



Evaluation of the UNFPA support to the HIV response (2016-2019)

Indonesia



COUNTRY CASE STUDY



UNFPA Evaluation Office

2020



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UNFPA Evaluation Office

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FOREWORD

A founding Cosponsor of UNAIDS, UNFPA is a key partner in the global HIV response. It is a co-convenor (together with other United Nations Funds and Programmes) on HIV prevention among adolescents, youth and key populations, as well as on the decentralisation and integration of SRHR and HIV services. UNFPA also plays a technical role in prevention and condom programming within the Global Prevention Coalition and, as a chair of the UNAIDS Committee of Cosponsoring Organizations, is at the centre of the mechanism for coordinating the global response to HIV and AIDS.

Compared with a decade ago, HIV infections have declined globally, AIDS-related deaths have seen a dramatic reduction and considerable progress has been made towards the 90-90-90 targets. However, the global HIV care continuum is marred by considerable variations with several regions experiencing sharp increases in new infections. It also presents gaps that are greater for men, young people and key populations, while women continue to be disproportionately affected by the epidemic. Across the world, almost 10 million people await treatment and 1.7 million people acquire HIV every year, half of whom are among key populations and their partners.

The purpose of this evaluation is to assess the performance of UNFPA in integrating its approach to supporting the HIV response within the broader context of SRHR, population dynamics, gender equality and human rights. As part of this assessment, the evaluation paid particular attention to the contribution of UNFPA to: the prevention of sexual transmission; the linking of HIV with other aspects of SRHR and SGBV; and the promotion of gender equality and human rights in the context of HIV.

The evaluation of the UNFPA support to the HIV response covers the period from 2016 (when the current UNAIDS strategy was rolled out) to 2019 and is structured around a series of regional and country case studies. It also rests on key informant interviews, a comprehensive review of documents and data sets at global, regional and country levels, as well as an online survey of key informants in 59 countries. The case studies were selected to provide an illustrative example of UNFPA work to support the HIV response in very diverse contexts.

The overall evaluation highlights how UNFPA has been able to leverage the UNAIDS Division of Labour to guide its support to the HIV response at global, regional and country levels and has made an important contribution to meeting the needs of the most vulnerable. However, it also indicates that the absence (at corporate level) of a transformative result conveying a strong priority for realizing the rights of, in particular, the key populations, as well as a lack of an explicit strategy for UNFPA support to the HIV response have inhibited UNFPA from fully deploying its capacities to champion the rights of KPs. UNFPA has, however, demonstrated that linking and integrating SRHR, HIV and SGBV services is an effective approach to meeting the needs of the AGYW, other vulnerable groups and KPs. In fact, the evaluation points to the need to develop and strengthen guidance to regional and country offices on piloting and scaling integration at national level.

The overall evaluation also recommends that UNFPA builds on the results it has achieved and develops a strategy for its support to the HIV response. This strategy should detail the role of the Fund at global, regional and national levels and, aligning its responsibilities as a UNAIDS Cosponsor with UNFPA core mandate areas, should seek synergies between the HIV programming and other internal strategies and programmes in support of the transformative results. UNFPA should also continue to assert the critical importance of comprehensive condom programming and extend support to both supply chain strengthening and demand creation, especially among young people.

The present report provides the reader with a summary of the overall evaluation, followed by the Indonesia case study. Anchored in the Asia-Pacific, epidemic and cultural setting, where the more common pattern is that of concentrated epidemics among KP groups, the Indonesia case study results in a rich and detailed account of a UNFPA response tailored for the people in greatest need. It should be read in conjunction with the overall evaluation report and I encourage the reader to compare it with the other case studies (Georgia and Namibia).

This evaluation would not have been possible without the invaluable inputs and support from a wide range of stakeholders, both within and outside UNFPA. I am deeply appreciative of the considerable time and contributions of colleagues working on the HIV response in UNFPA headquarters, regional offices and country offices who generously shared their knowledge. This evaluation also benefited from the critical insights of all technicians reunited in the Evaluation Reference Group, who co-authored a set of recommendations based on the independent conclusions of the report. Last but not least, I am extremely grateful to the colleagues in the Country Office in Jakarta for the crucial role they played in facilitating the extensive data collection by the evaluation team for the present case study.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
ASRH	Adolescent Sexual Reproductive Health
BAPPENAS	Ministry of National Development Planning/National Development Planning Agency
BKKBN	National Population and Family Planning Board
CCM	Country Coordinating Mechanism
CO	Country Office
CP9	UNFPA's 2016-2020 Ninth Country Programme
CPAP	Country Action Plan
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
EECA	Eastern Europe and Central Asia
ESA	Eastern and Southern Africa
FGM/C	Female Genital Mutilation/Cutting
FSW	Female Sex Workers
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-Based Approach
IAC	Indonesia AIDS Coalition
ILO	International Labour Organization
IMS-HIV	"Infeksi Menular Seksual" - HIV
IPPI	Indonesian Positive Women's Association
IU	Implementation Unit
JIP	Jaringan Indonesian Positive
JKN	Jaminan Kesehatan Nasional
JUNTA	Joint United Nations Team on AIDS
KAP	Key Affected Population
KP	Key Population
MISP	Minimum Implementation Service Package
MNH-FP	Maternal and Newborn Health – Family Planning
MoH	Ministry of Health
MoWECP	Ministry of Women's Empowerment and Child Protection
MSM	Men Who Have Sex with Men
MSW	Male Sex Worker
NAC	National AIDS Commission
NAP	National Action Plan
NFM	New Funding Model
NFMc	New Funding Model Continue
NGO	Non-governmental organization
NSAP	National Strategy and Action Plan (2015-2019 HIV and AIDS Response)
OPSI	Organisasi Perubahan Sosial Indonesia (sex worker network organization)
P4P	Partners for Prevention
PE	Peer Educator
PL	Peer Leader

PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PMTS	'Pencegahan Melalui Transmisi Seksual' ('Comprehensive Programme for the Prevention of Sexual Transmission of HIV')
PR	Principle Recipient
PSEA	Protection against sexual exploitation and abuse
PWID	People Who Inject Drugs
RPJMN	2015-2019 National Mid-Term Development Plan
SDG	Sustainable Development Goal
SGBV	Sexual Gender-Based Violence
SOPs	Standard Operating Procedures
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSR	Sub-Sub-Recipients
STI	Sexually Transmitted Infection
SW	Sex Workers
TA	Technical assistance
TB	Tuberculosis
TG	Trans-gender
The Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
TWG-HIV	HIV Technical Working Group
UBRAF	United Budget, Results and Accountability Framework (UNAIDS)
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VAW	Violence Against Women
WHO	World Health Organisation

GLOSSARY OF TERMS

Term	Definition	Source
Combination HIV prevention	A combination HIV prevention approach provides defined packages of services, including behavioural, biomedical and structural components, tailored to high priority population groups within their specific local contexts. A focus on supporting prevention choices helps to overcome fragmentation of prevention programmes into distinct streams for each prevention tool or intervention, often championed by different agencies and implemented separately. This does imply, however, that local stakeholders – including local governments, local civil society organizations and local communities – are at the centre of their own responses.	UNAIDS (2018) <i>HIV Prevention 2020 Road Map</i>
Key populations	UNAIDS considers gay men and other men who have sex with men, sex workers and their clients, transgender people, people who inject drugs and prisoners and other incarcerated people as the main key population groups. These populations often suffer from punitive laws or stigmatizing policies, and they are among the most likely to be exposed to HIV. Their engagement is critical to a successful HIV response everywhere - they are key to the epidemic and key to the response. The term “key populations at higher risk” also may be used more broadly, referring to additional populations that are most at risk of acquiring or transmitting HIV, regardless of the legal and policy environment.	UNAIDS (2015) <i>Terminology Guidelines</i>
Risk	Risk is defined as the risk of exposure to HIV or the likelihood that a person may acquire HIV. Behaviours, not membership of a group, place individuals in situations in which they may be exposed to HIV and certain behaviours create, increase or perpetuate risk. Avoid using the expressions “groups at risk” or “risk groups” - people with behaviours that may place them at higher risk of HIV exposure do not necessarily identify with any particular group.	UNAIDS (2015) <i>Terminology Guidelines</i>
Sexual and reproductive health package	This term refers to programmes, supplies and multi-integrated services to ensure that people are able to have not only a responsible, satisfying and safer sex life, but also the capability to reproduce and the freedom to decide if, when and how often to do so. It is particularly important that this decision be free of any inequality based on socioeconomic status, education level, age, ethnicity, religion or resources available in their environment. A sexual and reproductive health package aims to guarantee that men and women are informed of, and have access to, the following resources: safe, effective, affordable and voluntary acceptable methods of birth control; appropriate health-care services for sexual and reproductive care, treatment and support; and comprehensive sexuality education.	UNAIDS (2015) <i>Terminology Guidelines</i>
Sexual gender-based violence	This is now the terminology that is increasingly being used in all contexts, as this is one of the most common forms of violence encountered, including in intimate partner relationships as well as against those who have different sexual orientations.	
Vulnerability	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	UNAIDS (2015) <i>Terminology Guidelines</i>

	<p>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.</p>	
Vulnerable populations	<p>Vulnerable populations are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics. These guidelines do not specifically address vulnerable populations, but much of the guidance can apply to them.</p>	<p>WHO (2014) <i>HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines</i></p>
Young people, youth and adolescents	<p>Child: a person under 18 years of age, as defined by the United Nations. Adolescent: a person aged 10 to 19 years, as defined by the United Nations. Young person: a person between 10 and 24 years old, as defined by the United Nations. Youth: a person between 15 and 24 years old, as defined by the United Nations. The United Nations uses this age range for statistical purposes, but respects national and regional definitions of youth.</p> <p>Children: According to Article 1 of the Convention on the Rights of the Child, “a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier”. Adolescents: Individuals between the ages of 10 and 19 years old are generally considered adolescents. Adolescents are not a homogenous group; physical and emotional maturation comes with age, but its progress varies among individuals of the same age. Also, different social and cultural factors can affect their health, their ability to make important personal decisions and their ability to access services. Youth: This term refers to individuals between the ages of 15 and 24. Young people: This term refers to those between the ages of 10 and 24.</p>	<p>UNESCO (2018) <i>International technical guidance on sexuality education: An evidence-informed approach</i></p> <p>WHO (2014) <i>HIV Prevention, Diagnosis, Treatment and Care for Key Populations – Consolidated Guidelines</i></p>
Linkages and integration	<p>Linkages refer to bi-directional synergies in policy, systems and services between SRHR and HIV. It refers to a broader human rights-based approach, of which service integration is a subset. Integration refers to the service delivery level (whether at a facility or in the community) and can be understood as joining operational programmes to ensure effective outcomes through many modalities (multi-tasked providers, referral, one-stop shop services under one roof, etc.).</p>	<p>Interagency Working Group on SRHR and HIV Linkages (2017) <i>SRHR and HIV Linkages: Navigating the work in progress 2017</i></p>

EXECUTIVE SUMMARY OF THE OVERALL EVALUATION OF THE UNFPA SUPPORT TO THE HIV RESPONSE (2016-2019)

Purpose and scope of the evaluation

UNFPA is a key partner in the global response to the human immunodeficiency virus (HIV). It works at global, regional and national levels and advocates for sexual and reproductive health and rights (SRHR), scaling up integrated SRHR services, intensifying HIV prevention, supplying male and female condoms and lubricants, and tackling gender inequalities. UNFPA is a founding cosponsor of UNAIDS and, in the UNAIDS Division of Labour, is a co-convenor (with UNDP) on HIV prevention among key populations (KPs). UNFPA is also a co-convenor on HIV prevention among adolescents and youth (with UNICEF and UNESCO), and the integration of SRHR and HIV services (with WHO).

The purpose of this evaluation is to assess the performance of UNFPA in integrating its support to the HIV response within the broader context of SRHR, population dynamics, gender equality and human rights. The evaluation covers the period 2016-2019 and all types of interventions and responses to HIV supported by UNFPA at global, regional and national levels.

Methodology

The evaluation aims to identify the contribution made by UNFPA and adopts a theory-based approach with analysis of the intended results of UNFPA support. It also analyses the contextual factors related to the nature of the HIV epidemic and the response. The evaluation team developed a theory of change for all aspects of UNFPA support and, ultimately, detailed evaluation questions, which set out the areas of research. Associated with each question, key causal assumptions were tested via indicators using primary and secondary data gathered, analysed and presented by the evaluation team.

Data collection was structured around two regional and five country case studies supported by a wide range of methods: key informant interviews, a review of all relevant documents and data sets at global, regional and country level, and an on-line survey of key informants in 59 countries.

Main findings

The UNAIDS Division of Labour has served as an organizing framework to guide UNFPA efforts to promote HIV prevention and to link and integrate sexual reproductive health and rights/HIV/sexual gender-based violence (SRHR/HIV/SGBV) programming and services. Some UNFPA regional offices and country offices studied have been able to match their respective capacities, comparative advantages and mandates to their assigned role in HIV support, often with minimal resources. Country offices in Eastern Europe and Central Asia (EECA) and East and Southern Africa (ESA) have benefited from technical assistance, coordinated advocacy and programmatic support from regional offices: a level of support which may not be available in other UNFPA regions. For UNFPA overall, there is a tension between the role UNFPA has assumed under the UNAIDS Joint Programme, and the perceived diminished priority of HIV within the UNFPA strategic plan 2018-2021 (with reduced human and financial resources allocated to HIV dedicated programming). This has limited the ability of UNFPA to fulfil its expected leadership roles.

UNFPA has directed considerable effort towards promoting the rights of the most vulnerable, including adolescent girls and young women (AGYW), other young people at risk and KPs. This includes identifying crucial issues for policy and advocacy, and supporting efforts to improve the legal and policy environment for young people and key populations. However, these efforts are

hindered by the fact that the transformative results in the UNFPA strategic plan 2018-2021 do not refer specifically to the rights of young people and key populations in relation to HIV prevention, testing and treatment (although the ESA Regional Office has adopted a fourth transformative result: The elimination of sexual transmission of HIV and sexually transmitted infections). Another constraint to effective rights promotion has been the limitations UNFPA has experienced in basing its groundwork for rights policy and advocacy on an understanding of the challenges faced by the most vulnerable at the point of service delivery.

UNFPA has demonstrated a commitment to promoting linkages and supporting the integration of SRHR/HIV/SGBV services to improve access for marginalized, at-risk persons and key populations.

UNFPA has also contributed to achieving quality, client-centred services at country level, especially in ESA, with strong support from the regional office, effective regional partners, and access to multi-year/multi-country funding for support to linkages and integration. However, efforts to scale integration of SRHR/HIV/SGBV services to national level face significant institutional and operational challenges. UNFPA has gained important experience at the regional and national level in ESA, but this does not yet sufficiently inform advocacy at global level. There is also a gap in UNFPA support to supply chain management for condoms and, in general, support to comprehensive condom programming (CCP) in the countries studied.

UNFPA has been active in forging partnerships and working with networks on critical aspects of the HIV response. At regional and country level, UNFPA has demonstrated an ability to foster strong relationships with organizations and networks led by adolescents, youth and key populations to support their capacity to engage meaningfully in national dialogue and action. At global level, a lack of common understanding within the organization on the priority assigned to the HIV response impairs UNFPA capacity to execute its mandate for leadership on HIV prevention. For instance, UNFPA has not yet maximized its comparative advantage and taken a lead role in revitalizing condom programming and SRHR/HIV/SGBV integration in response to the ECHO trial that highlighted the need to integrate HIV prevention, including condom programming, into family planning services.

UNFPA is an active and respected participant in mechanisms for coordinating support to the HIV response at global, regional and national levels. At global level, UNFPA staff participate actively in mechanisms and processes for budgeting and accountability of the UNAIDS Joint Programme and play a central role in the UNAIDS Committee of Cosponsoring Organizations (CCO) and the Global HIV Prevention Coalition. At both regional and country levels, UNFPA has supported efforts to improve sustainability and encourage national investment alongside its United Nations partners and other sources of financial support. However, many countries remain highly dependent on external sources of finance for HIV prevention.

Conclusions

1. UNFPA has been able to utilize the UNAIDS Division of Labour to guide its support to the HIV response in a manner consistent with its comparative advantages. However, strategic plan 2018-2021 does not explicitly recognize the central role UNFPA should play in preventing sexual transmission of HIV and realizing the rights and meeting the needs of key populations. As a result, there is an imbalance between the outward-facing ambition of UNFPA to fill a leadership role in the global HIV response and the inward-facing attention and priority paid to this responsibility. This imbalance, combined with the lack of an agreed UNFPA HIV strategy supported by a theory of change, and the necessary financial and human resources, has limited the ability of UNFPA to use advocacy to shape the global agenda and ensure prioritization of comprehensive HIV prevention. In countries where external resources are limited and the allocation of UNFPA core resources is constrained by the UNFPA business plan, these factors have contributed to an insufficient level of

attention to HIV prevention in family planning and a lack of prioritization for comprehensive condom programming.

2. UNFPA has made important contributions to realizing the rights and meeting the needs of the most vulnerable, including adolescent girls and young women and key populations. However, a number of factors inhibit the capacity of UNFPA to play its expected role in championing their rights and the ability of country offices to engage on sensitive issues in order to reform the broader legal and policy framework. The absence (at corporate level) of a transformative result conveying a strong priority for realizing the rights of, in particular, key populations, and the lack of an explicit strategy for UNFPA support to the HIV response, diminish the focus required for more effective action on rights. This is further limited by a UNFPA business model that does not foresee service delivery as a mode of engagement in many countries, hence constraining the capacity of country offices to address the ability of the most vulnerable and key populations to access quality services in HIV prevention, testing and treatment free from discrimination. These are often countries (as in EECA) where the pace of HIV infection is rising and is concentrated among key populations. Yet, support to rights promotion and meeting the needs of the most vulnerable is of limited effectiveness when not rooted in efforts to improve access to rights-based services.

3. UNFPA support has demonstrated that linking and integrating SRHR/HIV/SGBV programmes and services is an effective approach to meeting the needs of adolescent girls and young women, other vulnerable groups and key populations. UNFPA has also responded effectively to the proven link between sexual and gender-based violence and HIV infections among adolescent girls and young women by extending the integration agenda to include SGBV. UNFPA has made an important contribution to achieving quality, integrated services in SRHR/HIV/SGBV, especially in countries taking part in the 2gether 4 SRHR programme in ESA. This can be attributed to access to consistent financial support for this large multi-country project focused on linkages and integration, combined with a strong regional partnership with the Southern Africa Development Community (SADC), and sustained advocacy and technical support by UNFPA staff. However, the understanding, level and nature of support to integration varies widely across UNFPA regions and countries. Furthermore, the relative absence of UNFPA support to comprehensive condom programming in many countries can undermine some of the results obtained through linkages and integration of SRHR/HIV/SGBV.

4. UNFPA has effectively forged partnerships and worked with networks at regional and country level to promote meaningful participation of adolescent girls and young women, key populations and other vulnerable groups in the policy process. UNFPA has also contributed to the effectiveness of networks and civil society organizations (CSOs) led by adolescents, youth and key populations. However, empowering these partners requires adequate and sustained investment over time in order to build their capacity to engage in advocacy and policy-making to improve the HIV response, broader SRHR policies and the overall legal framework. Yet, UNFPA support to networks is currently constrained by a lack of guidance on how to extend participation beyond the stages of programme design and implementation into accountability by partner governments for effectively realizing the rights of young people, key populations and other vulnerable groups.

5. UNFPA participates actively in platforms and mechanisms for coordinating actions in support of the HIV response at global, regional and national levels. These platforms have successfully avoided duplication of efforts and conflicting messages from the United Nations country teams in host countries. UNFPA participation in coordinating mechanisms does, however, require a significant investment of time and resources. In addition, coordination among partners with a view to increasing and sustaining investments in HIV prevention, testing and treatment has been limited. This is despite the fact that the need is particularly acute in countries transitioning to upper-middle income country (UMIC) status, where resource-allocation models for large-scale programmes can result in abrupt reductions in multilateral support. Reliance on external funding for key aspects of

the HIV response by many countries presents a continuing risk to the sustainability of progress made.

Recommendations

1. Clarifying the role and strategic orientations of UNFPA on HIV

While the UNAIDS 2018 Division of Labour helps to guide UNFPA interventions, it cannot replace a clear statement from UNFPA senior management regarding the roles and responsibilities of the organization in the HIV response. UNFPA, as a matter of organizational priority, should develop and adopt a strategy for its support to the HIV response. This strategy should include the appropriate level of human and financial resources, setting priorities, and accommodating the flexible application of the business model. It should be supported by a theory of change detailing the role of UNFPA at global, regional and national levels, aligning UNFPA responsibilities as a UNAIDS cosponsor with UNFPA core mandate areas, and seeking synergies between UNFPA HIV programming and other internal strategies and programmes, in support of the transformative results of the strategic plan 2018-2021.

2. Meeting the needs of those left behind and promoting their rights

UNFPA needs to take steps to close the gap between rhetoric and action regarding human rights-based approaches in SRHR. To this end, it should develop tools for operationalizing the UNFPA commitment to rights in different technical areas, including in contributing to the HIV response. This should include explicit programming tools placing the promotion of rights - including the rights of adolescent girls and young women, key populations and other vulnerable groups - as a core strategic pillar of UNFPA work in support of the HIV response. It should also include efforts to promote rights literacy among UNFPA staff, service providers and communities. Finally, it should encompass the strengthening of accountability mechanisms or other components related to the identification (and follow-up) of potential violations of rights, especially in relation to access to quality SRHR services.

3. Linking and integrating SRHR/HIV/SGBV

Linking and integrating SRHR/HIV/SGBV services is key to an effective and sustainable national response to HIV. There is a need for UNFPA to build on lessons learned from the ECHO trial results, as well as from the experiences in EECA, ESA and other regions, to develop and strengthen guidance to regional and country offices on piloting and scaling linkages and integration at national level. This guidance should take stock of the diversity of contexts in which UNFPA operates, and should be communicated across all regional and country offices. The intent is to ensure that UNFPA maintains strong leadership on linkages and integration, and that country offices can be effective in supporting related programmatic action at country level, with regional offices providing the advocacy and technical support as needed.

4. Asserting leadership in comprehensive condom programming

UNFPA should continue to assert the critical importance of comprehensive condom programming and promoting its role in championing triple protection (prevention of HIV, other sexually transmitted infections (STIs) and unintended pregnancies). This should include providing support to condom programming (male and female condoms and lubricants) that is comprehensive and covers both supply and demand. Important elements of a comprehensive approach should include, in particular, further integration of condom programming into UNFPA support to family planning programmes. It should extend to strengthening supply chains (including in countries that do not currently benefit from the UNFPA Supplies Programme) and bolstering demand creation, especially

among young people. A comprehensive approach to condom programming should also foresee the reinforcement of public-private-people partnerships for increasing access to, and uptake of, condoms and lubricants.

