

##### **The UNAIDS Joint Programme contribution to strengthening HIV and Primary Health Care outcomes: interlinkages and integration**

#### **Interview guide for Joint Programme Cosponsors in country**

Introduce the consultants and KIIs. Note names and positions

Introduce the assignment: Euro Health Group has been contracted to conduct an evaluation of the UN Joint Programme's work on leveraging the HIV and PHC interlinkages in order to strengthen these and identify opportunities for the Joint Programme work on PHC in the future.

The evaluation will identify how efforts to address HIV have been – conceptually and operationally – linked to the PHC approach and whether or how this can be further strengthened. The evaluation should capture the HIV-PHC interface, drawing on where things stand based on current experience and the way forward. The timeframe of the evaluation is from 2020 to date. At country level the UN Joint Programme on HIV includes the UNAIDS Secretariat Country Office and up to 11 Cosponsors. In this evaluation we are focusing on the work of WHO, UNICEF, UNFPA and the World Bank in addition to UNAIDS Country Office.

The evaluation will not only assess how the Joint Programme has supported integration of HIV into PHC and how HIV integration has improved HIV prevention, testing and treatment outcomes but also how this has strengthened PHC outcomes more broadly, e.g., improving the ability of PHC to care for people with chronic illnesses.

All information provided to the evaluation team will be kept confidential, and potential citations will not be traceable to any person or their details.

Thank you for your willingness to talk to us.

#### **List of questions**

- Can you describe any recent examples from your country where the Joint Programme has contributed to strengthen:
  - integrated service delivery (including in primary care)
  - multisectoral action and policy
  - empowerment of communities

Any notable achievements since 2020?

How is progress tracked?

## Probing Qs

- Can you mention any recent examples of Joint Programme activities at country level to build political commitment for sustainable financing and delivery of integrated HIV services (e.g., comprehensive HIV services in health benefit packages)?
  - Any recent examples of Joint Programme multisectoral actions and policy?
  - To what extent is the Joint Programme promoting community-led approaches for demand generation and service delivery when appropriate? (and How can this potentially be improved?)
- Where does the Joint Programme *add value* through its joint ways of working on HIV and PHC integration and linkages? (e.g., convening power, collaboration, synergies etc) Probe: How is the Joint Programme using its *comparative advantage*, resources and ways of working to support HIV and PHC integration and linkages at country level? (Joint Programme leadership, advocacy, policy dialogue, convening, funding, guidance, technical support, strategic information at global, regional and country levels)
  - To what extent do you think the Joint Programme has appropriate and adequate skills and resources to leverage the HIV and PHC interlinkages? What, if any, are the main gaps, and where should the Joint Programme strengthen its capacity?)
  - What are the *main barriers* to integrating HIV into PHC and how is the Joint Programme addressing these, at country level? (probing: are Joint Programme partners at the UHC table when discussing UHC/PHC etc?)
  - What are the *key enablers* to advance HIV and PHC integration? (Probing: How is the Joint programme tapping into these?)
  - How is the Joint Programme identifying and assessing the *main barriers and challenges to, and risks of*, HIV integration in PHC?
  - To what extent do you think that the Joint Programme has leveraged on HIV assets (investment, learnings, approaches, innovations) for broader health gains? Specific examples Any specific examples? (probe: are there any missed opportunities?)
  - What is the Joint Programme doing to ensure *equitable access* to HIV services delivered through a PHC approach? Which locations and population groups are potentially benefiting /or being left behind?
  - Where should the Joint Programme focus its *efforts in the future* on HIV and PHC integration and linkages to maximize HIV and broader health outcomes? What should it do better or differently going forward (probing: Missed opportunities for the Joint Programme on the HIV-PHC interfaces) How can the Joint Programme best contribute to ensuring the equity, quality and sustainability of HIV services that are integrated with, or linked to, PHC?)
  - Is there an imperative to integrate HIV more in PHC? How can this support HIV outcomes? How can it support broader health outcomes?
  - To what extent are relevant plans, strategies and activities related to HIV and PHC harmonized and aligned *internally* within the Joint Programme (UNAIDS, WHO, UNICEF, UNFPA, WB) at the country level? And *externally*? (Global fund, PEPFAR etc?)
  - What can and should the Joint Programme do in the future to maximize on the interlinkages between HIV and PHC?

## Annex 2 – Individuals met and group discussion participants

Key informant interviews		
1	Valerie Julliard	UN Resident Coordinator
2	Erlangga Agustino Landiyanto	UNRCO Technical Staff
3	Diandra Pratami	UNRCO Technical Staff
4	Anjali Sen	UNFPA Representative
5	Asti Setiawati Widiastuti	UNFPA Technical Staff
6	Sujala Pant	UNDP Deputy Resident Representative
7	Agus Soetianto	UNDP Technical Staff
8	Siprianus Bate-Soro	UNDP Technical Staff
9	Mukta Sharma	WHO Team Lead of Communicable Diseases
10	Budi Arto	WHO Technical Staff
11	Irvin Romyco	WHO Technical Staff
12	Mrunal Shetye	Chief of Health UNICEF
13	Artha Camellia	UNICEF Technical Staff
14	Pandu Harimurti	Senior Health Specialist World Bank
15	Somil Nagpal	Senior Health Specialist World Bank
16	Tina Boonto	UNAIDS Country Director
17	Pungkas Bahjuri Ali	BAPPENAS - Director of Public Health and Nutrition
18	Imran Pambudi	MOH - Director of Communicable Disease
19	Maria Endang Sumiwi	MOH - DG of Public Health
20	Dr Endang Lukitosari	MOH - Head of HIV Working Group
21	Lanny Luhukay	MOH – Communicable Disease Staff
22	Dr Pranti	MOH - HIV Working Group Staff
23	Carmelia Basri	Chair of TWG-HIV
24	Kirana Pritasari	Chair of CCM Indonesia
25	Nurul Hasanah Mardhanu	Programme Officer CCM Indonesia
26	Pudji Suryantini	Secretariat CCM Indonesia
27	Farid Hafifi	Mahameru LSM
Focus group with BKKBN (National Family Planning Agency)		
1	Safrina Salim	BKKBN/National Family Planning Agency - Director of Reproductive Health
2	Murni Manurung	BKKBN/National Family Planning Agency
3	Retno Damayanti S.	BKKBN/National Family Planning Agency
4	Mutia Zahrotunnisa	BKKBN/National Family Planning Agency
5	Nurul Hasanah	BKKBN/National Family Planning Agency
6	Takwani Suci P.	BKKBN/National Family Planning Agency
7	Noer Aziza	BKKBN/National Family Planning Agency
8	Popy Irawati	BKKBN/National Family Planning Agency
Focus group with the Joint UN Team		
1	Erlangga Agustino Landiyanto	UNRCO
2	Diandra Pratami	UNRCO
3	Lintang K. Wijayani	UNHCR
4	Asti Setiawati Widiastuti	UNFPA
5	Early Dewi Nuriana	ILO
6	Ade Aulia	UNODC
7	Terra Taihitu	UNDP