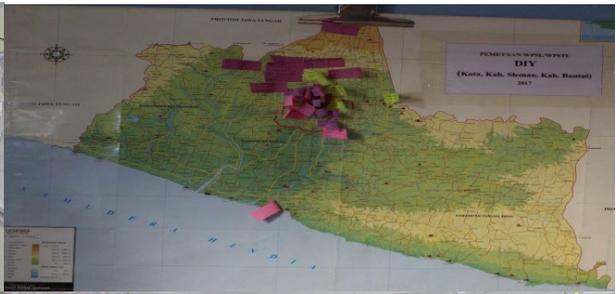
5. Forging partnerships and supporting networks

UNFPA should increase support to the development of the community of regional and national networks by leveraging and allocating resources to strengthen the capacity of CSOs (particularly those catering for or led by KPs, adolescent girls and young people) to engage effectively in policy dialogue, and to access funding from national and international sources. UNFPA should also promote linkages between global, regional and national networks for advocacy and engagement of KPs, AGYW and other young people. Finally, UNFPA should explore collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria to support grant applications and the implementation of HIV prevention programmes, especially for programmes focused on AGYW and KPs.

6. Coordination and sustainability

UNFPA should take action to address risks to the sustainability of the HIV response as part of its role as a UNAIDS Cosponsor participating in the Joint Programme at global, regional and country levels. UNFPA should also advocate and collaborate with other development partners to promote sustainable HIV programming, including transition from external funding and integration of HIV into national and sector development programmes. It should advocate for increased emphasis on prevention within HIV responses under national stewardship and support national strategies and plans for incorporation of the essential package of SRHR interventions, including on HIV/STIs, into universal health coverage mechanisms. UNFPA should also consider technical assistance to national authorities developing proposals for external funding for the HIV response and ensure that the support to capacity development of health-care providers for family planning and other SRHR services does incorporate rights-based HIV prevention, testing and links to treatment.

Read the **evaluation report** of the UNFPA support to the HIV response (2016-2019) [here](#)



1 INTRODUCTION OF THE CASE STUDY

This note presents the results of the field country case study of Indonesia, undertaken for the evaluation of United Nations Population Fund (UNFPA) support to the human immunodeficiency virus (HIV) response 2016-2019. It is one of three field country case studies carried out during the evaluation (Georgia, Indonesia and Namibia). These case studies are complemented by desk-based country case studies for Turkey and Zambia, and desk-based regional case studies for Eastern and Southern Africa (ESA) and Eastern Europe and Central Asia (EECA) regions.

1.1 Evaluation of UNFPA support to the HIV response (2016-2019)

The purpose of the evaluation is to assess the performance of UNFPA in integrating its approach to HIV within the broader context of sexual and reproductive health and rights (SRHR), population dynamics, gender equality and human rights. As part of this assessment, the evaluation will pay particular attention to the contribution of UNFPA to:

- The prevention of the sexual transmission of HIV
- The linking of HIV with other aspects of SRHR
- The promotion of gender equality and human rights in the context of HIV

The **objective of this evaluation** is two-fold:

1. To **assess** how the framework set out in UNFPA Strategic Plans, 2014-2017 and 2018-2021 and in the United Nations Joint Programme on HIV and AIDS (UNAIDS) Unified Budget Results and Accountability Framework (UBRAF) 2016-2021 and further specified in thematic strategies and programmes (for example, UNFPA strategies for Adolescents and Youth and for Family Planning as well as for the UNFPA Supplies Programme) has guided the programming and implementation of UNFPA interventions in relation to HIV.
2. To **facilitate learning** and to derive good practices from UNFPA experience in supporting efforts to address HIV across a range of key programmatic interventions in the three above-mentioned overlapping and mutually reinforcing thematic areas and in differing regional and national contexts.

1.1.1 Evaluation questions

The evaluation examines six major evaluation questions.

Table 1: Evaluation questions by area of investigation

Evaluation criteria, areas of investigation and evaluation questions
<p>Area of Investigation 1: UNFPA support to linking SRHR, HIV and SGBV, including integrated SRHR, HIV and SGBV service delivery</p>
<p>Evaluation Question: To what extent has UNFPA contributed to establishing and strengthening bi-directional linkages (policies, systems, communities and services) between SRHR, HIV and SGBV and to integrating SRHR, HIV and SGBV service delivery? (Relevance, Effectiveness, Sustainability)</p>
<p>Area of Investigation 2: UNFPA support to the HIV response corresponds to the needs of the at-risk and the most vulnerable, the marginalized and key populations (KPs)</p>
<p>Evaluation Question: To what extent has UNFPA support to HIV strategies and programmes contributed to meeting the needs of the at-risk, most vulnerable and marginalized people, especially (but not exclusively) adolescents and youth, key populations, women and persons with disabilities? (Relevance, Effectiveness, Gender Equality)</p>
<p>Area of Investigation 3: UNFPA support to the promotion of human rights and gender equality in the context of HIV</p>
<p>Evaluation Question: To what extent has UNFPA support contributed to engage and empower communities (including, but not only, adolescents and youth, key populations and women) to understand and claim their rights while also effectively advocating for policies and laws affecting human rights, gender equality and access to SRHR, HIV and SGBV services? (Relevance, Effectiveness, Gender Equality)</p>
<p>Area of Investigation 4: UNFPA efforts to act as a broker to forge partnerships and facilitate meaningful participation of a broad spectrum of partners in the HIV response</p>
<p>Evaluation Question: To what extent has UNFPA been effective at global, regional and country levels in forging and/or supporting networks, coalitions and partnerships to ensure meaningful participation of governments, civil society (especially adolescents and youth and key populations) and the private sector in dialogue and action on HIV prevention – including programme design, planning and implementation? (Effectiveness, Gender Equality, Sustainability)</p>
<p>Area of Investigation 5: UNFPA efforts to optimize its comparative advantage within UNAIDS Division of Labour</p>
<p>Evaluation Question: To what extent has UNFPA been able to ensure its comparative advantages at global, regional and national levels are recognized within its roles and responsibilities under the UNAIDS Division of Labour? (Effectiveness, Coordination, Efficiency, Sustainability)</p>
<p>Area of investigation 6: UNFPA efforts to support coordination of actions and resources to strengthen national leadership</p>
<p>Evaluation Question: To what extent has UNFPA effectively supported and participated in platforms for coordinating and sustaining resources and programmes aimed at preventing HIV, especially at national level? (Efficiency, Coordination, Sustainability)</p>

1.1.2 Region and country case studies

A key feature of the evaluation is the completion of a series of field and desk-based regional and country case studies.

Table 2: Case studies

Desk regional case studies	Field country case studies	Desk country case studies
Eastern and Southern Africa (ESA)	Namibia	Zambia
Eastern Europe and Central Asia (EECA)	Georgia	Turkey
	Indonesia	

The evaluation team also conducted visits to UNFPA regional offices for ESA and EECA in support of the regional desk studies.

1.2 Objectives of the field country case studies

The country case studies aim to provide insights into the evaluation questions and a comprehensive nuanced picture of programme actions and their results. They allow the evaluation to explore the evaluation questions in greater depth than would be possible in desk studies. The country case studies are not individual programme evaluations at the country level. Their objectives are to:

- Provide input for answering the evaluation questions and causal assumptions
- Triangulate data collected from other sources and respondents with qualitative and quantitative information collected in-country
- Identify lessons learned.

1.3 Approach and methodology

Each field country case study uses a theory-based evaluation approach based on the theory of change and causal assumptions developed for UNFPA activities related to the HIV response. The reconstruction of the theory of change is described in detail in Annex A. The causal assumptions form the basis of the Evaluation Matrix (Annex B) and allow for each evaluation question, to determine the contribution of UNFPA to the HIV-related outcomes in the theory of change.

The data collection methods used in each field country case study are:

- Identification and review of core documents at country level, including country programme documents and annual work plans, monitoring and evaluation frameworks, programme review and evaluation documents, monitoring and progress reports, national plans and programmes, minutes of coordination meetings and documents produced by other bilateral and multilateral agencies supporting the HIV response
- Review of financial data regarding programme investments
- Key informant interviews with a wide range of stakeholders at the national level (Annex C)
- Visits to programme and service delivery sites, including interviews with service providers, social workers, counsellors
- Interviews and group discussions with individuals accessing sexual and reproductive health (SRH) and/or HIV services supported by UNFPA
- Debriefing workshops with key informants at the national level to present preliminary findings and receive feedback on any gaps in the data used or factual errors or misrepresentation.

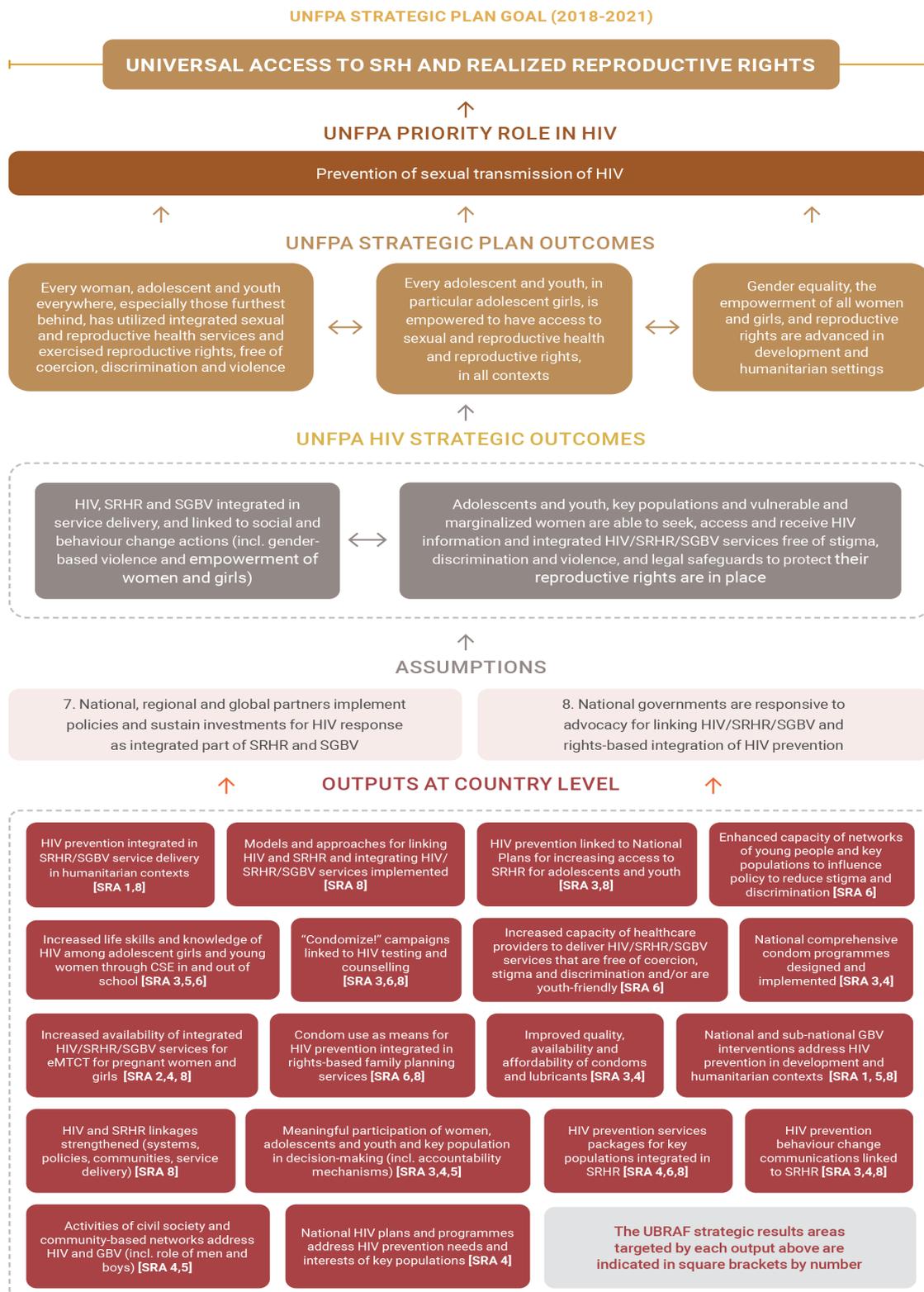
1.4 Overall theory of change

This section presents the **overall** theory of change for UNFPA support to the HIV response as developed during the inception phase, updated during data collection, and refined during the analysis and reporting stages of the evaluation. The theory of change presented here attempts to

captures **all** of the different ways in which UNFPA currently supports the response to HIV, in **vastly differing contexts** and at **different levels** (global, regional and national). **In this sense, nowhere has the evaluation team seen this theory of change implemented in its entirety.**

In fact, the theory of change encompasses a wide range of activities and a multi-layered chain of results, which are difficult to effectively implement and sustain given the current staffing and financial resources available to UNFPA for the HIV response.

Figure 1: Overall theory of change

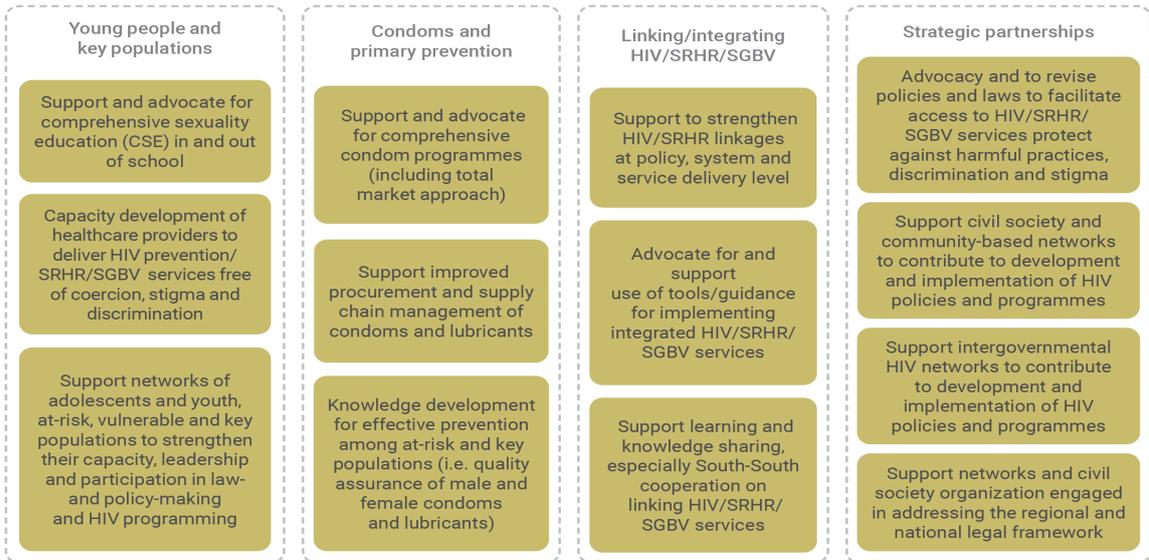


ASSUMPTIONS

- 1. National leadership supported by HIV partners (especially UNFPA)
- 2. UNFPA support addresses national HIV priorities
- 3. Effective coordination of external support by JUNTA
- 4. UNFPA support builds on comparative advantage in each region and country
- 5. UNFPA support is matched by technical and financial capacity
- 6. Focused UNFPA support applicable to the nature of the epidemic



UNFPA ACTIVITIES AND INVESTMENTS



PROBLEM

Almost four decades into the epidemic, and despite substantial progress, the number of people newly HIV-infected remains high. The nature of the epidemic has also been evolving with more than half of all new HIV infections (in 2018) occurring among key populations – sex workers, people who use drugs, gay men and other men who have sex with men, transgender people and prisoners – and their partners, while, in some regions, girls and young women continue to face disproportionate HIV risks. Structural factors contributing to HIV vulnerability include gender inequalities and violence, limited livelihood options, stigma and discrimination, gaps in knowledge of HIV status and lack of access to adequate health facilities.

External factors: Political developments – increasing discrimination – international HIV and SRHR financing trends – conservative attitudes towards key populations

Guiding principles: Human rights and gender equality – meaningful participation of affected populations – focus on groups left behind, most at-risk and most vulnerable – actions tailored to context – evidence-informed approach

1.5 Carrying out the Indonesia field country case study

1.5.1 Data collection activities

The Indonesia country case study mission was carried out from 15-26 July 2019 by a team composed of the evaluation manager from UNFPA Evaluation Office, one international consultant and one national consultant. The case study mission was preceded by a review of relevant documents provided by the Indonesia Country Office (CO). These documents were supplemented by documents gathered during the mission from key informants. For a list of documents referred to in the case study, see Annex D.

The evaluation team carried out extensive interviews with key stakeholders for UNFPA activities related to SRHR and HIV, notably:

- The UNFPA Indonesia CO, including the Country Representative and members of the HIV, gender, family planning and adolescent teams
- Senior managers at the Ministry of Health (MoH)
- Staff and volunteers of civil society organizations (CSO) and UNFPA implementing partners, including representatives of key populations (KPs)
- Staff of development partners supporting the HIV response (World Health Organisation (WHO), United Nations Children’s Fund (UNICEF), United Nations Development Programme (UNDP), UNAIDS, Country Coordinating Mechanism (CCM) of the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund))
- Interviews with public and private sector health service providers
- Interviews with individuals belonging to key affected populations.

1.5.2 Limitations

The evaluation team did not travel outside of Jakarta due to budget and time constraints. While this is reasonable for a country with a relatively small programme portfolio (apart from its work on the Global Fund-financed programme focusing on female sex workers (FSW)), it limits our understanding of the distal results at the outcome level, especially in a country of this size and diversity.

Nevertheless, the team was able to access almost all the key informants identified and these limitations do not undermine the validity of the findings reported in Chapter 3.

2 COUNTRY CONTEXT AND PROGRAMME RESPONSE

2.1 Overview of the HIV epidemic

An overview of the HIV epidemic in the Asia-Pacific Region is provided opposite.

Indonesia's overall HIV prevalence rate is low at 0.4 per cent and the number of new infections per year has dropped significantly since 2010 (by roughly one fifth). However, this is the fourth most populous country in the world and has a growing population (201 million in 2003, 255 million in 2015 and predicted to grow to 305 million by 2035).¹ This means that Indonesia is home to a large group of people living with HIV (PLHIV) (630,000 PLHIV in 2018, of which 63 per cent were men aged 15 and over, 35 per cent women aged 15 and over, and 2 per cent children aged 0-14 years²). Roughly, one in every eight PLHIV in the Asia Pacific region lives in Indonesia, and roughly one in every six new infections in the region occurs in Indonesia. Given these scale factors, it has been noted that 'if Indonesia will succeed in ending acquired immunodeficiency syndrome (AIDS) as a public health threat, it will also contribute to the regional and global success'.³

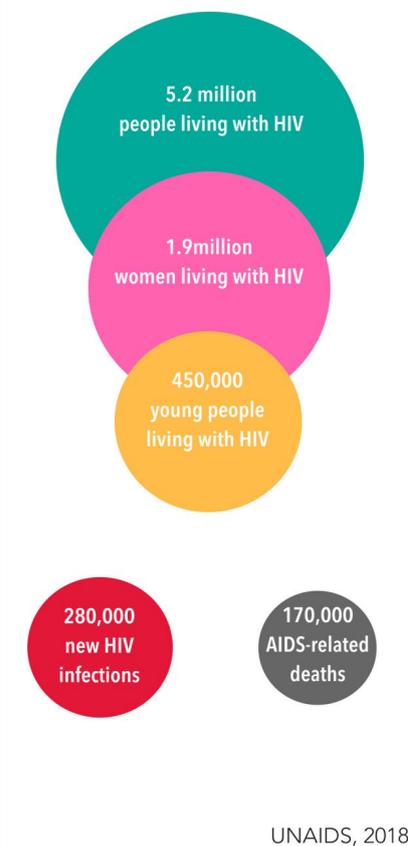
Indonesia is classed as a low-middle income country (the largest economy in South-East Asia). However, the country is culturally, ethnically, religiously and linguistically diverse, and is also very contrasted in terms of socio-economic variables and geography (consisting of more than 17,000 islands). National data on HIV, therefore, tends to mask variations in the epidemic between different groups and locations. Most notably, the provinces of Papua and West Papua are characterised by a low-level generalized epidemic (HIV prevalence was 2.3 per cent in 2013),⁴ while the more common pattern across the country is that of concentrated epidemics among KP groups.

This case study cannot identify and report on all variations and nuances of the epidemic in such a diverse context; generalisation and selective reporting are necessary.

2.1.1 HIV and AIDS data and trends

Most of Indonesia is characterised by concentrated HIV epidemics among KPs. According to UNAIDS 2017, the HIV prevalence rates among KPs are 29 per cent for people who inject drugs, 26 per cent for men who have sex with men (MSM), 25 per cent for transgender people, 5 per cent for sex workers, and 3 per cent for prisoners.⁵ The size of these KP groups varies considerably. For people who inject drugs and transgender people, each group is estimated to comprise under 40,000 people.

Figure 2: Overview of the Asia-Pacific Epidemic



¹ <https://indonesia.unfpa.org/en/node/25335/>

² UNAIDS, *Country Factsheet INDONESIA 2017* <https://www.unaids.org/en/regionscountries/countries/indonesia>; UNAIDS Indonesia Country Snapshot 2018

³ *Indonesia Country Update* provided by UNFPA

⁴ <https://indonesia.unfpa.org/en/topics/hiv-aids-5>

⁵ <https://www.unaids.org/en/regionscountries/countries/indonesia>

FSW are estimated to number just under a quarter of a million, and the MSM group is estimated to represent above three-quarters of a million.⁶

2015 data from serological surveys and Global AIDS Response Progress Reporting,⁷ and other sources add detail to the national picture:

- HIV prevalence among transgender people is 25 per cent nationally, but in Jakarta, it is 34 per cent. A study cited by Avert estimated that the proportion of transgender people who sell sex was above 80 per cent in Indonesia.⁸
- HIV prevalence among people who inject drugs is also much higher in Jakarta than nationally (44 per cent as opposed to 29 per cent). In 2013, the rate in Pontianak, West Kalimantan was in excess of 60 per cent.⁹
- Among MSM, national HIV prevalence is 26 per cent, but the rate is 36 per cent in Denpasar, Bali.
- HIV prevalence among FSW in Surabaya, East Java is three times the national estimate (15 per cent as opposed to 5 per cent). Across the country, condom use with last commercial partner is reported to be in excess of 80 per cent.¹⁰

Back in 2013, J.V.R. Prasada Rao, United Nations Secretary-General’s Special Envoy for AIDS in the Asia-Pacific region, identified Indonesia as ‘a country critical to ending the AIDS epidemic in the region’ and noted that ‘Indonesia was one of 193 United Nations (UN) member states to adopt the Sustainable Development Goals (SDG) and commit to ending the AIDS epidemic as a public health threat by 2030’. His assessment was that ‘This commitment is certainly ambitious but it is achievable’.¹¹

2.1.1.1 Indonesia progress on Fast Track Targets

Between 2010 and 2016, Indonesia saw new HIV infections decrease by over 20 per cent.¹² However, it is highly unlikely that Indonesia will achieve the 90:90:90 targets by 2020 – see table below.¹³

Table 3: Indonesia progress on Fast Track Targets 2015-2018

Year	Per cent of PLHIV who know their status	Per cent of people who know their status who are on Anti-Retroviral Therapy (ART) ¹⁴	Per cent of people on ART who achieve viral suppression
2015	29	36	not available
2016	35	36	not available
2017	42	34	not available
2018	58	33	2

⁶ UNAIDS Indonesia Country Snapshot 2018. <https://www.aidsdatahub.org/country-snapshot-2018-indonesia-unaid-regional-support-team-asia-and-pacific-and-aids-data-hub-2018>

⁷ UNAIDS Indonesia Country Snapshot 2018. <https://www.aidsdatahub.org/country-snapshot-2018-indonesia-unaid-regional-support-team-asia-and-pacific-and-aids-data-hub-2018>

⁸ <https://www.avert.org/professionals/hiv-around-world/asia-pacific/overview>

⁹ UNAIDS Prevention Gap Report 2016.

¹⁰ <https://www.avert.org/professionals/hiv-around-world/asia-pacific/overview>

¹¹ (<https://unaid-ap.org/2015/12/01/indonesia-on-a-fast-track-to-end-the-aids-epidemic-by-2030/>)

¹² <https://www.unaids.org/en/regionscountries/countries/indonesia>

¹³ <http://aphub.unaids.org/> supplemented with 2018 data supplied by UNAIDS Country Director during key informant interview (for the second cascade/target 2018 data reported as 18 per cent PLHIV or 33 per cent PLHIV who know their status; for the third cascade/target, 2018 data reported as 2 per cent people on ART achieved viral suppression).

¹⁴ Anti-retroviral therapy

- **Per cent of PLHIV who know their status.** Indonesia has scaled up HIV testing in recent years and shows a positive record of accomplishment on the first Fast Track indicator. The number of HIV tests rose from 1 million in 2013 to 2.5 million tests in 2017. During the first three months of 2019, 807,488 people were tested for HIV. However, even at this higher level of testing, four in every ten PLHIV are estimated to be unaware of their status. Indonesia is a long way from achieving the first of the 90:90:90 targets.¹⁵
- **Per cent of people who know their status who are on ART.** As with HIV testing, Indonesia has made great strides to scale-up of the provision of ART.
 - In 2016, there were an estimated 620,000 PLHIV, 13 per cent of whom (80,500 people) were accessing ART.¹⁶ By 2017, the Global Fund reported 91,369 people on ART,¹⁷ a 15 per cent increase in a year. By March 2019, the Indonesian MoH reported 111,648 PLHIV on treatment.¹⁸ Despite these gains, the per cent of people who know their status who are on ART has declined since 2015.
 - A study published in *The Lancet* in 2018 found that 16 per cent of MSM and 20 per cent of FSW who started on ART were not retained in care (i.e. attending three-monthly appointments).¹⁹
 - The UNAIDS *Country Snapshot 2018* presents data for 2017 showing that of the estimated 12,000 pregnant women living with HIV, only 1,536 received ART for Prevention of mother-to-child transmission (PMTCT).²⁰ The data for pregnant women on ART suggests the challenges faced even among the general population, on top of which KPs are much more likely to experience stigma and discrimination. One respondent from a community organization suggested this may be in part due to the referral practices of public health centres (the puskesmas – see section 3.2.3 below). It is reported that the puskesmas typically refer pregnant women with HIV to the provincial referral hospital for delivery and ART, which may create significant time, distance and financial costs for the woman.
- **Per cent of people on ART who achieve viral suppression.** The situation is less clear for the third of the fast track target areas. In 2017, the Global Fund reported only 790 people on ART with suppressed viral load²¹ and a study published in 2018 concluded that Indonesia was achieving poor rates of retention and viral suppression, particularly for PLHIV from KPs. The study sample was 831 people newly infected with HIV from KP groups (mostly MSM) in Bali, Bandung, Jakarta, and Yogyakarta. Avert summarise the findings:

“At every step along the treatment cascade people were lost [...] 85 per cent of the participants attended an ART site after diagnosis and 73 per cent of the participants started treatment. Just over half (55 per cent) of the original participants were retained in care (i.e. had two visits to the health centre 90 days apart after ART initiation), while 39 per cent had a viral load test at six months. But those who did

¹⁵ WHO, UNFPA AND UN Women, *Concept Note. Support for Pilot Implementation of Partner Notification in Health Care and Community Setting in Indonesia, 2019 – 2020*.

Ministry of Health Republic Indonesia, *HIV AIDS progress quarterly report*, 2019 Ministry of Health the Republic of Indonesia. (By March 2019, it was estimated that 338,363 or 58.7 per cent of PLHIV knew their status).

¹⁶ <https://www.unaids.org/en/regionscountries/countries/indonesia>

¹⁷ <https://www.theglobalfund.org/en/portfolio/country/?k=d0e17d32-68e3-481a-9ca5-bac4e685c119&loc=IDN>

¹⁸ Ministry of Health Republic Indonesia, *HIV AIDS progress quarterly report*, 2019 Ministry of Health the Republic of Indonesia.

¹⁹ Cairns, Indonesia: tackling HIV in one of the world’s fastest-growing epidemics, AIDS MAP, 2018.

<http://www.aidsmap.com/news/sep-2018/indonesia-tackling-hiv-one-worlds-fastest-growing-epidemics>

²⁰ UNAIDS, *Indonesia Country Snapshot, 2018*, UNAIDS, undated.

²¹ <https://www.theglobalfund.org/en/portfolio/country/?k=d0e17d32-68e3-481a-9ca5-bac4e685c119&loc=IDN>

remain in care and those who did have a viral load test had high rates of viral load suppression. [...] The data revealed that care retention rates were much better in places where participants could get tested and then immediately linked to treatment services, as opposed to locations where only testing was available. The researchers note that this is important evidence for integrating HIV testing and treatment into primary care services – which has been happening slowly²²

Lack of viral load testing is clearly a major barrier to Indonesia securing success on the third Fast Track target. The Lancet study found that of those retained in care, 33 per cent of people injecting drugs, 26 per cent transgender women, 18 per cent of FSW and 14 per cent of MSM failed to receive a viral load test. However, among the people from these KPs that did receive a viral load test, there was a suppression rate of 96 per cent.²³

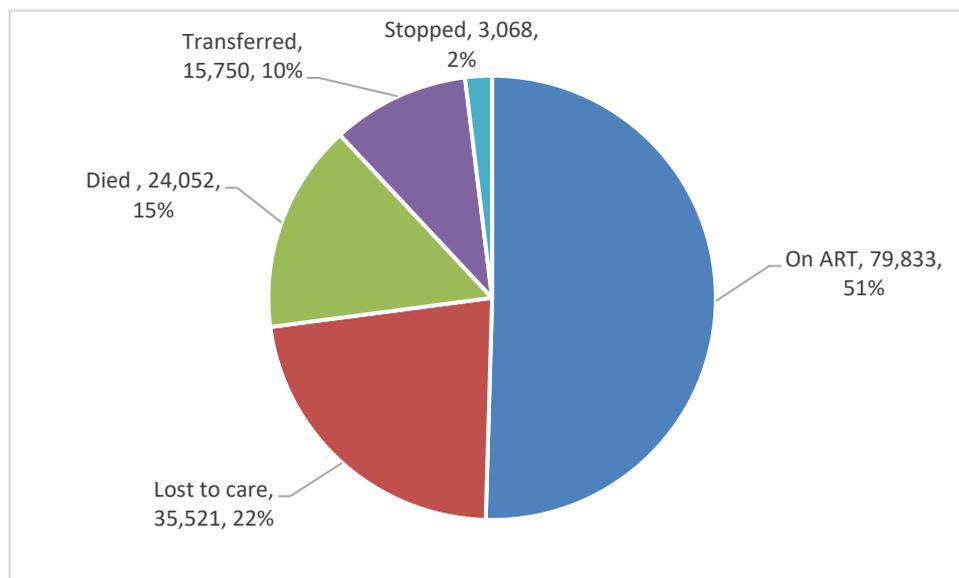
This suggests that PLHIV and especially those from KPs, experience the negative consequences of both stigma and discrimination and lack of access to basic services required for their care through the puskesmas system.

2.1.2 Key challenges and issues

There are several major challenges restricting Indonesia’s successful response to HIV.

By combining substantial domestic resources with finance from the Global Fund and the US Government, Indonesia has scaled up HIV testing. However, for the second and third of the Fast Track targets, the picture is bleak. There are significant numbers of people lost to the system between testing HIV positive and initiating ART, and among those who initiate ART, 24 per cent are lost to care or are known to stop taking their medication, and 15 per cent still die – see the figure below.

Figure 3: Outcomes of people starting on ART, as of March 2017²⁴



PLHIV face considerable stigma and discrimination in Indonesia, as do members of minority and vulnerable population groups such as MSM, transgender people, young people, sex workers, and those injecting drugs, among others. There is a growing moral conservatism in the country. This restricts expression and reinforces silence rather than discussion of key issues such as sex and

²² <https://www.avert.org/news/only-35-key-populations-indonesia-are-effective-hiv-treatment>

²³ Cairns, Indonesia: tackling HIV in one of the world’s fastest-growing epidemics, AIDS MAP, 2018.

<http://www.aidsmap.com/news/sep-2018/indonesia-tackling-hiv-one-worlds-fastest-growing-epidemics>

²⁴ Global Prevention Coalition, *Joint HIV Prevention Assessment Indonesia*, presentation, Jakarta, 29 September 2017.

sexuality, gender roles and gender inequality, diversity, the full range of HIV prevention measures, care and support needed by PLHIV and those affected by HIV in their families and communities and human rights more generally. It also contributes to fear of reporting rights violations, such as violence against FSW or transgender people, and gender-based violence (GBV).

Pervasive and severe GBV constitutes a major challenge to Indonesia's development, HIV response, and achievement of rights for all. Forty-nine per cent of girls under 11 years old have undergone female genital mutilation (FGM), with even higher rates reported in rural areas.²⁵ It is reported that '1 in 3 (33.4%) women aged 15-64 years old have ever experienced physical and/or sexual violence perpetrated by their partner or non-partner in her lifetime. Around 9.4% women have experienced it in the last 12 months.'²⁶ Roughly, one in every nine girls are married before they reach 18 years.²⁷ This situation creates and reinforces vulnerability of girls and women, making them more susceptible to HIV infection and restricting the ability of women living with HIV to exercise their rights.

Another challenge is that Indonesia has pursued a rather specific emphasis for HIV prevention, best described as 'test and treat' or 'test and start'. The country has given much less priority to the wider package of measures required for a comprehensive HIV prevention strategy, for greater success against the Fast Track targets, and for creating an effective multi-sectoral response to HIV. While a more integrated approach is stated in policy, ground-level service delivery exhibits little emphasis on integration between HIV services and general SRH services, including family planning and maternal health services. Condom supply for HIV prevention (as opposed to family planning for married couples) is not guaranteed across the country, and access to free condoms for KPs and young people is, in practice, severely limited. Indeed, one of only three recommendations to emerge from the resource requirements analysis conducted by Health Policy Plus and the Sub-Directorate for HIV and AIDS and STI (sexually transmitted infections) of the MoH was: '*Develop a comprehensive strategy for domestic financing of HIV prevention services and commodities, including a national condom strategy that considers how HIV can leverage existing government and private sector condom procurement processes and distribution channels for reproductive health.*'²⁸

In 2017, the country's National AIDS Commission (NAC) was dissolved by Presidential decree as part of a wider process to streamline bureaucratic structures. This is discussed further in the section below, and many other places in this report. When the NAC was dissolved in 2017, the MoH ceased its responsibility as the secretariat of NAC; functions were held by the Coordinating Ministry of Human Development and Culture. Details for the coordination and leadership functions that NAC used to perform have not yet been delineated or operationalised by the Coordinating Ministry of Human Development and Culture. Civil society groups report that MoH has been harder to interact with and has provided less clear leadership, than the NAC.

An effective multisectoral response necessarily includes a vibrant, active and empowered civil society. However, one commentator summarises the general socio-political situation thus: "social and political space to promote a principled politics based on universal values is narrowing".²⁹ Specific to the health sector and HIV response, "The changing legal and political environment in Indonesia is affecting health care workers and KPs alike, causing nervousness about providing health services to, and being members of, KPs".³⁰ Now that general elections have taken place (April 2019),

²⁵ UNFPA, *Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020 Annual Report 2018*, Jakarta: UNFPA, undated. p.4

²⁶ 2016 Indonesian National Women's Life Experience Survey, *Study on Violence Against Women and Girls Key Findings*, (UNFPA logo on second page; undated). p.1

²⁷ UNFPA, *Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020 Annual Report 2018*, Jakarta: UNFPA, undated. p.4

²⁸ Health Policy Plus and Sub-Directorate for HIV/AIDS and STI of the Ministry of Health, Indonesia, *Updated Resource Requirements for Sustainable Financing of the HIV Response in Indonesia*, HP+ Policy Brief June 2018. p.4

²⁹ <https://peacepolicy.nd.edu/2019/03/20/indonesian-civil-society-struggling-to-survive/>

³⁰ APMG Health (2018) *Assessment of HIV Services Packages for Key Populations in Indonesia*. p. 5

it is important that vital 'space' becomes wider again, to engage the community- and faith-based groups essential to secure improvements in HIV prevention, treatment, care and support. However, at the time of the evaluation, there were amendments to the country's penal code being proposed which would greatly restrict condom promotion activities - i.e. amendment that states

"...any person without rights and without being asked expressly displays a tool to prevent pregnancy ... can be convicted' - and restrict the ability of peer educators and civil society organizations – i.e. '..only authorized personnel can demonstrate the prevention of pregnancy in the context of implementing family planning, prevention of communicable diseases, the importance of education and health education".

A final major challenge is the political and administrative system. The country has pursued a major policy of decentralisation. This may have many positive results for local democracy and caters to the diversity of needs experienced in the multiplicity of locations and cultures across the country. However, it also poses practical challenges in terms of transferring clear strategy, policy and service design from the national level to the local implementation level, and in terms of monitoring and quality assurance etc.

2.1.3 Policy and health system response

In Indonesia, the MoH is responsible for overall oversight and regulation of health services. These services are provided by the private, public and civil society sectors. For those able to pay or who have private health insurance, there is a thriving private sector, especially in the larger towns and cities.

The public healthcare system is based around the puskesmas. These are multi-functional government-funded community health centres aiming to provide healthcare from 'cradle to grave' at the sub-district level. When required, cases are referred to the district hospital (primary referral unit) or provincial hospital (i.e. advanced referral units and other special health facilities).

In 2014, the government began implementing the Jaminan Kesehatan Nasional (JKN) scheme to secure universal health care across the country. This is a form of health insurance – i.e. people in employment and their employers pay contributions – that allows Indonesians to access health services from both public and private sector suppliers. By February 2019, an estimated 217.5 million citizens (around 81 per cent of the population) were enrolled and it is predicted that the entire population will be covered by the end of 2019.³¹

While the JKN has brought aspects of universal coverage to the Indonesian population, the continuum of care for PLHIV exposes the gaps or blockages that remain in the system. For example, while those on ART can receive their treatment free of charge, they are required to pay for the viral load and other tests required for the ongoing monitoring of their care and treatment. A recent report stated that there are still 5 per cent of PLHIV who do not want to access JKN services because there are still clinics that provide free service, or due to the complexity of procedures, or because they do not understand how to access JKN services.³²

The policy framework of the Indonesia national HIV response is in a state of flux.

In 2015, the HIV and STI National Action Plan for the Health Sector (NAP)³³ was prepared by referring to the 2015-2019 National Mid-Term Development Plan (RPJMN) and the 2015-2019 MoH Strategic Plan where the issue of HIV and AIDS is part of the disease control and environmental health

³¹ https://en.wikipedia.org/wiki/Healthcare_in_Indonesia. UNAIDS, ILO and IAC, *Social Protection Research for PLHIV: Utilization of JKN services among PLHIV and affected populations*, 2019

³² UNAIDS, ILO and IAC, *Social Protection Research for PLHIV: Utilization of JKN services among PLHIV and affected populations*, 2019

³³ Ministry of Health Republic Indonesia, *The HIV and STIs National Action Plan for the Health Sector 2015-2019*, Ministry of Health The Republic of Indonesia. pp.11, 39, 47.

strategy. This HIV and STI NAP is intended as a key reference document for government, private sector, working partners and the community when developing HIV strategies and during HIV-related implementation. It delineates activities in line with the NAP on health and other non-health sectors (for example the National Strategy and Action Plan for HIV and AIDS Response, NAP Maternal and Child Health, NAP Tuberculosis (TB), Malaria NAP, NAP Reproductive Health, and action plans in other sectors) to achieve the goal of reducing new HIV infections with a particular approach to KPs, special populations and community groups that are vulnerable to HIV and AIDS and STIs. Two main HIV control strategies are delineated: increase coverage of HIV and AIDS and STI services through the continuum of care and strengthen the national health system in the implementation of a continuum of care for HIV and AIDS and STIs. In health services, STI management is part of the Integrated Reproductive Health Services, the scope of which is maternal and child health, family planning, adolescent reproductive health, management of STIs and HIV and elderly reproductive health.

During the evaluation process, the HIV and STIs NAP for the Health Sector was not mentioned by key informants. In contrast, the unclear status of the *Draft National Strategy and Action Plan 2015-2019 HIV and AIDS Response in Indonesia* (NSAP 2015-19) was mentioned.

The NAC produced the NSAP 2015-19, the country's third national strategy on HIV, in 2015. NSAP 2015-19 was aligned to Indonesia's national development plan (the RPJMN 2015-2019) and was produced "within a sustainable development framework in an effort to maintain the momentum of the HIV and AIDS response, which is currently transitioning towards self-financing and the integration of the programme into governmental and community systems".³⁴

The NSAP 2015-19 was driven by a vision "to end the epidemic in Indonesia as a public health threat by the year 2030" and the ambitious goal "to accelerate the achievement of ... zero new infections, zero AIDS-related deaths, and zero stigma and discrimination". It promised

"To ensure universal access to prevention and treatment services and to mitigate the impact of HIV and AIDS; focus on KPs (including young KPs and migrant workers) in geographical areas where the risk is highest; strengthen and maintain cost-effective and high-quality integrated services; create an enabling environment that is free of stigma and discrimination, gender-sensitive and rights-based; and apply the principles of good governance, transparency and accountability".

The strategy identified the importance of linkages and integration to "broaden the coverage of HIV-related promotion, prevention and treatment services", ensure integration of TB and HIV services and integration of PMTCT into antenatal care (ANC) services, and secure a continuum of care for PLHIV.³⁵

However, there is disagreement and/or misunderstanding about the status of the NSAP 2015-19 since it was not formally adopted before the NAC was dissolved in 2017 (as a result of Presidential Regulation No. 124 of 2016). For certain stakeholders, it stands as the country's current national strategy, others say it has been ignored since the dissolution of the NAC.

There is a similar level of uncertainty over the status of the *Pencegahan Melalui Transmisi Seksual* which is also referred to as 'PMTS Paripurna'.³⁶ *Pencegahan Melalui Transmisi Seksual* translates as 'Comprehensive Programme for the Prevention of Sexual Transmission of HIV'. Developed by the NAC in 2014, PMTS Paripurna had four main components: increased positive role of stakeholders, behaviour change communication, condoms and lubricant supply management and management of

³⁴ National AIDS Commission, *Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia*, National AIDS Commission, 2015. P. 1

³⁵ National AIDS Commission, *Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia*, National AIDS Commission, 2015. P. 15, 25

³⁶ Komisi Penanggulangan AIDS, *PMTS Paripurna (Comprehensive HIV Prevention Through Sexual Transmission Guidelines) Partnership between Government, Private Sector, Communities and Media*, Komisi Penanggulangan AIDS, 2014.

STIs and HIV. This programme promised much, but after NAC was dissolved it has not been fully implemented.

In 2019, the MoH had developed a draft specific health sector plan on HIV, but this was not publicly available during the evaluation.

At the time of the UNFPA HIV evaluation in July 2019, the country’s main coordinating platform/ structure for support to the HIV (and TB and malaria) response was the CCM formed under the auspices of the Global Fund grant project.

The HIV Technical Working Group (TWG-HIV) was formed under the auspices of the Global Fund-financed project. It consists of CCM members and non-CCM members. TWG-HIV has a more technical role to develop an annual workplan; lead, assist and monitor the Global Fund-financed project proposal development; determine proposal content and foci; propose new principle recipients (PRs); budget allocations among PRs; and monitoring of PRs’ performance.