8	Leonita Agustine	UNAIDS
9	Sindi Putri	UN Women
<b>Focus group with UNAIDS</b>		
1	Lely Wahyuniar	UNAIDS, Strategic Information
2	Jieon Oh	UNAIDS, UN Volunteer
3	Bagus Rahmat Prabawo	UNAIDS, Prevention
4	Leonita Agustine	UNAIDS, Strategic Information
5	Luh Putu Ari Dewiyanti	UNAIDS, Community Mobilisation, Young People and Demand Generation
6	Adi Nugroho	UNAIDS, Community Mobilisation
7	Elis Widen	UNAIDS, Community Mobilisation
8	Myranda Putri	UNAIDS, Strategic Information
9	Yasmin Purba	UNAIDS, Human Rights and Gender
10	Bella	UNAIDS, Human Rights and Gender
11	Faid Nawawi	UNAIDS, Media and Communication
12	Novita	UNAIDS, Admin
13	Farisa	UNAIDS, Admin
14	Gono	UNAIDS, Admin/IT
15	Hasan	UNAIDS, Admin/Op
<b>Focus group with civil society organization representatives</b>		
1	Representative	Inti Muda
2	Representative	GWL-INA
3	Representative	IPPI
4	Representative	IAC
5	Representative	JTID
6	Representative	JIP
7	Representative	PKNI
<b>Focus group with the Indonesian Positive Network (JIP)</b>		
1	Representative	JIP
2	Representative	JIP
3	Representative	JIP
4	Representative	JIP
5	Representative	JIP
6	Representative	JIP
7	Representative	JIP
8	Representative	JIP
<b>Focus group with international development organization representatives</b>		
1	Tetty Rachmawati	USAID-PEPFAR
2	Sheila Piry	DFAT
3	Prudence Brothwick	Unit Manager - Health Human Development, DFAT
4	David Stanton	Deputy Director, Health Office USAID
<b>Focus group with Jakarta Provincial Health Office and North Jakarta District Health Office</b>		
1	Dr Rahmat Aji Pramono	Jakarta PHO
2	Jessie Yunus	Epic



3	Dwi Oktaviani	Jakarta PHO
4	Juni Astaty	Jakarta PHO
5	Lusi Indah Pratiwi	Jakarta PHO
6	Dedy Purwanto	North Jakarta DHO
7	Putri Air Prawitasari	North Jakarta DHO
<b>Focus group with Penjaringan Primary Health Centre in Jakarta and partner</b>		
1	Dr Devy Winata	Penjaringan PHC
2	Manda	Penjaringan PHC
3	Herdayati	PKBI North Jakarta
4	Tubagus Rohman	Epic
5	Rayhan	Epic
6	Budiyanto	Yayasan Pelita Ilmu
7	Andhika F	Penjaringan PHC
8	Dwi Ayu	Penjaringan PHC
9	Nadiva Silvina	Yayasan Pelita Ilmu
10	Anwar	Yayasan Pelita Ilmu
11	Sasli Rahmat	Penjaringan PHC
12	drg. Lindawati	Penjaringan PHC
<b>Focus group with Banten Provincial Health Office and Tangerang City District Health Office</b>		
1	Neneng Nurhayati	Banten PHO
2	Karlina Rachmawati	Banten PHO
3	Fika Febriana	Epic
4	Farida Helmy	Tangerang City DHO
5	Nur Afni	Banten PHO
6	Devita Dwi Ami	Tangerang City DHO
7	Lisa Felina	Tangerang City DHO
8	Desi Putri	Tangerang City DHO
9	Awani Ceria Luksita	Tangerang City DHO
10	Sheila Piry	DFAT
<b>Focus group with Karawaci Baru Primary Health Centre in Tangerang City</b>		
1	Ahmad Syahron Rosyadi	Karawaci Baru PHC
2	Nung Supriyati H.	Karawaci Baru PHC
3	Lola Alia Yolanda	Karawaci Baru PHC
4	Zaenal Mustofa	Karawaci Baru PHC
5	Siti Jamilatul M	Karawaci Baru PHC
6	Ahmad Farid Amin	Karawaci Baru PHC
7	Atika Maulina	Karawaci Baru PHC
8	Indira Permata Sari	Karawaci Baru PHC
9	Dr Dece	Karawaci Baru PHC
<b>Focus group with Cibodasari Primary Health Centre in Tangerang City</b>		
1	Dr Masitoh	Cibodasari PHC
2	Dr Didi	Cibodasari PHC
3	Ratna Murningsih	Cibodasari PHC
4	Abd. Haris	Cibodasari PHC
5	Nurul Badiyah	Cibodasari PHC
6	Dyan Melasari	Cibodasari PHC