Table 4: Indonesia CCM and TWG-HIV composition³⁷

Indonesia CCM	HIV Technical Working Group (TWG-HIV)
<p>The Indonesian CCM has 54 members and alternates representing the following sectors:</p> <ol style="list-style-type: none"> 1. Government 2. Development Partners 3. Civil Society representing five sub-sectors: <ol style="list-style-type: none"> a. Local Non-governmental organization (NGO) community b. Local faith-based organizations c. Academia or professional associations d. Private sector e. People living with or affected by AIDS, TB and malaria. <p>Members and alternates are engaged in CCM Indonesia not as an individual or from their individual organization but as the representatives of their constituency and they are entitled to report back to their constituency about the Global Fund and CCM.</p>	<p>CCM Indonesia maintains four Technical Working Groups (TWGs) for HIV and AIDS, TB, malaria and health systems strengthening. Each TWG consists of two sub-groups: a 9-member “core” voting group, and an adjunct group of up to 16 additional members, for a maximum total of 25.</p> <p>The TWG-HIV has full voting rights and is empowered to make formal recommendations pertaining to national HIV programme interventions to the CCM and the Oversight Committee. Adjunct TWG members are expected to participate in and contribute to discussions, but do not have the authority to vote on final recommendations made by the core TWG.</p>

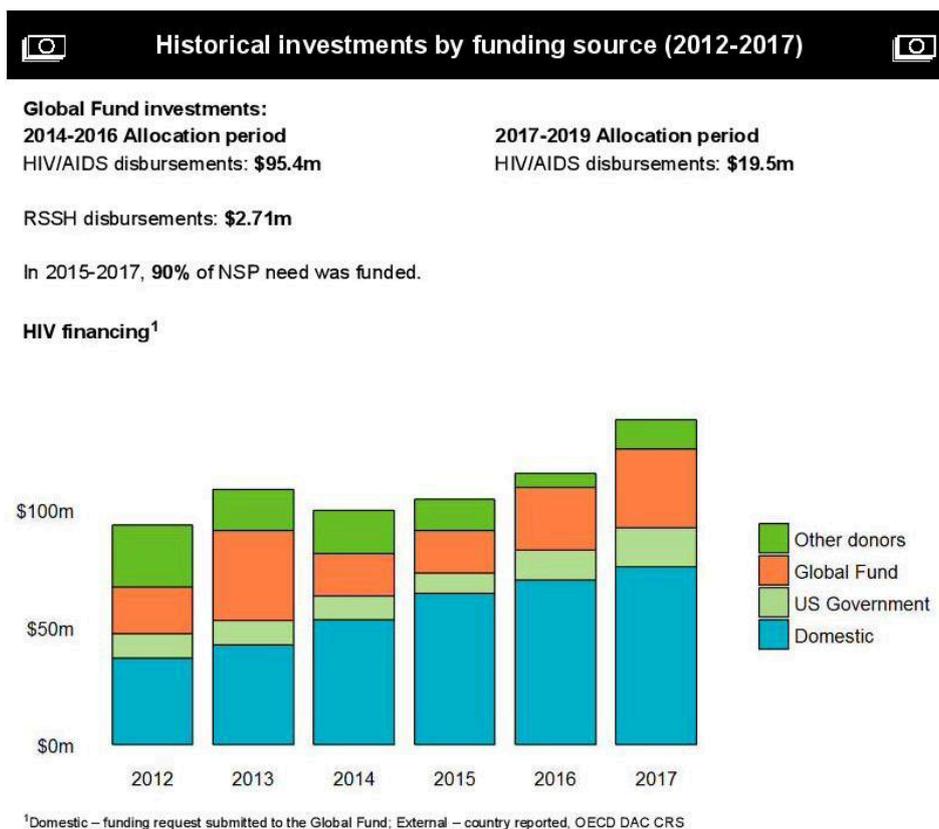
2.1.4 Financing

The figure below, reproduced from the Global Fund, shows the breakdown of historical and planned investments in Indonesia’s HIV response covering the period 2012 to 2020.³⁸

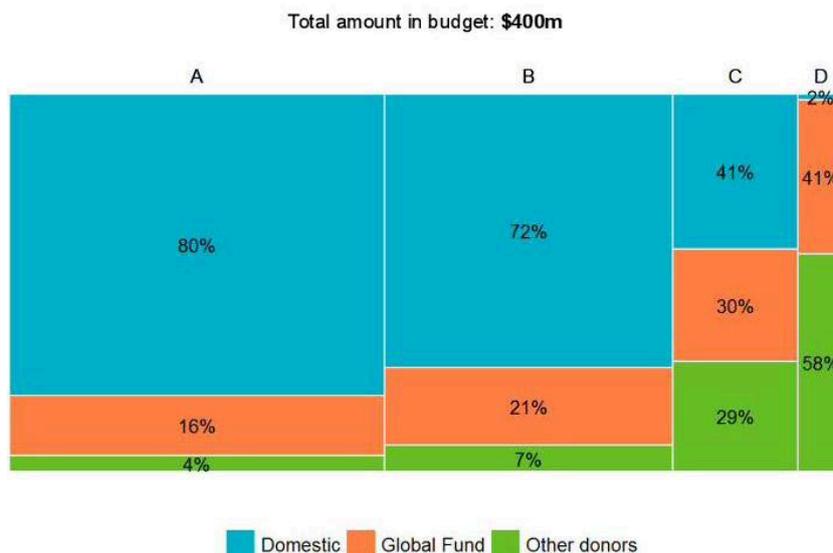
³⁷ Reproduced verbatim from: UNFPA, *Outreach Implementation Manual for Female Sex Workers Programme in Indonesia. Final Version*. UNFPA (undated). p. 10

³⁸ Global Fund Indonesia Country Results Profile for HIV. https://www.theglobalfund.org/media/7972/idn-h_result_profile_en.pdf. Note the acronym ‘RSSH’ stands for ‘resilient and sustainable systems for health’. See also Indonesia data on <https://aidsinfo.unaids.org/>

Figure 4: Historical investments by funding source (2012-2017) and planned investments by funding source and intervention (2018-2020)



Planned investments by funding source and intervention²



Label	Program Area	Total budget
A	Treatment, care and support - ART	\$175m
B	Prevention programs	\$134m
C	Program Management	\$58m
D	RSSH	\$22m
Not in graph	Human rights programs	\$4m
Not in graph	Other	\$3m
Not in graph	PMTCT	\$2m
Not in graph	TB/HIV	\$2m

²Detailed financial gap analysis reported by country based on Global Fund Modules

Total funding for the HIV response has increased steadily over time, as has the proportion of total funding from domestic sources. These are positive indications. Since 2015, domestic sources provide the largest financial contribution, followed by the Global Fund and the US Government. Investments from other donors represent a small but important proportion of the total, as illustrated by the second part of the figure. ‘Test and treat’ (or ‘test and start’) interventions dominate expenditure on the HIV response (see columns A and B in the second part of the figure) and domestic sources are predicted to meet in excess of 75 per cent of related costs. Other essential interventions, ranging from programme management to PMTCT and TB/HIV programmes, human rights initiatives and work to strengthen and improve the sustainability of health systems are primarily supported by non-domestic resource providers.

The increased domestic allocation to HIV is important and welcome. However, without substantial additional resources, it appears increasingly unlikely that Indonesia will meet its Fast Track targets. More problematically, as pointed out in the Policy Brief prepared by Health Policy Plus and Sub-Directorate for HIV and AIDS and STI of the MoH in 2018, “While the majority (57 per cent) of Indonesia’s HIV response has been financed by domestic sources, many activities for HIV prevention and KPs remain entirely funded by external sources. Further, Indonesia pays some of the highest prices for HIV commodities in its peer group of lower-middle-income countries in Asia, particularly for anti-retroviral drugs (ARV) and viral load testing reagents. This is a fact that the country is attempting to address through revised procurement processes and price negotiations with suppliers.”³⁹ The study also found that:

“total financing needs for HIV service delivery will more than double between 2018 and 2023, increasing from IDR 4.2 trillion to IDR 11.6 trillion (USD 300 million to USD 830 million). HIV testing will be the highest cost intervention across all years due to the large number of individuals targeted for testing under the current testing strategy (which includes testing all pregnant women for HIV by 2023). Only a minority of the testing volume is based on active case-finding. HIV testing costs could be reduced in the future if Indonesia scales-up more efficient testing strategies, such as index testing, or new service delivery models for KP outreach and testing that improve testing yields.”⁴⁰

“Given the projected increase in costs required to meet Indonesia’s ambitious HIV goals, the government of Indonesia will need to increase domestic funding for HIV through central and local government allocations, and, possibly, through additional integration of HIV into the JKN benefits package”.⁴¹

2.2 UNFPA HIV activities in Indonesia

2.2.1 UNFPA Indonesia strategy and activities

UNFPA started working in Indonesia in the early 1970s and over time, it has come to focus on SRH, HIV, youth, gender and population issues.⁴² Since 2015, their work has been guided by the 2016-2020 Ninth Country Programme (CP9) which delineates an expected role in the provision of

³⁹ Health Policy Plus and Sub-Directorate for HIV/AIDS and STI of the Ministry of Health, Indonesia, Updated Resource Requirements for Sustainable Financing of the HIV Response in Indonesia, HP+ Policy Brief June 2018. pp. 1-2.

⁴⁰ Health Policy Plus and Sub-Directorate for HIV/AIDS and STI of the Ministry of Health, Indonesia, Updated Resource Requirements for Sustainable Financing of the HIV Response in Indonesia, HP+ Policy Brief June 2018. pp. 3.

⁴¹ Health Policy Plus and Sub-Directorate for HIV/AIDS and STI of the Ministry of Health, Indonesia, Updated Resource Requirements for Sustainable Financing of the HIV Response in Indonesia, HP+ Policy Brief June 2018. pp. 4.

⁴² <https://indonesia.unfpa.org/en/node/25335/>

advocacy, policy advice, and knowledge management in four strategic outcome areas and five outputs:

- **Integrated SRH.** Outcome 1: Increased availability and use of integrated SRH services, including family planning, maternal health and HIV that are gender-responsive and meet human rights standards for quality of care and equity in access.
 - CP Output 1: Improved policies and programmes to address barriers to ensuring rights-based maternal health and HIV- SRH linkages, including in humanitarian settings
 - CP Output 2: Strengthened rights-based, equitable and quality family planning policies and programmes, utilizing regional and international partnerships, including south-south cooperation
- **Youth and adolescents.** Outcome 2: Increased priority on adolescents, especially on very young adolescent girls in national development policies and programmes, particularly increased availability of comprehensive sexuality education (CSE) and SRH services.
 - CP Output 3: Improved policies and programmes to fulfil the rights and needs of adolescents and youth, including in humanitarian settings
- **Gender equality and women's empowerment.** Outcome 3: Advanced gender equality women's and girls' empowerment and reproductive rights including for the most vulnerable and marginalized women adolescents and youth.
 - CP Output 4: Improved policies and programmes to address barriers in the prevention and responses to GBV and harmful practices, including in humanitarian settings
- **Population dynamics.** Outcome 4: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, SRHR, HIV and gender equality.
 - CP Output 5: Increased availability of quality population data and analysis on population dynamics and its linkages with national policies and programmes related to SRH, gender equality, humanitarian response and sustainable development.

To implement the CP9, there is a *Country Programme Action Plan (CPAP) 2016-2020* (signed in early 2016). This specifies outputs, strategies, and the roles and responsibilities of both the Government and UNFPA to implement the CP9. This CPAP was also aligned with the United Nations Partnership for Development Framework 2016-2020 and the Government of Indonesia's RPJMN 2015-2019.

The UNFPA business model designates Indonesia a 'yellow' country according to the colour quadrant scheme based on indices of need and ability to pay. This colour designation directs the Indonesia country programme to focus on capacity building (focus is on an enabling environment and on institutional levels, not individual level); partnerships and coordination, including south-south and triangular cooperation; knowledge management; and advocacy, policy dialogue and advice. In yellow quadrant countries, service delivery is a strategy 'not deployed'.⁴³

During the period covered by this evaluation, UNFPA Indonesia's HIV work has concentrated on an implementation role in the country's Global Fund-financed programme of work. This role has been the primary focus of the UNFPA Indonesia HIV team and the budget attached to the role has dominated the CO's budget (see section 2.2.2 below).

Starting in April 2016 at the request of the MoH, UNFPA took over the implementation of the FSW programme funded through the Global Fund – New Funding Model (NFM) programme for 2016 – 2017 (and subsequently the New Funding Model Continue or NFMc 2018 – 2020). This FSW programme had previously been managed by the NAC as the PR, with UNFPA fulfilling a purely

⁴³ UNFPA, *Strategic Plan 2018-2021*, New York: UNFPA. 2018.

technical support role. However, when the Government made MoH the new PR, UNFPA was asked to take a role as sub-recipient (SR) responsible for both the technical support and programme management roles for the FSW programme. As per the letter from CCM dated 23 May 2017 and the Memorandum of Understanding between MoH and UNFPA signed 29 January 2018, the role of UNFPA is Technical Assistant for FSW implementation programme and technical assistance to Indonesia AIDS Coalition (IAC), which focused on supporting initiatives related to

- FSW programme
- Procurement of condoms and syringes
- Activities of “*Building Resilient and Sustainable System of Health*” modules, such as community system strengthening, removing legal barriers, advocacy, etc.
- Activities to remove human rights barriers to access for HIV-related services.

The core team for the FSW programme consists of the MoH (officially the PR), UNFPA (as SR and focal point), Organisasi Perubahan Sosial Indonesia (OPSI, the sex workers network organization, as technical advisor) and IAC. The intention has been that IAC is in the core team as ‘PR in waiting’, i.e. to take on overall responsibility for the programme once organizational capacity has been built.⁴⁴

The role of UNFPA in the FSW programme involves sub-granting to four civil society organizations (CSOs) (PKBI DKI Jakarta, Yayasan Kalandara, Yayasan Kerti Praja, and PKBI Papua) as well as supporting and collaborating with OPSI to help them fulfil their technical advisor role.

To fulfil its brief as SR, UNFPA has overseen the development of standard operating procedures for outreach to sex workers (see Annex E) and strives to secure the achievement of the following outputs:

- 1) Technical capacity delivered across the SRs and Implementation Units (IUs) for the implementation of the Sex Workers Strategy and new outreach model – national Level, provincial and district level
- 2) Technical assistance/mentoring delivered to the SRs in the development of the testing and mentoring model and HIV – SRH linkages for IUs, Peer Leaders (PLs) and Peer Educators (PEs)
- 3) Support provided to the high functioning IUs (districts) and establish them as learning sites to foster scale-up.⁴⁵

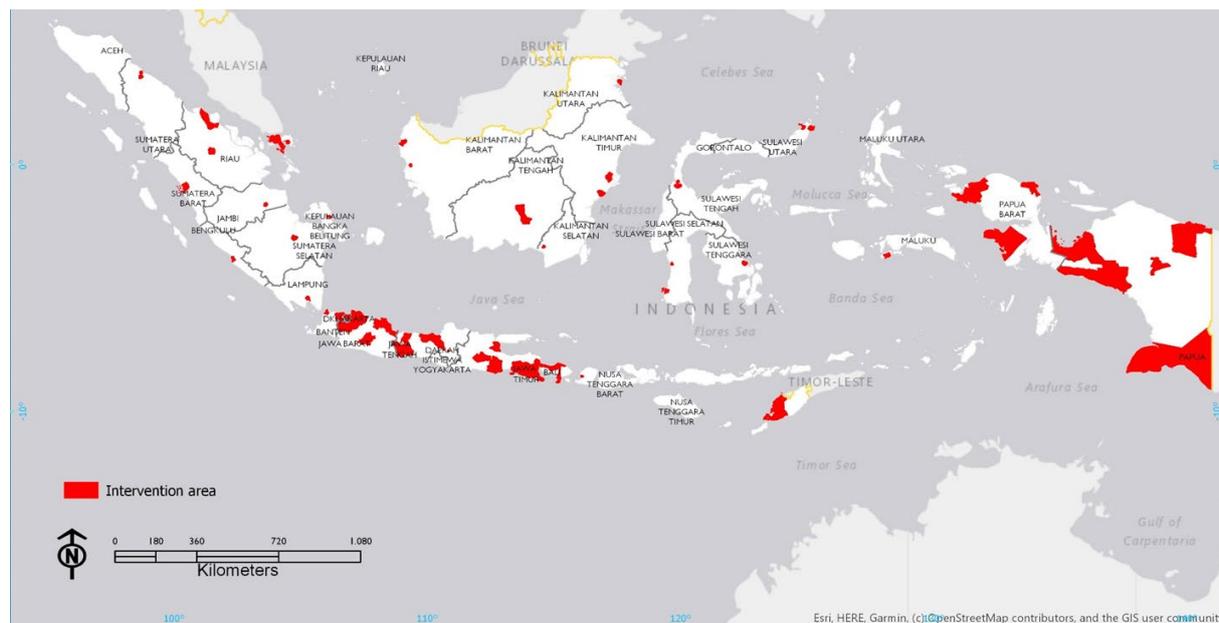
To illustrate the scale of the programme, in 2018 UNFPA reported “Together with MoH, the HIV Prevention programme implemented in 88 districts/municipalities across 30 provinces in Indonesia through the peer-to-peer outreach model for key-affected populations (FSW), reaching 82,702 FSW and resulting in 34,009 FSW who have been tested. These results yielded 1,241 FSW HIV case findings, 490 FSW accessed ARV treatment.”⁴⁶

⁴⁴ UNFPA has provided technical assistance, particularly on financial and grant management to Indonesia AIDS Coalition to become a new PR of Global Fund grant project. In addition, UNFPA is also preparing Indonesia AIDS Coalition to be able to replace the role of UNFPA in running the FSW programme. For this reason, Indonesia AIDS Coalition has recruited a special staff to prepare the FSW programme. However, in interviews for this evaluation Indonesia AIDS Coalition expressed doubt that this planned future scenario was in the organization’s best interests as an organization with a vision/mission focused on advocacy.

⁴⁵ Indonesia Country Update provided by UNFPA Indonesia. See also annex 4 for the SOPs for FSW outreach.

⁴⁶ The Government of the Republic of Indonesia and UNFPA, *The Government of the Republic of Indonesia and UNFPA: 2018 Key Achievements*, Jakarta: BAPPENAS and UNFPA, undated. p.2. Note, there are a total of 514 districts in Indonesia.

Figure 5: The location of HIV Programme intervention on FSW - 2017⁴⁷



In addition to the FSW programme, the CO reports two other funded HIV initiatives.⁴⁸

The first is the partner notification initiative. In 2016, UNFPA commissioned Atma Jaya HIV and AIDS Research Center to conduct field research to help in the development of an intervention model for partner notification, i.e. to encourage and facilitate PLHIV to disclose their status to their intimate partners and encourage those partners to take an HIV test and/or take appropriate steps to avoid infection.⁴⁹ This was seen as an important step in broadening HIV prevention to the sexual partners of members of KPs. UNFPA Indonesia then funded the development of outreach and peer support guidelines with support from the MoH and Spiritia Foundation.⁵⁰ In 2017, UNFPA used the findings and guidelines to pilot *HIV/STI Prevention among Intimate Partner Transmission* in five cities in Indonesia.⁵¹ From mid-2019, UNFPA Indonesia will work with Jaringan Indonesia Positif (JIP), the national network of PLHIV, and JIP constituents to implement the guidelines in the same five cities. UNFPA is collaborating with MoH, WHO, UNAIDS, UN Women, Spiritia, OPSI, Gaya Warna Lentera and Indonesian Positive Women’s Association (IPPI) as the advisory team and also facilitators in the implementation of the pilot test. In 2019-20, UNFPA plans to partner with WHO and UN Women to take the initiative forward by developing standard operating procedures (SOPs) to prevent violence in intimate partner relationships in KPs and PLHIV. These SOPs will then become an integrated part of the guideline.

The second is UNALA. UNALA is an innovative initiative operating since 2014 in Yogyakarta Province in collaboration with CSO Yayasan Siklus Sehat Indonesia. The project’s evaluation in 2018 summarised it thus:

⁴⁷ Source: UNFPA, *UNFPA Indonesia Annual Report 2017: Strengthening partnerships for a better tomorrow*, (Final Draft) Jakarta: UNFPA, undated.

⁴⁸ See Table 5 in section 2.2.2 below for an overview of UNFPA Indonesia HIV-related programmes and expenditures. These are funded HIV-related programmes as reported by UNFPA Indonesia Country Office in response to requests for information from the evaluation team.

⁴⁹ Atma Jaya HIV-AIDS Research Center, *Field Study Report. Risk Factors and Protection against HIV Transmission in Heterosexual Intimate Couples in Indonesia*. Jakarta: Atma Jaya University, 2016.

⁵⁰ Spiritia is a civil society organization and Global Fund PR.

⁵¹ Cities of West Jakarta, Bandung, Denpasar, Surabaya, Makassar. UNFPA, *UNFPA Indonesia Annual Report 2017: Strengthening partnerships for a better tomorrow*, (Final Draft) Jakarta: UNFPA, undated.

“UNALA is an innovative social franchising model, led by the private sector, to deliver high-quality, youth-friendly, and stigma-free sexual and reproductive health (SRH) information and services for young people. The name “UNALA” was chosen because it means “your ability to make decisions” in Sanskrit, which is also underlined in its tagline, “You(th) decide, we provide.” UNALA’s expected result is improved potential for unmarried and married youth aged 15 to 24 through increased access to SRH information and services in Yogyakarta. UNALA established a network of private health care providers working closely with youth networks to provide counselling, physical examinations, and referrals to specialists and laboratories. It has worked with youth-based organizations, NGOs engaged with youth, several schools and universities, and private partners for offline demand generation and outreach. In addition, multiple online channels—social media applications and the project website—are used to inform youth about the various UNALA offerings.”⁵²

In fact, UNFPA has been involved in a range of other HIV-related activities, as will be seen in sections below. For example, UNFPA also supports the implementation of teacher training for CSE (specifically the development of a guidebook for teachers to integrate CSE into the curriculum) and supported the Coordinating Ministry of Human Development and Culture to develop a national action plan for adolescent health with HIV prevention as one of the issues addressed. One finding of this evaluation country case study is that internal communication and coordination within the Indonesia UNFPA CO is not conducive to the design and planning of HIV-related interventions across the spectrum of activities implemented in the gender, adolescent health, and family planning portfolios.

2.2.2 Financial allocations

The decision to take on the FSW programme marks a conscious choice, supported by the Regional Office, to deviate from the current assignment of Indonesia to interventions pertaining to its status as a ‘yellow quadrant’ country office (see above). This, in turn, is reflected in the UNFPA Indonesia finances.

UNFPA Indonesia began CP9 estimating that a total of USD 17 million would be required from ‘regular resources’ and additional resource mobilization.⁵³ Data supplied by the CO – see table below - shows that the budget estimate has been substantially revised in light of incoming Global Fund finance for the FSW programme among others. By 2019, the 2016-2019 working budget had risen to over USD 24 million; in 2016-2019 expenditure on the Global Fund-financed FSW programme represents USD 5.8 million.

The UNFPA Indonesia CO identified seven ‘projects’ considered being HIV-related. In this context, the ‘HIV-related’ tag is given to a range of activities that have a direct HIV component or aspire to have a strong HIV component (and a strong rights-based approach) within a broader SRH activity. The table below provides a brief description of project activities that were tagged by the Indonesia CO as HIV-related and indicates the source(s) of funding, total budget allocation, and total planned expenditure from 2016-2019.

⁵² Kobilke and Majid, *Summary Executive - Evaluation Report. UNALA, Sexual and Reproductive Health Services Model for Youth in Yogyakarta, Indonesia, November 2016 to July 2018*, UNFPA, 2018. p.2.