Focus group with Surabaya District Health Office		
1	Rosita Dwi Yuliandari	Dinkes Kota Surabaya
2	Nanik Sukristina	Dinkes Kota Surabaya, Head of Surabaya DHO
3	Migit Supriati	Dinkes Kota Surabaya
4	Maya Cristinawati	Dinkes Kota Surabaya
5	Ika Sari Damayanti	Dinkes Kota Surabaya
Focus group with East Java Provincial Health Office		
1	Inna Mahanani	Dinkes Provinsi Jatim, Head of East Java PHO
2	Mohamad Yoto	Dinkes Provinsi Jatim
3	Sulvy D.A	Dinkes Provinsi Jatim
4	Waritsah Sukarjiyah	Dinkes Provinsi Jatim
5	Ratna Dwi Wulandari	Dinkes Provinsi Jatim
6	Risna Nur Fajariyah	Dinkes Provinsi Jatim
7	Dewi Ratih	Dinkes Provinsi Jatim
8	Nurmah Indrijati	Dinkes Provinsi Jatim
9	Eka Putri	Dinkes Provinsi Jatim
10	Risa Etika	GELIAR RS SOETOMO IDAI JATIM
Focus group with Sememi Primary Health Centre		
1	Dr Rahmat Sudi	Puskesmas Sememi
2	Mohamad Yunus	Puskesmas Sememi
3	Chintaniati A	Puskesmas Sememi
4	Rina Wahyu Utami	Puskesmas Sememi
5	Saniyah	Puskesmas Sememi
6	Zulfa Shelly	Puskesmas Sememi
7	Yuliani	Puskesmas Sememi
Focus group with Kedungdoro Primary Health Centre		
1	Dr Diah Roichan Arifiani	Puskesmas Kedungdoro
2	Salma Nur Fadhilah	Puskesmas Kedungdoro
3	Dr Ratih Sekar Ayu	Puskesmas Kedungdoro
Focus group with Airlangga University staff		
1	M Ardian CL	GELIAT FKM UNAIR
2	Nyoman Anita Damayanti	GELIAT FKM UNAIR
3	Sri Wulan Sari Ekawati	GELIAT FKM UNAIR
4	Rachmat Harjono	GELIAT FKM UNAIR
5	Dr Yati Suparyati	GELIAT FKM UNAIR
6	Ajeng Febrianti	GELIAT FKM UNAIR
7	Laura Havika Yamani	GELIAT FKM UNAIR

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## Annex 4 – JUNTA Work Plan 2020-2023

The division of labour in the current Joint Programme Strategy (2021-2025) is in accordance with the 2018 UNAIDS Division of Labour, and is as follows:

- HIV prevention among KPs – UNFPA, UNDP
- HIV prevention among young people – UNFPA, UNICEF
- HIV testing and treatment – WHO
- HIV and UHC – WHO, World Bank
- Human rights, stigma, and discrimination – UNDP, UNAIDS, UN Women
- HIV services in humanitarian settings – UNHCR
- Elimination of mother-to-child transmission of HIV and keeping mothers, children, and adolescents alive and well – UNICEF, WHO
- HIV-sensitive social protection – ILO
- Decentralization and integration of sexual and reproductive health and rights and HIV services – UNFPA, WHO
- HIV prevention, harm reduction, treatment and rehabilitation harm reduction for people who use drugs and HIV in prisons – UNODC
- Leadership, advocacy, and communication – UNAIDS
- Strategic information – UNAIDS
- Coordination, convening, and country support implementation – UNAIDS.

**Table: UBRAF financing by agency, activity, and year (2020-2023)<sup>114</sup>**

Co-sponsor	Activities	2020 US\$	2021 US\$	2022 US\$	2023 US\$	Total US\$
UNAIDS	Innovative testing; strengthening HIV prevention packaging for KP including PrEP; strengthening implementation of HIV self-testing; advocacy for the inclusion of HIV in UHC development and integration of HIV with testing and treatment for co-infections such as TB, Hepatitis B/C, and other STIs (triple elimination); supporting for Community-Based Monitoring and Feedback (CLM/ community-based monitoring framework); campaign for effective treatment cascade; TA for national prevention strategies; private sector engagement; dissemination of public information through media campaigns; access and demand generation for HIV prevention and testing for young KP;	-	-	1 960 090	655 000	2 615 090*

<sup>114</sup> UNAIDS. JPMS extracts 2020-2023. Accessed June 2023.