⁵³ Government of the Republic of Indonesia and UNFPA, *Country Programme Action Plan 2016 – 2020 for the Programme of Cooperation between The Government of Indonesia and the United Nations Population Fund*, 2016. P.22

Table 5: Overview of UNFPA Indonesia HIV-related programmes and expenditures, and total UNFPA Indonesia CO budget, 2016-2019⁵⁴

Projects	Period	Overall budget	BUDGET				EXPENDITURE				Donor	Intervention zones	Implementing partner(s)	Gov. counterpart / stakeholders
			2016	2017	2018	2019	2016	2017	2018	2019				
Partner notification	2016-20	380,300	251,400	75,450	20,250	33,200	132,526	28,580	16,479		FPA90 (UNFPA)	5 cities	MOH	MOH
		279,664	59,400	69,277	75,538	75,449	49,321	64,145	69,943	55,192	UBRAF			
ASRH (UNALA)	2016	162,761	63,852	82,785	16,124		63,827	83,030	16,017		FPA90	National	Yayasan Siklus Sehat Indonesia	MOH
		385,533			150,958	234,575			140,645	142,289	UZJ32 ⁵⁵			
CSE (UNALA)	2016-19	18,884	12,912	4,787	1,185		12,911	5,392	1,172		FPA90	National	Yayasan Siklus Sehat Indonesia	MOH
		123,719			80,248	43,471			60,597	43,242	UZJ32			
TA to FSW NFM (FSW)	2016-17	3,119,680	373,965	2,745,715			174,457	2,378,391	41,643		Global Fund	76 districts	SSRs ⁵⁶	NAC (2016), MOH (2017)
FSW prog capacity building ⁵⁷ (FSW)	2018	65,028			65,028				60,211		UBRAF	National	MOH and OPSI	MOH
TA to FSW-NFMc (FSW)	2018-20	5,350,124			2,371,283	2,978,841			1,644,875	1,579,817	Global Fund	88 districts	SSRs ⁵⁸	MOH
Support to FSW-NFMc (FSW)	2019	100,000				100,000				38,386	UBRAF	88 districts	OPSI	MOH
SUB TOTAL UNFPA INDONESIA HIV	2016-19	9,985,694	761,529	2,978,014	2,780,614	3,465,536	433,042	2,559,538	2,051,581	1,858,926				
TOTAL UNFPA INDONESIA	2016-19	24,057,365	3,394,167	4,984,583	6,743,857	8,934,758	3,341,158	4,814,912	6,440,946	5,282,882				

⁵⁴ Data supplied by UNFPA Indonesia, i.e. the CO determined what does and does not count as HIV-related. Note also, 2019 expenditure data covers Q1 and Q2 only; the evaluation visit was in early Q3.

⁵⁵ UZJ32 is funding from The Development of Foreign Affairs, Trade and Development (DFATD), the government of Canada.

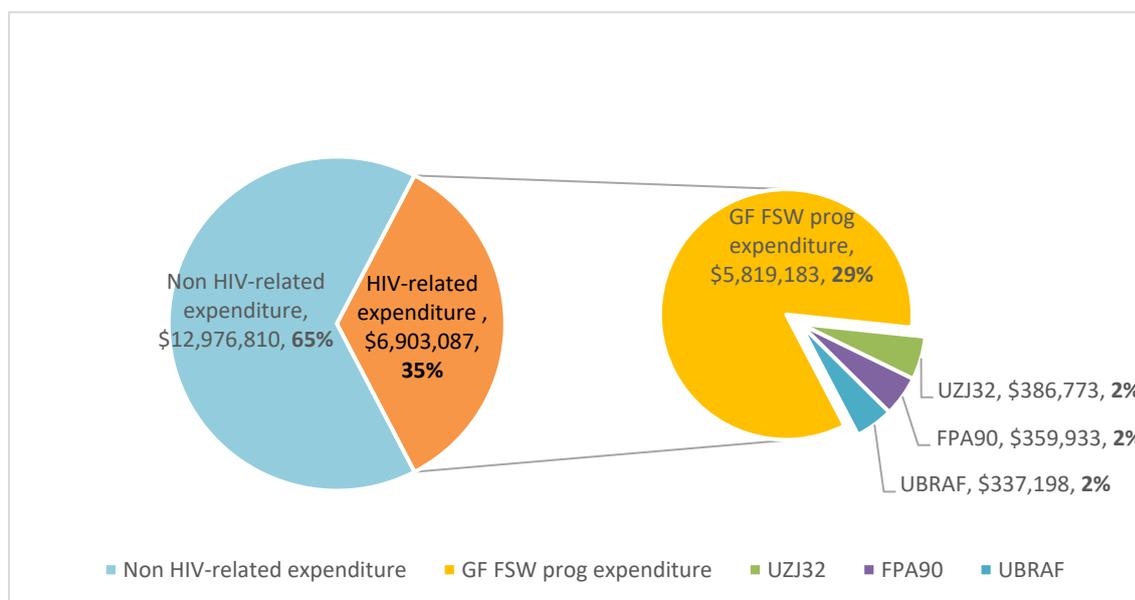
⁵⁶ UNFPA SSRs: PKBI DKI Jakarta, Yayasan Kalandara, Yayasan Kerti Praja, PKBI Papua

⁵⁷ Comprising a series of capacity building with FSW community; workshop on implementing outreach and peer support guideline; workshop on HIV implementing partners to develop 2019 annual workplan.

⁵⁸ PKBI DKI Jakarta, Yayasan Kalandara, Yayasan Kerti Praja, PKBI Papua, OPSI

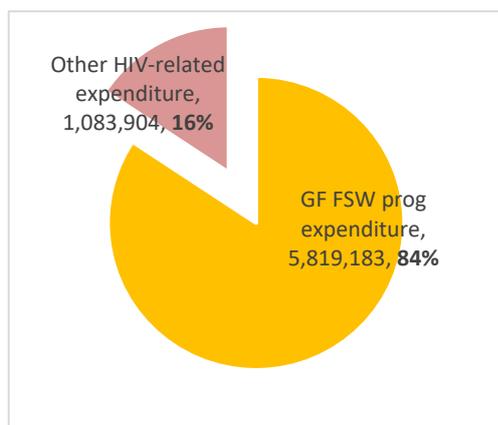
Of the seven HIV-related projects highlighted by the CO, four are directly linked to the Global Fund-financed FSW programme (see: Technical assistance to FSW NFM, FSW programme capacity building/planning, technical assistance to FSW-NFMc, support to FSW-NFMc). Two more provide support to the UNALA initiative (adolescent sexual and reproductive health (ASRH) and CSE). The final project covers the partner notification initiative.⁵⁹ During the period 2016-19, 35 per cent (USD 6.9 million) of total UNFPA Indonesia CO expenditure was devoted to HIV-related activities, as shown in the figure below.

Figure 6: UNFPA Indonesia total expenditure on HIV and non-HIV programmes, 2016-19, USD and percentage



The figure below shows that 84 per cent (USD 5.8 million) of HIV-related expenditure during the period was sourced from the Global Fund.

Figure 7: UNFPA Indonesia expenditure on HIV programmes breakdown, Global Fund and other HIV-related, 2016-19, USD and percentage



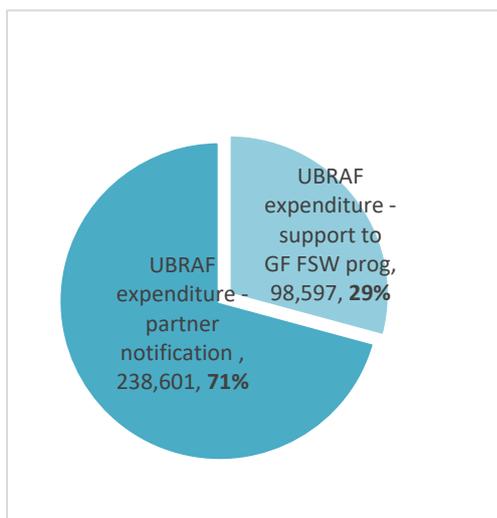
⁵⁹ As noted in the section above, UNFPA has been involved in a range of other HIV-related activities. However, these were not included in datasheet provided by the CO to describe HIV-related programmes and expenditures.

UNFPA CO core funds for HIV work dropped considerably in 2016-17-18, in light of reduced allocations from UNFPA headquarters. Core funds were budgeted at USD 328,164 in 2016, USD 163,022 in 2017 and USD 37,559 in 2018 to fund the partner notification ASRH and CSE work. As funds declined, budget execution rate increased: 2016 expenditure USD 209,264, budget execution 64 per cent; 2017 expenditure USD 117,002, budget execution 72 per cent; 2018 expenditure USD 33,668, budget execution 90 per cent.

UBRAF funds are negligible in financial terms, representing only 2 per cent of total CO expenditures 2016-19.

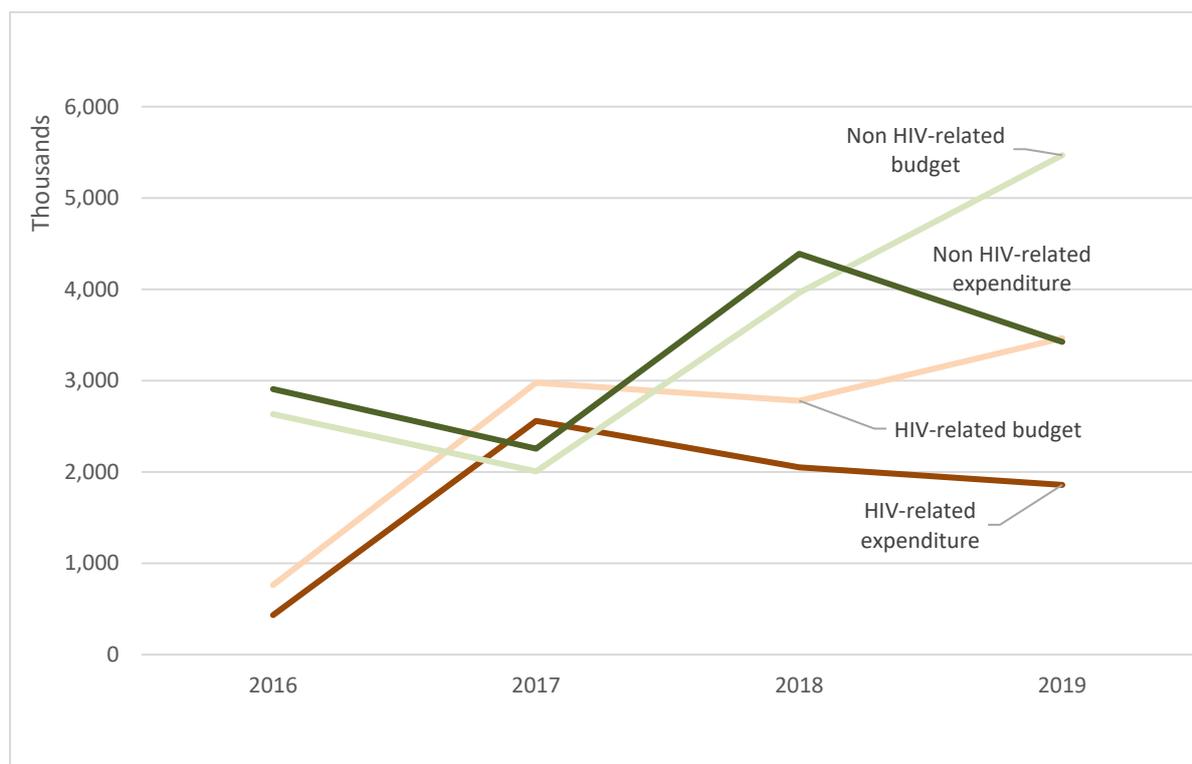
The figure below shows these funds have been spent on two main activity sets: various forms of support/complementary activity to the FSW programme (USD 98,597 or 29 per cent of UNFPA Indonesia's UBRAF expenditure) and partner notification (USD 238,601 or 71 per cent of UNFPA Indonesia's UBRAF expenditure).

Figure 8: UNFPA Indonesia UBRAF expenditure breakdown, by activity, 2016-2019, USD and percentage



UNFPA Indonesia budgets and expenditures for HIV-related and non-HIV-related activities form a complex picture, as shown in the figure below.

Figure 9: Total budget and expenditure, by year, HIV-related and non-HIV activities, 2016-2019, USD (in 000s)



In the most general terms, budgets and expenditure increased between 2016 and 2019 for both HIV-related and non-HIV-related activities. However, there are several anomalies to the overall pattern:

- The CO's non-HIV related budget dropped dramatically between 2016 and 2017. This was as a result of the reduced funding allocation of UNFPA core funds.
- The HIV-related budget (and expenditure) dropped in 2018. This is because a new phase of Global Fund-financed work (the NFM Continuous or 'FSW-NFMc' referred to in Table 5 above) had started, in which funding was set at a slightly lower level to that of the previous (2016-2017) phase.
- HIV-related expenditure was low in both 2018 and 2019 compared to the relevant budget. 2018 expenditure was USD 729,034 lower than the budget. This was due to the delay of funds being transferred from the donor. Funds of USD 610,899 were received late in the year, but only after UNFPA had already closed its books for the year. The delayed receipt of funds impacted on implementation and necessitated carry forward of activities and expenditures to 2019.
- Non-HIV-related expenditure appears to drop dramatically from 2018-2019. In 2018, this was mainly due to late receipt of funds from donors (Canada and the Global Fund). For 2019 expenditure, this is an artefact of the evaluation occurring in early quarter three of the year; the anomaly may be corrected by the end of the activity and accounting period.

2.2.3 Key implementing partners

UNFPA works closely with various government ministries and agencies including: MoH, National Population and Family Planning Board (BKKBN), Ministry of National Development Planning / National Development Planning Agency (BAPPENAS), Ministry of Women's Empowerment and Child

Protection (MOWECP), BPS-Statistics Indonesia, National Commission on Violence Against Women (VAW). Historically, there was also a good collaboration with the NAC until it was dissolved in 2017.

In terms of civil society partnerships, UNFPA Indonesia has supported and collaborated with OPSI, PKBI DKI Jakarta, PKBI Papua, Kaliandra Foundation and Kerti Praja Foundation primarily through Global Fund sub-sub recipient (SSR) relationships.

Table 6: Key implementing partners of UNFPA Indonesia

Implementing partner	Areas of programme support
Government ministries, parastatals and official bodies:	
BAPPENAS	Coordinating Agency for all areas of UNFPA mandate
BKKBN	Family planning
BPS	Population, SRH, and gender data
Komnas Perempuan	Violence against women, harmful practices
MoH	Maternal Health, ASRH
MoWECP	Violence against women, harmful practices
NGOs:	
Siklus Foundation	ASRH (UNALA project)
PKBI DKI Jakarta	HIV, FSW programme (SSR)
PKBI Papua	HIV, FSW programme (SSR)
Kaliandra Foundation	HIV, FSW programme (SSR)
OPSI	HIV, FSW programme (SSR)
Kerti Praja Foundation	HIV, FSW programme (SSR)

3 CASE STUDY FINDINGS

3.1 Strategic direction setting and coordination in the national context

UNFPA in Indonesia has taken on a specific role as part of the implementation team for the FSW component of the Global Fund-financed programme. This role has come to define and dominate the work of the CO HIV team. UNFPA has sought and achieved improvements to the FSW programme to broaden its HIV prevention impact, for example in promoting partner notification protocols. However, this is still a very restrictive focus, given the broad mandate of UNFPA to lead on comprehensive HIV prevention, rights-based approaches and achievement of SRHR for all. UNFPA has not actively or overtly attempted to position comprehensive HIV prevention or rights as priority issues for Indonesia. The importance of doing this is great, given the current state of the epidemic and the fact that Indonesia lacks an approved national strategy on HIV.

For details of the evidence, supporting findings in Section 3.1 see Annex B: Assumptions 1.1, 1.6, 4.1, 4.2, 4.4, 5.2, 6.1, 6.2, 6.3, and 6.4

3.1.1 UNFPA strategic response, including the positioning of HIV prevention as a priority

There are three important context issues to note before commenting on UNFPA Indonesia's strategic response and efforts to position HIV prevention as a priority.

First, the country is lacking an approved national strategy on HIV. As noted elsewhere, there is disagreement or misunderstanding about the status of the *Draft National Strategy and Action Plan 2015-2019 HIV and AIDS Response in Indonesia*, produced by the NAC in 2015. The NSAP 2015-19

was never formally adopted before the NAC was dissolved. During the country case study field visit, a new MoH HIV strategy was reported to be under development, i.e. a key opportunity for advocacy and technical support to shape HIV prevention policy and ensure prioritisation of comprehensive HIV prevention and integration of HIV, SRHR and GBV.

Second, the Global Fund-financed project plays a central role in the national HIV response in Indonesia and contributes a major component of the nation’s HIV prevention strategy. At the national level, priority is given to the Global Fund-financed work since successful implementation is required if renewed Global Fund finance is to be secured.

In the 2017 Funding Request to the Global Fund, Indonesia outlined its intentions thus:

“For HIV, this funding request aims to provide treatment to 215,000 people by 2020 (188,000 within allocation) and provide HIV tests for 10,743,832 tests (Reagents are provided by government, consumables and operational cost are requested from Global Fund) from all priority population groups, including key affected populations (KAPs), TB patients, pregnant women, prisoners and partners of all PLHIV. Innovative prevention approaches will be carried out to increase coverage of prevention services for KP (for transgender people, from 48% to 72%; for MSM from 58% to 90%; for FSW from 32% to 60% and for PWID from 57% to 59%).”⁶⁰

It is important to note that the Global Fund-financed programme has a particular emphasis on the HIV testing and treatment (a ‘test and treat’ approach), while other necessary strategies and activities to ensure a successful comprehensive HIV prevention programme⁶¹ receive much less attention. Similarly, stakeholders feel that in the Global Fund-financed programme success is defined primarily in terms of numbers, and not measures of quality.

Third, there are inter-acting and reinforcing directives in the global UNFPA Strategic Plan, the UNFPA Indonesia Country Plan and the UNAIDS division of labour⁶² which clarify expectations for the strategic response of UNFPA. In the UNAIDS division of labour, for example, cosponsors’ roles within a joint programme are allocated according to mandate and areas of expertise. What this means for UNFPA is shown in the table below.

Table 7: UNFPA roles in the UNAIDS division of labour

UNFPA in joint team convener/co-convener role	UNFPA in agency partner role
HIV prevention among KPs (gay men and other MSM, migrants, sex workers, transgender people)	HIV testing and treatment (innovative testing strategies; access to treatment cascade; high-burden cities Fast-Track HIV services; medicines and commodities)
HIV prevention among young people (combination prevention; youth health and educational needs)	HIV services in humanitarian emergencies

⁶⁰ CCM Indonesia, *The Global Fund Funding Application Request Form, Indonesia, 2017*. p. 31

⁶¹ See: UNAIDS, *HIV Prevention 2020 Road Map*, Geneva: UNAIDS, undated. Also: UNAIDS, *Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies 10 to Reduce New HIV Infections A UNAIDS Discussion Paper*, Geneva: UNAIDS, 2010.

⁶² UNFPA, *Strategic Plan 2018-2021*, New York: UNFPA. 2018. p. 9. Lessons learnt from evaluating the previous UNFPA Strategic Plan: a) it was important that the strategic plan be accompanied by a robust theory of change; (b) increasing access to sexual and reproductive health required a strong emphasis on demand generation, including raising awareness; (c) the supply side of integrated sexual and reproductive health services should be approached from a national health system strengthening perspective; (d) improving the integration of sexual and reproductive health and HIV programmes could better meet diverse HIV prevention needs; and (e) interventions targeting young people, especially adolescent girls, required prioritization and increased funding.

Government of the Republic of Indonesia and UNFPA, *Country Programme Action Plan 2016 – 2020 for the Programme of Cooperation between The Government of Indonesia and the United Nations Population Fund*, 2016.

UNAIDS, *UNAIDS Joint Programme Division of Labour*, Geneva: UNAIDS, 2018. pp.10-11. Namely: a focus on HIV prevention among KPs and young people, as well as integration of HIV<->SRHR.

UNFPA in joint team convenor/co-convenor role	UNFPA in agency partner role
Decentralization and integration of SRHR and HIV services	Elimination of mother-to-child transmission of HIV and keeping mothers, children and adolescents alive and well (access to quality comprehensive elimination of mother-to-child transmission of HIV services; systems and services to meet the 90–90–90 targets for mothers, children and adolescents)
	Gender inequality and GBV (strategic actions for gender equality and women and girls; GBV)
	HIV-sensitive social protection
	HIV and universal health coverage, TB/HIV, other comorbidities and nutrition
	Investment and efficiency
	Human rights, stigma and discrimination (legal and policy reform; access to justice and rights; HIV health-care discrimination eliminated)

In apparent contradiction to the above, UNFPA’s strategic response has been to almost exclusively focus on the management of the Global Fund-financed programme of outreach and testing for FSW. This strategic shift was applauded in the evaluation of UNFPA’s role in the Global Fund-financed programme 2016-17:

“UNFPA has demonstrated dexterity in adapting to the changing HIV and AIDS-related dynamics in Indonesia merely by taking on the role of working directly with SRs in what amounts to an unofficial PR role. Non-Indonesian Global Fund PRs and SRs are in general frowned upon in Indonesia, and UNFPA has successfully transformed their role from being a TA provider primarily to the NAC to serving as what is in essence an “unnamed PR.””⁶³

The role UNFPA of managing the FSW programme is a major but very specific component within the HIV programme financed by the Global Fund. Building around this, UNFPA has advocated for the government to address partner notification as a way of broadening the prevention impact of the FSW work. However, UNFPA Indonesia’s work does not benefit from a clear and robust theory of change, integration of HIV, SRHR and GBV is not clearly and robustly advocated (further discussed below), and rather than challenge the almost exclusive focus on test and treat in the Global Fund-financed programme UNFPA has acted to propagate it by becoming a major implementer. Meanwhile, diverse HIV prevention needs go unmet, Indonesia remains without a comprehensive human rights-based HIV prevention strategy, and there is widespread silence on the final R of SRHR.

Since the dissolution of the country’s NAC, there is little evidence that UNFPA has actively and overtly attempted to position comprehensive HIV prevention as a priority issue for Indonesia beyond its work on the FSW and partner notification. The evaluation team inquired why this was. The team were told ‘Working in the background is the best way. Be silent but effective. You have to be super-skilful to work with government’. This may be true, however clear and unambiguous messages about the importance of a comprehensive HIV prevention strategy and integration of HIV, SRHR and GBV are required to fulfil expectations expressed in the global UNFPA Strategic Plan, UNFPA Indonesia CP9 and the UNAIDS division of labour.

⁶³ Magnani, Sutrisna and Indrasar, *Evaluation Report, Global Fund Program Evaluation, UNFPA Technical Assistance and Capacity Development to Support Implementation of the Indonesia National AIDS Commission’s Global Fund TA and Training Plan 2016 – 2017*, UNFPA, 2018. p.14

During the period covered by the evaluation, UNFPA Indonesia's HIV work portfolio has not been guided by an explicit or coherent theory of change linked to the global UNFPA Strategic Plan, UNFPA stated priorities for HIV⁶⁴ or the UNFPA Indonesia CP9

3.1.2 Coordination platforms

As mentioned earlier, Indonesia is in a slightly unusual position of not having a national AIDS coordinating authority (i.e. NAC) or equivalent body fulfilling the overall coordination function for the national HIV response. Structures set in place to take up the roles that NAC used to perform are not yet fully functional or understood by stakeholders. Indonesia is also lacking a multi-sectoral, approved national HIV strategy.

The country's main functioning coordination mechanisms are attached to the Global Fund-financed programme, i.e. the CCM, but more importantly the TWG-HIV. The TWG-HIV is a structure created to bring together implementers and stakeholders to secure the successful delivery of the Global Fund-financed programme. Stakeholders interviewed for this evaluation believe the TWG-HIV is working well and fulfilling an important coordination role. UNFPA is playing its part on the TWG-HIV and its presence and inputs are appreciated.

However, respondents highlight two challenges associated with the TWG-HIV as a coordination body. The first is that the TWG-HIV has a specific, limited focus. It focuses on the coordination of the Global Fund-financed programme of work, not the overall national HIV prevention response per se. The second is that stakeholders occasionally feel limited in what they can advocate for or comment on for fear of being seen to challenge government or for fear of losing support from the Global Fund grants.

Apart from the coordination mechanisms associated with the Global Fund-financed programme, UNFPA has helped to create and has participated in national coordination platforms:

- In 2016, for example, UNFPA reported contributing to "Establishment of a National cross-sector Coordination Team for integrated rights-based family planning programming" working with BAPPENAS, BKKBN and MoH.⁶⁵ Although directly referenced in the quote, respondents report that this initiative did not address rights issues relating to HIV, sexual health or sexuality.
- UNFPA participates fully in the Joint United Nations Team on AIDS (JUNTA) and its contribution is greatly appreciated by UNAIDS and other agencies. The efficacy of the JUNTA is called into question, however, given the division of labour by KP group rather than according to UNAIDS guidance, reports of UN agencies not sharing information or seeking potential synergies, and the organization of the JUNTA's work plan which lists activities agency by agency rather than according to a coherent and combined plan based on a logical framework or theory of change.⁶⁶
- Since 2014, UNFPA has chaired the Interagency Network for Youth Development which coordinates United Nations youth development initiatives across partners from UNICEF, UNAIDS, International Labour Organization (ILO), UNDP etc. Building on this coordination role, UNICEF and UNFPA propose to develop and co-chair a new coordinating platform called the United Nations Youth Working Group. This would fit with UNFPA taking on young KPs in a revised Indonesia JUNTA division of labour (see below).

⁶⁴ 'UNFPA's approach to HIV is based around three strategies: promoting human rights and reducing inequalities, integrating HIV responses into sexual and reproductive health care, and preventing sexual transmission of HIV.' Source: <https://www.unfpa.org/hiv-aids>

⁶⁵ UNFPA, *Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020*. Dated February 20, 2019. UNFPA. P.52

⁶⁶ See: United Nations Joint Team on AIDS Programme of Support for 2017-2019, *Joint Plan 2018-2019 revision*.

3.2 Linking and integrating HIV, SRHR and GBV

UNFPA Indonesia has not actively provided technical input, evidence and advocacy to secure integrated HIV, SRHR and GBV services. This marks a departure from the guidance of both the UNFPA Country Plan and the UNFPA global Strategic Plan. UNFPA Indonesia staff consider integration as a valuable approach in a generalised epidemic scenario, but less so with concentrated epidemics. It is only in the development of models for delivering SRHR in humanitarian contexts – the Minimum Implementation Service Package Operational Guidelines – driven largely by UNFPA global strategy and technical guidance, that integration has been meaningfully pursued and achieved.

For details of the evidence supporting findings in Section 3.2, see Annex B: Assumptions 1.1, 1.2, 1.3, 1.4, 1.5 1.7, 2.5 and 3.3

3.2.1 Models and approaches developed or adapted for integrated services

For the purposes of this evaluation, definitions of ‘linkages’ and ‘integration’ are taken from the Interagency Working Group on SRHR and HIV Linkages report of 2017 (see Glossary of terms).

In 2017,⁶⁷ UNFPA reported a range of key achievements in the field of SRHR, including supporting government to improve midwifery education standards, updating SRH-related SDG indicators, developing a costed national family planning implementation plan, and the adoption of the Minimum Implementation Service Package (MISP) Operational Guidelines into national disaster preparedness policies. In addition, nearly 100,000 FSW were reached with HIV prevention through the Global Fund-financed programme. In the field of adolescent SRH, a range of achievements was also noted, including the UNALA private sector initiative reaching over 2,500 young people with services and information, and making available Indonesia’s first comprehensive and multisectoral National Action Plan on Youth Development (2017-2019).

With just one exception, these initiatives did not involve any significant degree of advocacy or policy development for linkages and integration between HIV, SRHR and GBV. As such, they constitute missed opportunities or exemplify the difficulties attached to making progress on integration in Indonesia. For instance, the UNALA evaluation found that the initiative had paid little attention to HIV and recommended that “UNALA should identify ways to better target promotional activities to youth at risk of unwanted pregnancies, STI, and HIV and AIDS to increase overall project impact. This concerns sexually active unmarried and married youth, especially those who are in lower wealth quintiles, are out of school, live in villages, or are sex workers, street kids, or gang members.”⁶⁸

The exception in the list of *2017 Key Achievements* was the work around the MISP Guidelines⁶⁹, which were adopted and adapted to secure a high degree of integration of HIV, adolescent reproductive health and GBV services in humanitarian settings.⁷⁰ The MISP guidelines were developed through a global initiative of the Inter-Agency Working Group on Reproductive Health in Crises, of which UNFPA is a member.⁷¹

In 2017, UNFPA supported the MoH to develop national level MISP operational guidelines for reproductive health in ‘health crisis’, i.e. humanitarian settings. UNFPA reports that issues for FSW

⁶⁷ The Government of the Republic of Indonesia and UNFPA, *The Government of the Republic of Indonesia and UNFPA: 2017 Key Achievements*, Jakarta: BAPPENAS and UNFPA, undated.

⁶⁸ Kobilke and Majid, *Summary Executive - Evaluation Report. UNALA, Sexual and Reproductive Health Services Model for Youth in Yogyakarta, Indonesia, November 2016 to July 2018*, UNFPA, 2018. P. 14

⁶⁹ Ministry of Health Republic of Indonesia, *Operational Guideline on the Minimum Initial Service Package (MISP) for Reproductive Health Implementation in Health Crisis*, Ministry of Health, The Republic of Indonesia, 2017.

⁷⁰ Note: not identified by Indonesia CO as an HIV-related project.

⁷¹ <https://www.unfpa.org/resources/what-minimum-initial-service-package>

and MSM in humanitarian settings were not covered by the MISP. UNFPA and their partner organization OPSI advocated for their inclusion and relevant issues are now covered by the technical guidance.

More generally, the guidelines include requirements to create a reproductive health sub-cluster “headed by a coordinator who is responsible for coordinating the MISP for reproductive health components, including the GBV, prevention of HIV transmission, maternal and neonatal health, logistics, and adolescent reproductive health” (p. 10). Once the initial ‘emergency phase’ is concluded, the guidelines state that

“Comprehensive reproductive health services should be available as in a non-crisis situation. Comprehensive reproductive health services focus on the provision of a full range of services in a life cycle approach to meet the need of fetuses, newborns, under 5 five-year-old children, adolescents, adults, and elderly. Services are provided in an integrated manner: promotive, preventive, curative, rehabilitative, and integrated with other programmes (e.g. MNH-FP, IMS-HIV, sexual violence, adolescent reproductive health, etc.). This is to ensure that reproductive health services in normal situations can deliver a one-stop service for a comprehensive intervention through the integrated reproductive health services” (p.56).

Though mentioned in the definitions section (p. 71), the term ‘double protection’ is not used within the body of the MISP Operational Guideline.

Further to the development of the MISP operational guidelines, UNFPA has been working in a humanitarian setting in Central Sulawesi through their implementing partner Yayasan Kerti Praja (YKP) to provide an emergency response in which HIV is integrated. During the humanitarian crisis in Lombok (West Nusa Tenggara) UNFPA also collaborated with Yayasan Inset (local PLHIV organization) to ensure availability and access to ARVs and condoms.

In terms of advocating or achieving integration, UNFPA Indonesia has been most active and most successful in these humanitarian settings. It is relevant to note that in such settings the strategy, operating procedures and guidelines emanate from the global or headquarters level. The work on MISP in Indonesia is part of UNFPA’s global efforts supporting Disaster Risk Reduction programmes.

To ensure clarity it is important to note that UNFPA Indonesia does not procure condoms or play an integral role in the condom supply chain for either family planning or HIV prevention purposes. According to work plans, the role of UNFPA has focused on strengthening the government system for procurement supply chain management, including support for policy development and coordination on condoms for dual protection, and strengthening demand creation. The evaluation team did not receive any evidence with which to assess whether UNFPA was successful in strengthening the government system.

3.2.2 Capacity building for integrated services

UNFPA main contributions to building capacity for service delivery were linked to their ongoing role implementing the FSW programme, roll out of the MISP in humanitarian settings, strengthening of midwifery education and services, and improvements to the partner notification initiative.

- **FSW programme.** The UNFPA 2016 Annual Report presented results of the new outreach model under the Global Fund-funded FSW programme. UNFPA had built capacity among staff and volunteers involved in the initiative to implement the strategy, adopt the new outreach model in their everyday practice and fully understand PMTS.⁷² A core team of master trainers were trained from DKI Jakarta, Semarang, Denpasar and Jayapura and these

⁷² PMTS or ‘Pencegahan Melalui Transmisi Seksual’ translates as ‘Comprehensive Programme for the Prevention of Sexual Transmission of HIV’.

then provided training to 113 PLs leaders and PEs from 54 organizations working on the programme.⁷³

- **MISP.** In 2018, UNFPA reported that as part of its work in the humanitarian setting of Central Sulawesi, 60 facilitators were trained on psychosocial support, 228 humanitarian workers of various organizations trained on protection against sexual exploitation and abuse (PSEA) and GBV, and 80 partners from women and youth NGOs in disaster-affected West Nusa Tenggara and Central Sulawesi joined the training on PSEA and GBV in emergencies.⁷⁴ The MISP guidelines are designed to secure a high degree of integration of HIV, SRHR and GBV services in humanitarian settings.
- **Midwifery.** In 2018, UNFPA provided financial and technical support to the Board for Health Workforce Development and Empowerment in the MoH to “increase availability and use of integrated sexual and reproductive health services, including family planning, maternal health, and HIV, that are gender-responsive and meet human rights standards for quality of care and quality in access’ involving strategic intervention aimed at the ‘improvement of capacity of midwifery workforce particularly in enhancing the midwifery education and services.” This capacity building of midwifery did not focus on HIV or SRHR issues; a missed opportunity.⁷⁵
- **Partner notification.** In 2019, UNFPA committed to support MoH to provide capacity building for health providers on partner notification. The idea was to try to include a new component in the intimate partner notification programme to improve service delivery, i.e. ways of addressing partner notification, for MSM, female partners of MSM, partners of FSW, and partners of PLHIV. This may have major benefits for individuals from KPs and their partners and improve partner notification, but does not explicitly and proactively address integration issues; a missed opportunity.

With the exception of MISP, these efforts illustrate missed opportunities to promote integration or to build capacity for integrated services.

3.2.3 Progress made towards integration of HIV, SRHR and GBV

The NSAP 2015-19 clearly identified the importance of linkages and integration within the HIV response itself:

“The Continuum of Care is intended to strengthen the integration of the health care system with community-based prevention services [...] through close cooperation between the district/city government, health care managers, civil society, the community, KPs and PLHIV. Specifically, the Continuum of Care aims to strengthen the integration of the health system with community-based systems in order to broaden the coverage of HIV-related promotion, prevention and treatment services.”⁷⁶

The strategy also stated “The integration of HIV and TB services should also be given special attention, both in hospitals and at the primary health care level” and highlighted that success in PMTCT was due in part to ‘the integration of PMTCT into ANC services.’⁷⁷

⁷³ UNFPA, *Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020, Annual Report 2016*, UNFPA, 2017. P.14

⁷⁴ UNFPA, *Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020 Annual Report 2018*, Jakarta: UNFPA, undated. p.7

⁷⁵ Perhaps this explains why the CO did not list this as an HIV-related project.

⁷⁶ National AIDS Commission, *Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia*, National AIDS Commission, 2015. p.25

⁷⁷ p.25 and p. 41 respectively

Similarly, the UNFPA Indonesia Country Action Plan⁷⁸ highlights integration as follows:

- “Linking HIV and reproductive health in both concentrated and generalized epidemics is critical to synergize efforts addressing HIV, maternal health and family planning” (p.3)
- “Outcome 1: Increased availability and use of integrated SRH services, including those related to family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access” (p.8)
- Strategic interventions include “Provision of evidence-based advocacy for policies on the integration of HIV-SRH within the national programme on the prevention of HIV through sexual transmission (PMTS), and its linkages with maternal health and family planning programmes”. (p.10)

However, this evaluation found little evidence of integration being actively pursued either in the national HIV response or in the interventions selected by UNFPA. There does not appear to be strong support for the strategy of integration of HIV, SRHR and GBV.

For example, strategies exist to promote the integration of HIV and family planning and aspects of maternal and child health service provision,⁷⁹ but evaluation respondents reported that family planning and HIV are not well integrated at the service delivery level. Family planning is viewed as a service purely for married couples, whereas HIV services are viewed as services primarily for KPs. This is also reflected at the national level, where there are separate supply chains for ‘family planning condoms’ and ‘HIV condoms’.

There appears to be a low level of understanding of and commitment to linkages and integration among key stakeholders in Indonesia. For instance, the MoH put forward their ‘triple elimination’ work to provide a good example of integration in action. This provides pregnant women with testing for hepatitis, syphilis and HIV. Yet, this is combined testing rather than an integrated service; any resulting treatments are directed to different services/service providers.

It is telling that neither the country’s key HIV strategy document nor the Government of Indonesia’s *Family Planning 2020 Commitment* mention ‘comprehensive condom programming’, ‘triple protection’, ‘dual protection’ (or ‘female condoms’).⁸⁰ Furthermore, whereas the NSAP 2015-19 highlighted the importance of HIV, SRHR and GBV integration “notably at the primary healthcare level”⁸¹, UNFPA report that the country’s current HIV programme has been designed and its primary health care is being operated without bearing integration in mind. It is reported that there is no particular interest in making systems more integrated, as exemplified by the Jatinegara Puskesmas (site of UNFPA partner notification pilot project) visited by the evaluation team in Jakarta.

Jatinegara puskesmas provides a very wide range of services (family planning, dentistry, maternal health, mental health, medical checks for pilgrims, non-communicable diseases, ophthalmology, etc.) spread across 23 service units. However, staff reported that HIV counselling and testing are only provided in the specific HIV counselling and testing unit. Elsewhere, doctors would only raise HIV issues if a patient presents with significant symptoms that might be relevant. When asked about

⁷⁸ Government of the Republic of Indonesia and UNFPA, *Country Programme Action Plan 2016 – 2020 for the Programme of Cooperation between The Government of Indonesia and the United Nations Population Fund*, 2016.

⁷⁹ Family Planning Strategy Working Group, *A Rights-Based Strategy for Accelerating Access to Integrated Family Planning and Reproductive Health Services to Achieve Indonesia’s Development Goals*. Jakarta: UNFPA. (undated, but recorded as 2017)

⁸⁰ National AIDS Commission, *Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia*, National AIDS Commission, 2015. Government of Indonesia, *Family Planning 2020 Commitment*, Government of Indonesia, 2017

⁸¹ National AIDS Commission, *Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia*, National AIDS Commission, 2015. p.50 ‘The integration of HIV and sexual and reproductive health services, including STI, in the context of PSTDHIV needs special attention, notably at the primary healthcare level. STI and HIV services must be integrated into sexual and reproductive healthcare, while HIV services should also be integrated into maternal and child healthcare and mental health services for the rehabilitation of drug users.’

the integration of services, the puskesmas manager argued that it was more important that her facility provided ‘one roof’ under which all needs could be met. The evaluation team were told that condoms were freely available in both the HIV and family planning clinics, but this was not apparent.

In contrast, the evaluation team also visited a private clinic known to be popular with members of KPs. This clinic operated a very discreet and fully integrated model of service delivery with the client staying in one room while s/he is provided with all relevant services. All staff had received training in HIV counselling and SRHR, gender diversity and sexuality issues. Among the services available were STI screening, HIV counselling and testing and ART, SRH-related counselling, gynaecology, mental health, hormonal replacement treatment and pre-exposure prophylaxis. The clinic also had a specialist psychiatrist/doctor who was knowledgeable on GBV, although GBV cases were referred rather than treated in-house. Similarly, the clinic does not provide methadone therapy but has a referral mechanism for those who need methadone. In the private clinic, condoms were freely available in all consulting rooms as well as in the toilets.

In this private sector setting, all clients pay. However, clients that belong to KPs and who cannot afford to pay receive a discount (funded by United States Agency for International Development (USAID)) negotiated through a partnership with certain CSOs. This clinic provided much of the inspiration and initial start-up support for the UNALA project later developed with support from UNFPA in Yogyakarta, but the strong HIV, SRH rights and KPs focus of the private clinic’s work has not yet been incorporated into UNALA. UNALA could learn much from the passionate and explicit commitment shown by this private clinic to ensuring the SRHR of vulnerable and KPs.

UNFPA report that over the years, there have been attempts to integrate HIV and youth-friendly services, to integrate family planning into the PMTCT programme, and to better integrate SRH and HIV, but the focus of the national health system and HIV response is primarily on KP groups and vertical approaches. Whilst UNFPA has achieved limited success pushing for integration in specific service contexts, such as adding HIV and STI to cervical cancer services or working with the NAC (before its dissolution) to develop a strategy on dual protection, UNFPA efforts towards ‘integration’ are best viewed as moves to improve referral systems and coordination between services. To illustrate this: UNFPA has promoted the ‘case management’ approach within the Global Fund-funded FSW programme. “Case management is the coordination of multiple services on behalf of a person who is considered a “case””,⁸² i.e. ways of trying to make non-integrated services feel more coordinated from the client’s perspective without actively pursuing meaningful integration.

More challenging is the fact that UNFPA Indonesia does not actively advocate integration. This seems to be because integration is not *de facto* a political priority of the government and because there is a perception within UNFPA that integration as a general guiding strategy, (i.e. ‘full package integration’ of HIV, SRHR and SGBV services) is primarily suited to generalised epidemic situations. However, it also comes about because of the perception within the national response and within the JUNTA, that a vertical approach is better suited to Indonesia’s concentrated epidemic. As discussed below, the division of labour among UN partners in Indonesia is counter-productive on many levels, but notably on integration. It encourages a silo approach in which each UN agency is responsible for one KP. With a narrow focus on FSW, UNFPA seems to have lost focus on its corporate mandate area (as per both the UNAIDS joint programme division of labour and the UNFPA Strategic Plan and Country Plan).

3.3 Meeting the needs of the most vulnerable and at-risk populations

The UNFPA CO has undertaken a range of initiatives that address gender issues, which have a direct or potential impact on HIV, as well as *ad hoc* initiatives with a view to meeting the needs of people

⁸² UNFPA, HIV Case Management for Female Sex Workers in Indonesia, 2017. A Model of Practice, UNFPA, 2017. p.3

with disabilities, adolescents and youth and people in humanitarian settings. UNFPA has also made efforts to leverage that role to widen the realms of HIV prevention and build the national HIV prevention response by piloting a partner notification initiative. However, rather than developing a portfolio aimed at the strategic level of knowledge management, advocacy and policy dialogue addressing core and common rights issues or the specific needs of other at-risk and most vulnerable, marginalised and KPs, FSW as a KP group and FSW programme implementation have clearly been the primary focus.

For details of the evidence supporting findings in Section 3.3, see B: Assumptions 2.1, 2.2, 2.3, 2.5, 3.2, 3.3 and 3.4

3.3.1 Female sex workers

FSW and their sexual partners have an elevated risk of HIV infection in Indonesia. HIV prevalence is estimated to be 5 per cent among FSW nationally.⁸³ UNFPA, particularly the HIV team, has focused their attention on this KP. This focus is also reflected in the UNAIDS division of labour in Indonesia.

Prior to becoming a Global Fund SR, UNFPA and the former NAC were actively involved in designing and advocating for the adoption of an improved outreach model for reaching FSW with HIV prevention information, testing and securing access to treatment. UNFPA collaborated with MoH, NAC, UNAIDS, OPSI, and IPPI DKI Jakarta to develop a *Community-Led Mapping Technical Guideline* used to identify ‘hot spots’ on which to target implementation efforts.

“The new strategy focused on a more dynamic approach to identifying FSW at the highest risk of HIV transmission for priority intervention, greater use of IT to reach FSW, flexibility as to who provides outreach (i.e., peers vs. non-peers) and a broader focus on outcomes all along the HIV “cascade” as opposed to focusing only on primary prevention. The new model was also designed to accommodate emerging needs resulting from the accelerating trend of closure of brothels”.⁸⁴

During the period covered by the evaluation, UNFPA took on a larger and more direct role in managing the national FSW programme. UNFPA does this as a SR to the MoH as part of the Global Fund-financed programme of work.

In this SR/programme manager role, UNFPA Indonesia has become more integrally involved in delivering a key part of the national HIV response. It has continued to seek and achieve important service improvements for FSW themselves (such as improved case management and referrals to speed up initiation onto ART) and in terms of HIV prevention measures for the sex workers’ intimate partners (for example the development of a pilot initiative on partner notification). UNFPA and the representatives of sex workers report that quality of services for FSW has improved.

UNFPA has also worked with partners to develop new strategies to reach FSW, in light of continuing brothel closures (the Government is actively seeking the closure of all brothels by 2020). This means that the traditional strategies for reaching sex workers – at their place of work – have become increasingly ineffective. As sex workers shift to working in new ways – reportedly focused on the use of social media and mobile phones - UNFPA has collaborated to develop a new outreach implementation manual.⁸⁵ UNFPA report significantly increased HIV testing and treatment to FSW as a result of their technical assistance and programme implementation using the new manual. The new approach is to increase the number of sex workers among the outreach workers, to create a more peer-led approach.

⁸³ <https://www.unaids.org/en/regionscountries/countries/indonesia>

⁸⁴ Magnani, Sutrisna and Indrasar, *Evaluation Report, Global Fund Program Evaluation, UNFPA Technical Assistance and Capacity Development to Support Implementation of the Indonesia National AIDS Commission’s Global Fund TA and Training Plan 2016 – 2017*, UNFPA, 2018. p.12

⁸⁵ UNFPA, *Outreach Implementation Manual for Female Sex Workers Programme in Indonesia*. Final Version. UNFPA (undated)

The role managing the FSW programme has required UNFPA to contract new partners and, through the partners' implementation work, has given UNFPA unprecedented involvement in and understanding of ground-level implementation of HIV programming. The role played by UNFPA and the achievements of the programme are appreciated by government and civil society stakeholders in the HIV response. As one staff member of UNFPA Indonesia HIV team admitted, however, "Almost all our efforts in the area of HIV are covered by the Global Fund project". This could imply that the FSW programme has limited or distracted from other areas of HIV prevention and promotion of rights. Or it might imply that there are gaps in communication across the UNFPA CO teams (i.e. that the UNFPA total portfolio of HIV work is underestimated by those in the HIV team who are focused primarily on the FSW programme, and not so aware of other initiatives relevant to HIV).