Co-sponsor	Activities	2020 US\$	2021 US\$	2022 US\$	2023 US\$	Total US\$
	identification of and advocacy for removal of policy and programmatic barriers to effective HIV response; advocacy for the promotion of legal protection of the rights of PLHIV and KPs; supporting the National Commission on Human Rights to promote rights of PLHIV and KPs; strengthening interventions to address human rights barriers; elimination of HIV-related discrimination through strengthening of the Crisis Response Mechanism; supporting HIV-related gender interventions and integration of HIV into GBV services; strengthening strategic information through technical support to research, estimates and projections, analyses of resource needs, investment case analysis, and strengthening of data systems; supporting strategies related to sustainability and transition of funding; support for social contracting; and support for a multi-sectoral HIV response for a fully funded national and sub-national AIDS control programme in Indonesia.					
UNICEF	TA to MoH to strengthen PMTCT and EID, including triple elimination; study to analyse factors that make women vulnerable to contracting HIV and identify challenges/barriers to HIV services; PMTCT dashboard development; and scale up community engagement model to increase treatment for pregnant women and EID testing.	142 399	42 205	50 000	42 000	276 604
UNFPA	Scaling up partner notification; access to reproductive health and HIV services for young KP, including through CSE in out-of-school settings; test and treat for partners of KP; strengthening prevention programmes for female sex workers; total marketing approach including improvement of outreach and scale-up of condom distribution; support women living with HIV on PMTCT advocacy, including a review on the readiness of Indonesia to eliminate maternal to child transmission in 2023; support for elimination of maternal to child transmission (EMTCT) with policy papers and IEC materials; and strengthening the integration of HIV and sexual reproductive health and rights in partnership with UN Women, specifically related to data strengthening for violence cases in women living with HIV and integration of HIV into violence against women (VAW) services.	78 599	77 566	223 200	54 320	433 685
UN Women	Prevention and establishment of referral system for GBV against women living with HIV (strengthening the integration of HIV and VAW); TA to National Commission VAW to disaggregate VAW data by women living with HIV and women from KPs; distribution of COVID-19 personal protective equipment kits to outreach workers and women living with HIV; advocacy for gender-responsive HIV policy and response and eliminating all forms of HIV gender-related barriers, stigma and discrimination affecting women living with HIV; strengthening political role and participation of women living with and affected by HIV in the creation of the Penal Code Bill and the Elimination of Sexual Violence Bill; engagement of men and young men on gender and VAW issues; and	59 397	81 292	110 350	116 745	367 784