3.3.2 Girls and women

Two outcomes in the UNFPA Indonesia Ninth Country Programme focus on young women and girls and prevention of violence and harmful practices: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth' (outcome 3) and 'Improved policies and programmes to address barriers in the prevention and responses to gender-based violence and harmful practices, including in humanitarian settings' (outcome 4).⁸⁶ The Indonesia CO has a staff team focusing on gender (including one staff member that previously worked in the HIV team).

The table below shows the key achievements on gender equality highlighted by UNFPA.⁸⁷

Notably, 'HIV' is not mentioned in the table. Despite this, it is clear that the majority of achievements listed do contribute to the HIV response of UNFPA and Indonesia. These are contributions to creating a more enabling and rights-respecting social and policy environment. In not mentioning HIV, UNFPA Indonesia misses the opportunity to raise the profile of diverse HIV-related contributions, and to ensure that stakeholders working on SRHR and GBV are well aware of the HIV implications of their work as well as their SRH or gender equality achievements.

To illustrate this kind of missed opportunity to role-model joined-up thinking about HIV and GBV and SRHR, in February 2019 UNFPA Indonesia re-posted the global UNFPA, UN Women and UNICEF Joint Statement '*Take action to eliminate FGM by 2030*'. However, HIV was not mentioned.⁸⁸

⁸⁶ Government of the Republic of Indonesia and UNFPA, *Country Programme Action Plan 2016 – 2020 for the Programme of Cooperation between The Government of Indonesia and the United Nations Population Fund, 2016*. p.14

⁸⁷ As reported in UNFPA *Annual Reports or Key Achievements* publications for 2016, 2017 and 2018:

- The Government of the Republic of Indonesia and UNFPA, *The Government of the Republic of Indonesia and UNFPA: 2016 Key Achievements*, Jakarta: BAPPENAS and UNFPA, undated. p.4
- The Government of the Republic of Indonesia and UNFPA, *The Government of the Republic of Indonesia and UNFPA: 2017 Key Achievements*, Jakarta: BAPPENAS and UNFPA, undated. p.4
- UNFPA, *Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020 Annual Report 2018*, Jakarta: UNFPA, undated.

⁸⁸ Re-post web reference: <https://indonesia.unfpa.org/en/news/joint-statement-take-action-eliminate-female-genital-mutilation-2030>. WHO acknowledges that in terms of short-term health risks of FGM 'the direct association between FGM and HIV remains unconfirmed, although the cutting of genital tissues with the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo female genital mutilation together'. However, serious long-term risks are recorded both in terms of HIV ('given that the transmission of HIV is facilitated through trauma of the vaginal epithelium which allows the direct introduction of the virus, it is reasonable to presume that the risk of HIV transmission may be increased due to increased risk for bleeding during intercourse, as a result of FGM') and female sexual health ('removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, reduced frequency or absence of orgasm (anorgasmia). Scar formation, pain and traumatic memories associated with the procedure can also lead to such problems'). Source: https://www.who.int/reproductivehealth/topics/fgm/health_consequences_fgm/en/

The lack of explicit reference to HIV in Table 8 may mean that significant opportunities are being missed to explicitly integrate HIV, SRHR and GBV policy and service delivery. It may be an artefact of the type of document from which the table data is extracted; the *Key Achievements* publication each year is brief and meant to flag the country programme's main accomplishments. However, there are indications from the country case study visit that it is also indicative of lack of communication and coordination between teams within the UNFPA Indonesia office, i.e. a 'working in silos' approach.

More positively, UNFPA state that they are trying to improve PMTCT through advocacy to MoH. In Indonesia, 'PMTCT' focuses primarily on prong 3 (prevention of HIV transmission from HIV positive mothers to the infants). In light of this, UNFPA is partnering with Indonesian Positive Women's Association and OPSI to advocate that the other two prongs (i.e. primary prevention of HIV infection among women of childbearing age and prevention of unintended pregnancies among HIV-positive women) are also vital.

Similarly, in 2019-20, UNFPA, WHO and UN Women plan to collaborate to evolve the partner notification initiative.⁸⁹ On developing the intimate partner notification model, UNFPA realized the GBV component was missing although GBV issues were a major concern for intimate partners disclosing their status. UNFPA did not have money to address this and decided to collaborate with UN Women. UN Women had UBRAF money available and allocated USD 35,000 to cover consultants and a workshop. Collaboration with UN Women and WHO enabled UNFPA (and the evolving partner notification initiative) to benefit from the inputs of key gender and technical stakeholders. UNFPA report that 'We had the concept and they had the stakeholders and the money to make this possible'.

⁸⁹ See document: JOIN CONCEPT NOTE Partner Notification 2019 - 2020

Table 8: UNFPA Key Achievements on gender equality 2016-2018

2016	2017	2018
<p>“Evidence-based advocacy and policy dialogue on harmful practices resulted in the inclusion of child marriage and others into the national MOWECP priority agenda. The dialogue re-opened discussions for inclusion of these harmful practices in Indonesia’s reported SDG indicators.</p> <p>Improved coordination for health sector response to domestic and gender-based violence as well as the inclusion of male involvement approaches in the National Framework on GBV prevention and SRHR.</p> <p>Improved quality assurance for the Indonesia’s first VAW survey and strengthened coordination among related ministries in the conduct of the survey.</p> <p>Improved national GBV prevention and response programme referencing the situation analysis on GBV in humanitarian settings in Indonesia.</p> <p>Improved capacity of local partners in the integration of men and boys engagement approach in GBV prevention to contribute to the National Framework of Male Involvement”.</p>	<p>“Recommendation for development of regulation to strengthen mechanism of health sector response to GBV available</p> <p>Evidence-based advocacy on harmful practices available:</p> <ul style="list-style-type: none"> • Policy brief on harmful practices available as key reference for policy advocacy • Development of recommendation for SDGs indicator including the strategy and advocacy materials for harmful practices • Documentation of lessons learned and development of model for child marriage prevention <p>Partners for Prevention (P4P)⁹⁰ Pilot carried out in Papua:</p> <ul style="list-style-type: none"> • Approximately 75% of 80 participants (adolescents) trained have increasingly significant attitude change on gender equitable relationships • Approximately 75% of 60 participants (caregivers) trained have increasingly significant attitude change on gender equitable relationships • Evaluation report of the P4P pilot available <p>Studies on harmful practices (Child Marriage, FGM/C) available to provide evidence for SDG targets 5.3</p> <p>Indonesia’s first VAW Survey (SPHPN 2016) as baseline for SDGs and RPJMN (2020-2024) available, through the provision of expertise</p> <p>Guidelines for GBV prevention and response in disaster settings adopted into national disaster preparedness and response policies”.</p>	<p>“Health sector response to GBV was improved through technical advice for policy instruments, enabling its implementation at national and subnational levels.</p> <p>Together with MOWECP, guidelines and SOPs on the prevention of GBV in emergencies was adopted by Government. For the Central Sulawesi disaster response, 288 humanitarian workers across 40 organizations trained on the Prevention of Sexual Exploitation and Abuse.</p> <p>Assistance for the disaster response in West Nusa Tenggara and Central Sulawesi provided through the Government Women’s Protection Sub-cluster: 10,056 women and girls accessed services in the women-friendly tents. The lessons drawn from the response will be used to enrich the Government Emergency Response Masterplan that is currently being developed.</p> <p>Together with KOMNAS Perempuan, policy advice provided to parliamentarians and CSOs, to advocate for revisions towards the draft Penal Code on issues that will hamper gender equality specifically on sexual violence.</p> <p>UNFPA policy advice to MOWECP resulted in a National Guideline to Engage Men and Boys in the Prevention of GBV and SRH, operationalized through a MOWECP work plan on male involvement; this guideline will enable the development of national standard protocols under the leadership of MOWECP.</p> <p>Together with MOWECP and MOH, two advocacy strategies were developed and adopted on the elimination of FGM/C for CSOs (family-based advocacy) and for FGM/C prevention through the health sector. Partnerships with religious leaders (men and women ulama), youth, and health service providers, were established to complement policy efforts.</p> <p>Expert advice on child marriage prevention good practices adopted in a MOWECP strategy and model design for child marriage prevention at the subnational level, which will be implemented in a high prevalence area in Eastern Indonesia.</p> <p>Evidence for the development of the new RPJMN (2020-2024) provided through a background study on GBV and harmful practices, used for the development of the RPJMN technocratic paper”.</p>

⁹⁰ The Asia Pacific regional initiative on Partners for Prevention (P4P), involves UNFPA, UNDP, UN Women and UNV, working with boys and men to prevent gender-based violence. In Indonesia, UNFPA was involved in developing and implementing the programme, working with United Nations partners as well as with the national implementing partners and agencies. HIV issues were incorporated into the boys and men prevention module on GBV.

3.3.3 Meeting the needs of other key populations and marginalised groups

UNFPA has attempted to meet the needs of other KPs and marginalised groups in diverse ways, for example:

- **Male involvement.** UNFPA started working with the NAC in 2015 on the issue of male involvement. This was under the auspices of the PMTS Paripurna (*Comprehensive HIV Prevention Through Sexual Transmission*) programme. In particular, this male involvement initiative targeted seafarers and the clients of sex workers, both high-risk groups of men. Implementation of the model started in 2016, and the *Mid Term Review Evaluation Report of UNFPA 9th Country Programme* noted that ‘... with support from UNFPA, the National Framework on Male Involvement was developed and endorsed by MOWECP and has been used as a guidance for male engagement in various sectoral programmes on GBV prevention and SRHR’.⁹¹ However, implementation stalled in 2017 when the NAC was abolished. UNFPA points out that they have an agreed model ready to use but currently, in the absence of the NAC, there is no suitable implementing structure. In discussions linked to the Global Prevention Coalition, UNFPA and UNAIDS have agreed to try to persuade MoH to take full ownership of this policy and re-start implementation.
- **People with disabilities.** UNFPA documentation reported a partnership in 2016-17 with the Directorate General of Public Health, MoH, Ministry of Education and Culture, Ministry of Women’s Empowerment and Child Protection (MoWECP) in collaboration with CSOs and diverse other stakeholders for “mapping of policies, practise, and data availability on SRHR among persons with disabilities” and “secondary analysis of national data sets on SRHR among persons with disabilities” (p.2). The status of these initiatives is unclear; they were not known to staff interviewed.⁹²
- **Adolescents and youth.** As noted above, UNFPA has supported the pilot of the UNALA project, designed to meet the SRH needs of young people in Yogyakarta. In 2018, the project reported reaching over 3,400 youths aged 15-24 with SRH information⁹³ (though, as yet there is no HIV content or rights-based messages). UNFPA works with the MoH and Ministry of Education to train teachers on CSE, has supported the development of related modules and training materials, and provided quality control for the process. That noted, progress on CSE is problematic; initiatives so far are clearly not comprehensive, as they do not deal adequately and explicitly with the full range of issues regarding sexuality and sexual orientation.⁹⁴ UNFPA also partnered with the MoH for the development of the 2017 – 2019 National Action Plan on School Aged Children and Adolescent Health. The aim was to “address specific health needs of young people and to carry out evidence-based advocacy to the Ministry of Education and Culture for the inclusion of SRH education in the national

⁹¹ UNFPA, *Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020*. Dated February 20, 2019. UNFPA. p.71

⁹² *UNFPA Project Document: Maternal Health, HIV-SRH Linkages, and MISP* (File: Final MYWP Dirgen Public Health MOH 2016-2017) p.2; Interviews with UNFPA Indonesia staff

⁹³ The Government of the Republic of Indonesia and UNFPA, *The Government of the Republic of Indonesia and UNFPA: 2018 Key Achievements*, Jakarta: BAPPENAS and UNFPA, undated. p.3

⁹⁴ International technical guidance on sexuality education clarifies that ‘Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and, understand and ensure the protection of their rights throughout their lives.’ UNESCO, *International technical guidance on sexuality education. An evidence-informed approach*. Revised edition. Paris: UNESCO. 2018. p.2.

curriculum".⁹⁵ In 2019, the UNFPA youth and adolescent sexual health team plan to partner with Inti Muda (a civil society group formed by and for young KPs) to develop a concept note for CSE for out of schools. They expect to receive support from the UNFPA Regional Office.

- **Humanitarian settings.** In humanitarian crisis situations, women, adolescents and young people, and members of KPs often experience greater need and increased vulnerability. As noted above, UNFPA has worked with the government to produce the MISP guidelines, which provide standard operating procedures to provide an integrated approach to HIV, SRHR and GBV.

The above illustrates that UNFPA has some track record of working beyond the boundaries of the FSW programme. However, FSW as a KP group and FSW programme implementation have clearly been their primary focus in recent years. This narrow focus has been reinforced by the Indonesia JUNTA division of labour and compounded by the working in silos modus operandi of the country office and the UN partners. Thus UNFPA has not developed a portfolio aimed at the strategic level of knowledge management, advocacy and policy dialogue addressing core and common rights issues or the specific needs of other at-risk and most vulnerable, marginalised and KPs, such as MSM.

Following the Indonesia JUNTA division of labour (which departs substantially from the global repartition), MSM is the responsibility of other UN agencies. However, it was recently highlighted that the HIV prevention needs of MSM are not being met and this is a KP group with higher HIV prevalence and larger population size than FSW.⁹⁶ In this way, the national JUNTA division of labour impacts negatively on the capacity of UNFPA to deliver on its mandate.

3.4 Promoting rights

UNFPA has recorded limited successes promoting rights, particularly issues relating to sexual rights. Support to national family planning services has not included a strong SRHR component, and support to a national policy on adolescent health was concluded without sexual orientation and gender identity issues or SHSR issues having been incorporated. UNFPA Indonesia undoubtedly faces major challenges promoting SRHR in the current social and political environment in which conservatism is growing. However, the ability to effectively promote rights is also restricted by the way that the Indonesia JUNTA works. The organisation of HIV work by KP group is not conducive to collective and coordinated work promoting human rights across UN partners.

For details of the evidence supporting findings in Section 3.4, see Annex B: Assumptions 2.2, 2.3, 3.1, 3.3 and 3.4

3.4.1 Promoting rights

The goal of the UNFPA strategic plan 2018-2021 (and that of its predecessor, the strategic plan 2014-17) is to “achieve universal access to sexual and reproductive health, realize reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of Action of the

⁹⁵ UNFPA, *Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020, Annual Report 2016*, UNFPA, 2017. p.15

⁹⁶ FSW (estimated HIV prevalence 9 per cent according to IBBS 2011 data, population size 226,800), MSM (estimated HIV prevalence 26 per cent, estimated population size 754,300). Sources: Global Prevention Coalition, *Joint HIV Prevention Assessment Indonesia*, presentation, Jakarta, 29 September 2017; <https://www.unaids.org/en/regionscountries/countries/indonesia>

International Conference on Population and Development, to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”.⁹⁷

This clearly places rights issues at the core of the work to be undertaken by UNFPA. Furthermore, the 2018-21 strategic plan starts a process to align UNFPA strategy globally and in each country programme to the 2030 Agenda of the Sustainable Development Goals, meaning that UNFPA explicitly commits to principles including ‘the protection and promotion of human rights’ and ‘the prioritization of leaving no one behind and reaching the furthest behind first’.⁹⁸ This creates a clear mandate for UNFPA Indonesia to promote and secure SRHR.

UNFPA Indonesia has encountered many challenges and recorded limited achievements promoting rights. Examples of achievements include:

- In 2016, UNFPA was involved in an activity under the Global Fund-financed programme to train health care providers on reducing stigma and discrimination for FSW. The training was originally planned to focus specifically on FSW, but the MoH was keen to expand it to cover MSM as well. So UNFPA reprogrammed the training and it became known as the IPSPD programme (Indonesian acronym, translated as ‘implementation of reduction of stigma and discrimination’). This training is still used by Linkages,⁹⁹ UNAIDS, UNFPA, WHO and MoH. It is currently being implemented by the MoH with Global Fund money and Linkages in Jakarta.
- In 2015, UNFPA developed an SRH and HIV booklet for sex workers as well as a booklet covering issues of GBV and HIV and human rights. UNFPA supported OPSI (the sex workers network organization) to review and update these materials in 2018 with a view to forming a booklet on HIV and SRHR and also a booklet on GBV, HIV and Human Rights. These booklets are used by OPSI in the training they provide. Over time, UNFPA has supported OPSI on the integration of a human rights-based approach in their work through regular mentoring, help with proposal writing, and by supplying interpreters. Mentoring from UNFPA has also helped to make sure that OPSI is fluent on sexual orientation and gender identity issues and has integrated sexual orientation and gender identity issues into their SRH training materials, which is highly relevant since they represent trans-gender sex workers and male sex workers (MSWs) as well as FSW.
- The report of the mid-term review of the UNFPA Indonesia country plan reports that “UNFPA has been able to advocate the government to increase their attention and commitment to sensitive issues including provision of SRH information and services for young people although this is not an area that is considered in line with Gol’s policy”.¹⁰⁰

Examples of challenges that UNFPA has faced promoting rights include:

- UNFPA has supported the pilot of UNALA, a civil society-private sector initiative on adolescent sexual and reproductive health. UNALA seeks to provide clients with information and facilitate access to sexual and reproductive health services, however, the pilot was developed without a strong rights education approach, i.e. it is not empowering young people to understand and demand their rights related to SRH. In addition, it was developed without integrating HIV prevention into SRH information and services.
- Throughout the period covered by the evaluation, UNFPA Indonesia has supported BKKBN, the National Population and Family Planning Board, to strengthen ‘right-based family planning’. The strategy does mention HIV and recommends that family planning and HIV

⁹⁷ UNFPA, *Strategic Plan 2018-2021*, New York: UNFPA. p.1

⁹⁸ UNFPA, *Strategic Plan 2018-2021*, New York: UNFPA. p.5

⁹⁹ *Linkages across the continuum of HIV services for key populations affected by AIDS*, or Linkages, is an HFI project funded by PEPFAR.

¹⁰⁰ UNFPA, *Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020*. Dated February 20, 2019. UNFPA. p.44

services should be integrated. However, several concerns are noted re: issues of HIV, rights-based programming and integration:

- Respondents report that, taking stock of the current socio-political context, ‘rights-based’ in the family planning system must refer to ‘rights of married couples to reproductive health commodities and services’ and not SRHR or rights-based service provision for members of KPs. By the same token service provision of family planning cannot be integrated with sexual health, HIV and GBV.¹⁰¹
 - The HIV component of the strategy development was led by the UNFPA reproductive health team with family planning representatives in government and BKKBN. It is reported that the UNFPA HIV team was not consulted or involved and there was also no collaboration with the STI unit of the MoH (communication and collaboration are reported to be sub-optimal between the family health and communicable diseases sub directorates of MoH). This further illustrates the ‘working in silos’ approach (see sections 3.3.2 and 3.3.3).
 - UNFPA report that it has been difficult to make progress integrating family planning and maternal health strategy and service delivery. At the district level, family planning comes under the auspices of the family planning department, whereas maternal health is under the maternal health district office. As above, communication and collaboration are reported to be sub-optimal between these structures of government.
 - The family planning system is very decentralised. Regardless of the strategy, implementation may be quite different across different districts and facilities.
- In 2018, UNFPA Indonesia’s ASRH team supported the MoH to develop a national action plan on adolescent health. UNFPA advocated for HIV prevention and CSE to be included. The ‘adolescent reproductive health’ section of the action plan approved by the MoH, Ministry of Religious Affairs and the Ministry of Education is based on the *International Technical Guidance on Sexuality Education An Evidence-Informed Approach revised edition* (UNESCO, 2018). This means that many SRH, HIV and GBV issues are covered, including body image, HIV prevention, anatomy, gender equality, how to say “no”, GBV, stigma and discrimination and some contraceptive information for students in senior high school. However, issues of sexual orientation and gender identity were consciously excluded, as a result of a backlash from teachers and religious leaders. A UNFPA staff member noted, “People tend to panic if we use the word “sexual”. Thus, UNFPA has worked to improve a key resource for adolescent health but were unable to ensure that the final product covers a critical area of SRHR for adolescents.
 - In 2018, UNFPA provided financial and technical support to the Board for Health Workforce Development and Empowerment in the MoH to improve midwifery education and services. Although described as having a mission to ‘increase availability and use of integrated SRH services, including family planning, maternal health, and HIV, that are gender-responsive and meet human rights standards for quality of care and quality in access’, the actual content and focus of this capacity-building effort did not cover HIV or SRHR.¹⁰² This was a missed opportunity.

UNPFPA Indonesia appears to find it challenging to progress rights issues through programmes and policy and difficult to advocate for human rights, including SRHR. CO staff report that they can mention the generic phrases ‘human rights’ and ‘rights-based approaches’ in discussions with government, but find that more specific aspects of human rights, especially sexual rights, and many

¹⁰¹ Hence why UNFPA support to BKKBN is not listed by as a HIV-related programme/expenditure in Table 5 above.

¹⁰² File: AWP BPPSDMK FINAL 8 Mar 2018; interviews with UNFPA Indonesia staff

of the most basic practical implications of adopting a rights-based approach are not to be raised with government for fear of sanctions.

This may explain the status of many efforts by UNFPA in this area of promoting rights. Efforts have been made but results fall short of the ideal. There is clear demand from civil society partners and some UN agency peers for UNFPA Indonesia to be more active and more vocal on rights. One respondent from a civil society organization felt “We have all been too soft in recent years. UNFPA must be brave to talk to the government. They have been doing scattered things, but there is no clear strategy. This is true of the UN system more generally. We must all use evidence and science to make arguments’. Another respondent from a civil society organization observed that in Indonesia ‘advocacy has become completely reactive. It is now all about harm reduction, not about the positive changes we would like to see”.

3.5 Supporting networks and forging partnerships

In its role as a Global Fund SR, UNFPA Indonesia has solid relationships with several key actors in the nation’s HIV programme. In particular, it has built the capacity of the sex worker network organisation to engage at the national level in policy dialogue and advocacy. However, the responsibilities of the Global Fund-financed female sex worker programme combined with the JUNTA allocation of KP-specific roles for UN partners have concentrated the focus of UNFPA Indonesia to the extent that the country programme has achieved only limited formal relations with other coalitions or networks of KPs.