Co-sponsor	Activities	2020 US\$	2021 US\$	2022 US\$	2023 US\$	Total US\$
	needs assessment on social impact of COVID-19 for women living with HIV and women from KPs.					
UNHCR	HIV awareness raising for refugees and asylum seekers to promote information about testing and treatment; prevention of COVID-19 transmission by providing PPE; cash-based interventions to reduce rates of HIV infection; provision of medical allowance for known PLHIV in the refugee community; referral of known PLHIV in refugee community to HIV service providers, including for treatment of Syphilis and Hepatitis B; advocacy related to HIV/AIDS prevention and response for refugees and asylum seekers in Indonesia; scaling up voluntary counselling and treatment among the refugee community; support to ensure continuity of HIV prevention, testing, treatment, and GBV against PLHIV in refugee communities; training of refugee volunteers to conduct initial counselling to high-risk refugee community, referral to health service providers, and accompanying them during the VCT and HIV treatment.	27 396	32 571	24 500	24 850	109 317
ILO	Scaling up the workplace community to access VCT and strengthening Ministry of Manpower on Occupational Safety and Health Guidance for COVID-19; increasing capacity of private sector involvement on HIV prevention, testing, and treatment; Social Economic Impact Survey for PLHIV and KP due to COVID-19; promoting non-discriminatory policies to strengthen HIV prevention, treatment, and right to work; survey of KAP and social protection among young workers of 4.0 Industry; scaling up access on HIV prevention, VCT, and treatment for clients of sex workers; developing an online platform on promotion of HIV/AIDS prevention and services at the workplace; e-learning on HIV prevention, access, and treatment at the workplace; supporting private sector registration for the Company AIDS Awards; HIV awareness, harassment, GBV, and access to HIV testing and treatment for female workers; ID cards and health insurance for transgender persons; and accelerating prevention, testing, and treatment in Papua and West Papua in selected sectors (plantations, mining, and seaports).	89 811	74 570	83 000	55 050	302 431
IOM	Conduct a research study on HIV/AIDS vulnerability among migrant workers and families in Indonesia (2020); and develop voluntary HIV testing and awareness raising strategies among migrant workers and families in collaboration with national and local stakeholders.	-	-	-	-	-
UNODC	Development of an integrated online prison health information system; support the Ministry of Social Affairs and the Directorate General of Corrections in the COVID-19 response with PPE procurement and creation of COVID-19 guidelines for prisoners and people who use drugs; facilitation of virtual course for HIV outreach intervention; capacity building of civil society organizations (CSOs) through short course on	125 886	100 155	109 950	74 235	410 226

Co-sponsor	Activities	2020 US\$	2021 US\$	2022 US\$	2023 US\$	Total US\$
	Regulatory Impact Assessment; training and guidance on implementing HIV, Hepatitis C, and Hepatitis B programmes for people who use non-injecting stimulant drugs; increasing capacity of outreach worker and peer educator to support 90-90-90 achievement among people who use drugs; development and training concerning an integrated online prison health information system containing all health-related information and aligned with other pertinent disease health information systems (SIHA for HIV; SITB for TB; SIHEPI for Hepatitis C); and facilitate a series of workshops to establish networking and health referral system (specifically related to TB/HIV collaboration programmes).					
UNDP	Country capacity assessment on rights to health of all KPs and vulnerable groups; TA for procurement and supply management and the transition to tenofovir/lamivudine/dolutegravir (TLD), implementation of multi-month dispensing, and adoption of PrEP; support the MoH in strengthening supply chain management for ARVs and non-ARVs through one-stop-gate policy to reduce the incidence of overstock and stock-out; strengthen feedback mechanisms from the community, focused on human rights and gender issues to reduce stigma and discrimination of KPs; support MoH in increasing access to HIV treatment through telemedicine; TA for human right and gender-related programmes to principle recipients of the Global Fund; and following up on results from the 2020 assessment of Human Rights and Gender in partnership with UN Women and ILO.	32 697	106 062	35 000	21 000	194 759
WHO	Introduce online training platform for HIV and STI testing and treatment; support development of HIV and STI guidelines and EMTCT validation criteria; guidance for prevention services including PrEP and latent TB infection testing; strengthening/revitalizing of STI services and surveillance, including at PrEP pilot sites; programme review of HIV and STI; support strategy and action plan development for HIV and STI; TA to assist MoH in PrEP implementation and monitoring; TA to MoH in strengthening STI surveillance; support for revitalisation of STI services, including updating of technical guidelines and strengthening district mentor team; support to monitor HIV treatment programme implementation; support for expansion of STI and HIV services; support for HIV testing and use of effective ARV regimens; support for HIV drug-resistance surveillance; support for implementation of early infant diagnosis and paediatric treatment of HIV; and support for implementation of HIV, Syphilis, and Hepatitis B sentinel surveillance.	-	-	325 001	325 001	650 002*
	* Non-country envelope funding	<b>556 185</b>	<b>514 421</b>	<b>2 921 091</b>	<b>1 368 201</b>	<b>5 359 898</b>

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