For details of the evidence supporting findings in Section 3.5, see Annex B: Assumptions 1.6, 2.4, 3.2, 4.1, 4.2, 4.3, and 4.4

3.5.1 UNFPA efforts to broker national partnerships for policy and programme development

Examples of national partnerships for policy and programme development include:

- UNFPA ensured wide participation of key groups when developing guidelines for FSW programme outreach: “The workshop to develop guidelines for basic outreach was [...] attended by 20 participants from the SSRs (PKBI DKI Jakarta, Yayasan Kalandara, Yayasan Kerti Praja, and PKBI Papua), the MoH, OPSI Network, Indonesia AIDS Coalition and UNFPA. During the workshop, participants provided input to the guidelines (The Outreach Implementation Manual for FSW Programme in Indonesia) and on-site revision was conducted.”¹⁰³
- The Global Fund-financed FSW programme has created the opportunity for UNFPA Indonesia to collaborate closely with OPSI and build their capacity for advocacy and to engage in policy dialogue at the national level.
- UNFPA partnered with Siklus Foundation in piloting UNALA, an innovative social franchising model to broker partnership between civil society and private sectors to deliver youth-friendly SRH services and information for young people. The UNALA Evaluation Report in 2018 concluded that “UNALA has been a successful introduction of a fractional social

¹⁰³ UNFPA Indonesia, *Final Report January - December 2018 Technical Assistance and Capacity Development to Support Implementation of the Global Fund Programme on Female Sex Workers* (Files: GF_MOH_2018_Annual Report_TimShared with Annex_2019_03_20_All) p.10

franchise model. The fact that private health care providers have joined the UNALA network and agreed to provide SRH services to unmarried youth is a major milestone.”¹⁰⁴

Prior to acting as a Global Fund SR, UNFPA report having a degree of influence and leverage on specific areas of national policy-making. A UNFPA staff member stated, “Even before ... UNFPA already had a role influencing policy in specific areas. We were able to persuade government that it was also important to consider HIV prevention for the intimate partners of sex workers and other KPs. Now we have government buy in and have a pilot in 5 cities funded through UBRAF and growing interest from the Global Fund”.

Since taking on the role of managing the FSW programme, UNFPA reports that it has benefitted from more frequent opportunities to meet and liaise with, and attempt to influence key stakeholders, as well as greater opportunities to facilitate the meaningful involvement of diverse actors. The FSW programme ensures close connections with government and the CCM, membership of the Global Fund project TWG-HIV, contractual relationships with sub-sub-recipients, and wider opportunities to involve other KP groups. These create important opportunities for national partnerships for policy and programme development. However, there may be a major opportunity cost to the involvement of UNFPA as a Global Fund SR. As one UNFPA staff member commented:

“When we became a major player in the Global Fund work, it kind of tied our hands to talk about sensitive issues such as human rights. Our approach changed from “professional” to “co-worker” in which there was pressure not to confront sensitive issues. We no longer had the distance necessary to advocate and leverage on issues. Before we did not have such strong relationships, but we could be more risky in challenging on issues. Now we have to stay more in line and use the Representative or the KP communities to raise the more sensitive issues with government”.

3.5.2 Supporting networks of youth, key populations and women to participate in and influence policy dialogue and programming

As noted above, the JUNTA division of labour in Indonesia - splitting and allocating specific KP groups to each UN agency – limits the potential to achieve a concerted UN approach to build the capacity of CSOs and make meaningful participation in policy-making possible for them.

In addition, one senior manager of a civil society organization noted that many UN agencies have become SR of the Global Fund-financed programme. This, he argued, places UN agencies working closely with government, but not necessarily close to the key communities and community groups in the HIV response. His concern is that once Global Fund money ends, support to the community response will collapse. This is especially worrisome as Indonesia is short of actors willing and able to engage in advocacy to the government on tricky issues such as stigma reduction, rights, challenging discrimination, decriminalisation and the role and value of the community response within an explicitly multisectoral response. His argument is that this is a critical time for building advocacy capacity among coalitions and networks of adolescents and youth, KPs and women.

In its role as a SR of a Global Fund grant, the financial and technical support provided by UNFPA to OPSI (the sex workers’ network organization) is greatly appreciated. Over time, UNFPA has supported OPSI on the integration of a human rights-based approach in their work through regular mentoring, through help with proposal writing, and by supplying interpreters. UNFPA has also helped OPSI to provide input to their community research (funded by the regional network of sex workers) which assessed SRH services, including HIV services, for FSW. Mentoring from UNFPA has also helped to make sure that OPSI is fluent on sexual orientation and gender identity issues, and

¹⁰⁴ Kobilke and Majid, *Summary Executive - Evaluation Report. UNALA, Sexual and Reproductive Health Services Model for Youth in Yogyakarta, Indonesia, November 2016 to July 2018*, UNFPA, 2018. p.9

have integrated sexual orientation and gender identity issues into their SRH training materials, which is highly relevant because they represent transgender and MSW as well as FSW.

In 2018, UNFPA supported OPSI to develop an advocacy plan to react to government action closing brothels. This used evidence from a review that had been conducted on the impact of brothel closure on HIV and health and security issues for sex workers. A representative of OPSI stated 'UNFPA really put us in a strategic position. They really empower us and involve us. They know the MoH really well and want us to be involved and they make that happen'. However, OPSI reported that its main support to build advocacy capacity and to undertake advocacy comes from the *Partnership to Inspire, Transform and Connect the HIV* response (known as the PITCH programme) and from *Bridging the Gaps* (both initiatives primarily funded by the Netherlands Ministry of Foreign Affairs) and from Aidsfonds, a Dutch international NGO.

UNFPA staff have close relationships with many of the other coalitions and networks of KPs (including FSW, young KPs, gay men and MSM organization). For example, in 2016-17, UNFPA collaborated with Yayasan Siklus Sehat Indonesia in Yogyakarta over the development of the UNALA initiative, including targets to establish 'formal collaborations with the existing youth networks/civil organization to support the provision of SRH information'. However, it should be noted that the UNALA initiative does not yet have any substantial focus on HIV.

Similarly, since 2016, UNFPA has been supporting IPPI, the women living with HIV network. They have helped IPPI organise a workshop on HIV and SRH for women with HIV, and helped with the costs of printing materials developed in light of the workshop. The materials had been developed with aid from other donors in 2011. The workshop helped IPPI review and update the model/materials in light of changes in context over time, including bringing family planning issues and dual protection up to date. UNFPA also supported IPPI to develop a short video on HIV prevention for women.

In general, however, relationships with other coalitions or networks of KPs are primarily interpersonal rather than organised as part of the UNFPA country programme implementation and they do not seem to be explicitly focused on building advocacy capacity, but rather provision of moral and technical support in a time of growing conservatism.

3.5.3 South-to-south cooperation promoted by UNFPA

UNFPA Indonesia is actively involved in south-south cooperation and joint lessons learning.

In 2016, UNFPA and UNAIDS organised a visit to Mysore in India to learn about HIV prevention among FSW with an SRH component. OPSI and BKKBN were involved and were shown ways of reaching sex workers in the street, and training programmes for sex workers. In 2017, the Indian organization visited UNFPA Indonesia partners in Jakarta.

The Mid-Term Review of the Country Programme also identifies "South-South Cooperation with 12 Asian and African countries on the role of Muslim Leaders in family planning, on comprehensive, rights-based clinical family planning" and "the role of Islamic Youth Leaders in adolescent reproductive health" in 2016, "Continued South-South Cooperation through the international training programme and the bilateral programme with the Philippines" in 2017 and 2018¹⁰⁵. The south-south work with Muslim leaders did contain SRHR components, i.e. equitable access to contraceptives and HIV prevention with condoms as dual protection. However, it was not specific to marginalized groups, more to HIV prevention in general. On investigation, however, it appears that the objective of these activities was not related to bi-directional linkages and integrating HIV, SRHR and GBV.

¹⁰⁵ UNFPA, *Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020*. Dated February 20, 2019. UNFPA. p.52

3.6 Realizing the comparative advantage of UNFPA

UNFPA in Indonesia has taken on a specific role as part of the implementation team for the FSW component of the Global Fund-financed programme. A focus on FSW is also the role allocated to UNFPA by the Indonesia JUNTA, hence impacting on UNFPA contributions to other coordination fora. In this configuration, UNFPA Indonesia is not realising its comparative advantage in terms of providing technical input, evidence and advocacy for comprehensive HIV prevention and for rights-based integrated HIV, SRHR and GBV services.

For details of the evidence supporting findings in Section 3.6, see Annex B: Assumptions 5.1 and 5.3.

3.6.1 Role and strategic contribution of UNFPA within the UNAIDS division of labour

As noted in section 3.1.1, the UNAIDS global division of labour emphasises the collective responsibilities of the joint team as well as identifying specific roles for partner agencies. The division of labour applied in Indonesia follows a very different approach, division of labour according to KP group. This decision impacts in diverse significant ways upon the work of UNFPA and other UN agencies. It promotes or reinforces the silo approach and vertical programming, as opposed to securing integrated responses.

This negative situation is compounded by the planning procedures adopted by the JUNTA. Whereas the *United Nations Joint Team on AIDS Programme of Support for 2017-2019* was structured according to overall objectives, objectives and outputs, with contributions from all UN agencies located within a single joint plan, the revised version of the JUNTA plan 2018-19 takes the form of a simple list of disparate activities. It is structured by UN and lists activities under each organisational heading, with no attempt to highlight potential synergies or actual collaboration by partners. This does not appear to be an integrated joint team approach.

Below the division of labour by KP group and its implications are examined in greater detail.

Early in 2017, when the NAC was dissolved, the MoH asked UNFPA to take on the FSW programme implementation as an SR in the Global Fund mechanism. This was a major commitment involving a large budget. The UNFPA Regional Office approved the CO to take on this implementing role, even though, as a yellow quadrant country (see section 2.2.1 above); UNFPA is expected to work upstream rather than at service delivery level. Although one UNFPA CO staff member stated that 'senior management consider this is not a long-term strategy', implementing the FSW programme has come to shape UNFPA's role within the UN division of labour and its focus in terms of HIV prevention. It also reflects the general way that the UN agencies divide responsibilities for HIV work in Indonesia.

Among the UN agencies in Indonesia, there is general agreement that in most cases roles are divided according to KP group, not technical competence area per se. This is the allocation of responsibilities emanating from the Indonesia JUNTA (even though it does not reflect the UNAIDS global division of labour). UNICEF used to focus on young KPs, but is relinquishing this; its focus is on PMTCT primarily. UNDP meant to focus on MSM and the transgender communities, but encountered challenges when their actions were deemed to contravene government wishes; UNDP has largely stepped back from working with MSM as a result. United Nations Office on Drugs and Crime (UNODC) focus is on people who inject drugs while UN Women focuses on GBV and WHO on technical/clinical guidelines.

United Nations Educational, Scientific and Cultural Organization (UNESCO) does not have a national office presence in Indonesia. In practice, responsibility for CSE is reported to be shared between

UNFPA, UNICEF and UNESCO. As noted in section 3.3.3 above, progress on CSE remains problematic and results fall short when compared to international guidance.

It is widely understood that the core work of UNFPA should be FSW, because of their function as a SR of the Global Fund-financed programme. This was, however, questioned by at least one UN agency representative who stated 'I feel that UNFPA working directly on outreach to KPs may not be the correct role. I would have thought they would focus on the strategy level'.

To a much lesser extent, UNFPA also focuses on women most at risk of HIV. Linked to this, UNFPA is working with WHO and UN Women to develop proposals for a pilot initiative for 2020.

"WHO has recommended partner testing since 2012, the assisted HIV partner notification is in line with and builds on existing WHO recommendations supporting couples and partner testing, including offering HIV testing to the households, family members and partners of people who are HIV-positive. The voluntary assisted HIV partner notification services is part of a comprehensive package of testing and care offered to people living with HIV. [...] The (UNFPA) CO in collaboration with the MoH will engage an institution to work on the pilot implementation of the HIV prevention among intimate partner in 5 cities in Indonesia (West Jakarta, Bandung, Denpasar, Surabaya, Makassar). This consultancy work will look into HIV prevention programme particularly on outreach targeting KP and psychosocial support programme for PLHIV, strategy formulation to reach intimate partners including data collection and reporting, and increase the capacity of NGOs to prevent sexual transmission among intimate partners. As for mentoring and coaching in the local level, the national team which consist of UNFPA, UN Women, Yayasan Spiritia and the pilot institution will visit the 5 piloting districts every quarter."¹⁰⁶

In the future, UNFPA is tasked by the JUNTA to take on responsibility for young KPs and linked to this a new platform is proposed called the United Nations Youth Working Group with UNICEF and UNFPA as co-chairs. This future focus on young people from KPs seems to be generally agreed across UN partners. These moves may bring the role of UNFPA into closer alignment with the UNAIDS global division of labour. However, it perpetuates the allocation of roles and the organisation of UN work programmes by KP group. This ongoing deviation from UNAIDS guidance, has wider implications with regard to integration and condom supply, for instance.

UN agency staff report that no agency is explicitly responsible for advocating the integration of HIV, SRHR and GBV for KPs in the general public health system, or for advocating the value of integration in services for the general population. It is also clear from the above that neither UNFPA nor any other UN agency explicitly engages as a lead on crosscutting issues such as condom supply and HIV, SRHR and GBV integration. These gaps in the response appear to arise as a result of the division of labour agreed by the Indonesia JUNTA. The division of labour encourages a silo or vertical way of working, not an integrated approach; there is very little thinking around integration (beyond stated commitments in UNFPA or government documents).

3.6.2 Technical capacity to carry out assigned tasks

UNAIDS report that UNFPA is performing well. It is proactive, trusted by government and civil society organizations, and 'there when needed'. Another UN agency respondent stated, "I find it really useful to work jointly with other UN programmes. By combining resources, we achieve more together. We have benefitted a lot from the technical expertise of UNFPA, and their expertise working at community level."

Overall, no respondent questioned the technical capacity of UNFPA to carry out tasks with regard to HIV or HIV, SRHR and GBV linkages and integration, should those be undertaken. However, UNFPA

¹⁰⁶ UNFPA, *Concept Note Support for Pilot Implementation of Partner Notification in Health Care and Community Setting in Indonesia*. WHO, UNFPA AND UN Women. 2019 – 2020. pp. 1, 3

staff contend that HIV, SRHR and GBV linkages and integration is relevant to generalised and not concentrated epidemics (therefore not relevant in general to Indonesia).

This way of thinking/working seems to arise as a direct consequence of the Indonesia JUNTA division of labour by KP group. It encourages a silo/vertical programming approach, rather than pursuit of opportunities for cross-fertilisation across partners and programming areas (since all the KP groups encounter some similar kinds of issues and certainly experience similar violations of their rights) and an emphasis on integration in either advocacy or service delivery implementation.

4 CONCLUSIONS

UNFPA is confronted by a complex and difficult context for the provision of support to the HIV response in Indonesia and many factors make the achievement of effective comprehensive and rights-based HIV prevention difficult in this concentrated epidemic setting. Stakeholders report rising conservatism and actual or potential legal barriers, which divert attention away from evidence-based priorities, narrow programming options and stifle the actions and expression of civil society. The HIV response architecture changed markedly when the NAC was dissolved, and the structures intended to take on its roles have not yet become fully effective. Finances from the Global Fund have greatly enabled the HIV response, yet have also served to reinforce a national over-emphasis on test and treat, rather than a broader and more comprehensive HIV prevention effort. Additionally, the fragmentation and organisation of the Government health services into vertical programmes, make the integration of SRHR, HIV and GBV services very challenging.

1. UNFPA Indonesia has played an important implementation role in the country's Global Fund-financed HIV programme by managing the outreach programme to scale up testing and treatment for FSW. The role UNFPA is playing in the FSW programme is greatly appreciated by the government, CCM and civil society partners. UNFPA has leveraged its management role in the FSW programme to advocate and pilot intimate partner notification for KPs, which seeks to increase access to HIV prevention, testing and treatment for the partners and clients of FSW, people who inject drugs, MSM and transgender PLHIV.

2. Apart from the intimate partner notification initiative, UNFPA is not engaging significantly to advocate and support comprehensive/combinational HIV prevention in Indonesia. Yet, effective prevention relies on the complementary impact of diverse strategies that involve behavioural, biomedical and structural interventions. By focusing primarily on one component (in this case test and treat), UNFPA is overlooking the needs of other KPs and also the broader socio-economic issues, rights abuses, and common barriers that KPs experience and which impact on HIV transmission, access to services, ART retention etc. Indonesia's low-level achievements for the second and third fast track indicators illustrate the negative implications of these gaps and missed opportunities.

3. The narrow programme focus on FSW arises in part due to the division of labour agreed by the Indonesia JUNTA, which allocates roles by KP group. UNFPA is a party to this agreement (which departs significantly from the prescribed global UNAIDS division of labour) and occupies a role focusing almost exclusively on FSW and the management of the FSW intervention component of the Global Fund programme. Overall, this division of

labour also severely limits the ability of UNFPA to perform according to its mandate, realise its comparative advantage, re-position comprehensive HIV prevention as a priority for the country's response, secure the outcomes stated in the global UNFPA Strategic Plan, and secure the outcomes stated in the UNFPA Indonesia Ninth Country Programme.

4. The resources provided by the Global Fund for the FSW programme make a significant contribution to UNFPA Indonesia finances and personnel. In turn, the UBRAF-funded initiatives fill the programming gaps in and around the FSW programme that could not be supported by Global Fund finances (such as FSW empowerment through capacity-building activities and prevention of HIV through the intimate partners work). As a result, instead of addressing those areas in HIV prevention that are clearly defined within the UNFPA global mandate and the *global* UNAIDS division of labour and which are currently underserved, the UBRAF funds build on and around a very specific component of HIV prevention that already receives significant attention and Global Fund finance.

5. Beyond its work to support MISP, which prescribe a high degree of service integration when responding in disaster/emergency situations, UNFPA has not been effectively securing progress towards integration of SRHR and HIV and GBV services. There is, in Indonesia, a lack of understanding and/or consensus on what integration of HIV, SRHR and GBV mean, particularly in the context of a concentrated HIV epidemic. Although the achievement of integration is a stated commitment in the UNFPA Ninth Country Programme, UNFPA Indonesia has not challenged the national state of affairs by providing a strong and clear message in favour of integration. In addition, the design, funding channels and allocation of tasks in Indonesia's Global Fund-financed programme of work appear to support and hence perpetuate a vertical programming approach, which is not conducive to the achievement of accelerated and meaningful integration of HIV, SRHR and GBV service delivery.

6. The interplay of UNFPA focusing primarily on FSW, the JUNTA division of labour, and the dominating influence of the Global Fund-financed programme, has many implications for Indonesia's national HIV response. In particular, this leaves the country's dysfunctional supply chain for 'HIV condoms' unaddressed by UNFPA although commodities security is essential to realize UNFPA comparative advantage in the prevention of sexual transmission of HIV. Similarly, having its role defined primarily in relation to one KP group (FSW) instead of a broader thematic areas of responsibility (i.e., HIV prevention among KPs, HIV prevention among young people and decentralization and integration of SRHR and HIV services), significantly narrows down UNFPA focus and negatively impact on its ability to fulfil its mandate.

7. Rights issues are fundamental for all, and especially KPs in a concentrated epidemic, in terms of accessing SRH services and retention in treatment, care and support. By working in a scattered manner with roles allocated by KP group in a national conservative context, UN partners limit their own capacity to clearly express and promote the respect of rights for all. This approach also diminishes the effectiveness of UN advocacy and the ability of UN partners to 'speak with one voice'. As a result, UNFPA Indonesia has not demonstrated consistent and unequivocal advocacy for SRHR, especially sexual rights in a

number of key areas such as: the development of 'comprehensive sexual education' (shorn of information about sexuality and sexual orientation); the UNALA initiative for adolescents (which does not tackle HIV or SRH rights); or technical support to policy development around family planning (which lacks a national commitment to concrete rights-based SRH services for all).

ANNEXES

- A. Logical reconstruction of the overall theory of change**
- B. Evaluation matrix**
- C. Key informants interviewed**
- D. Main elements of bibliography**
- E. Standard operating procedure for field outreach to sex workers**

ANNEX A: LOGICAL RECONSTRUCTION OF THE OVERALL THEORY OF CHANGE

An explicit theory of change describing how UNFPA supports the HIV response is necessary to allow the evaluation to apply contribution analysis to map causality (including the contributions of other actors) and infer the contribution UNFPA interventions have made (or are currently making) to the observed results and outcomes they are trying to influence. It provides evidence about the contribution made and information on whether the UNFPA HIV support is likely to achieve the intended results as well as what lessons can be learned.

The theory of change is also an essential instrument to establish the evaluation matrix (Annex B). The evaluation matrix contains the core elements of the evaluation: what is evaluated (evaluation criteria, evaluation questions and related issues to be examined – “assumptions to be assessed”), as well as the sources of information, indicators and most appropriate and feasible data collection methods for each of the questions identified. The evaluation matrix is a key feature of the structuring phase of the evaluation as it serves as an instrument to organize data collection and analysis.

1. Defining a theory of change

A theory of change is the representation of how a programme or set of activities contribute to desired changes, as well as the causal links and related assumptions that inform it. It demonstrates how and why a desired long-term goal is achieved through a sequence of interrelated results.

The process of developing a theory of change begins with the depiction of the causal links explaining how the activities of the intervention are expected to lead to desired results. The depiction of these causal links – or **pathways** from activities to results - forms the **intervention logic** of the UNFPA support to the HIV response at global, regional and national levels.

A theory of change allows the evaluators to identify the **causal assumptions** behind the links from activities to results – what has to happen for the causal assumptions to be realised. It is, in fact, the combination of a well-constructed intervention logic and the identification of key causal assumptions (clearly spelt out in the evaluation matrix) which characterises a useful theory of change.

2. Evaluative purpose of the theory of change

By visualizing how UNFPA support to the HIV response operates at country, regional and global levels, the development of a theory of change serves the following purposes:

- Identifying causal linkages from UNFPA activities and investments through different results levels to the outcomes and of the *UNFPA Strategic Plan (2018-2021)* – without losing sight of the 2014-2017 Strategic Plan
- Linking UNFPA activities and investments, output level results contributing to the SRAs of the UNAIDS UBRAF 2016-2021
- Making explicit the causal assumptions linking UNFPA support to identifiable results at the output, outcome and goal levels
- Formulating the evaluation questions to be investigated against which findings and conclusions will be reported

- Setting the evaluation design, as depicted in the evaluation matrix, including sources of information and data collection tools, to test the validity of causal assumptions associated with each evaluation question.

3. Nested theories of change

The term “**nested theories of change**” refers to the fact that two distinct types of theory of change can be developed to provide the necessary level of detail for an evaluation (or for programme design). The first type is an **overall theory of change** for UNFPA support to the HIV response (figure 1); it is the foundation for all of the work that follows.

The second theory of change type, **pathways theories of change**, should not be seen in any way as separate from the first. Rather, each pathway illustrates a sub-set of the actions and results documented in the overall theory of change. Pathway theories of change achieve this end by illuminating the causal links connecting different groups and typologies of UNFPA activities and investments to output and outcome level results. An important feature of the role played by UNFPA in the HIV response is the need to tailor the response to the nature of the epidemic and the social and political context in each region and country. As a result, the contribution made by UNFPA in Indonesia will differ markedly from the contribution in Georgia or Namibia. As a matter of fact, UNFPA may support different types of activities, engage with different partners, and focus on different target groups in either country – always within the programming bounds established in the overall theory of change (figure 1).

4. Process for developing the theory of change

The process of developing/reconstructing the theory of change for UNFPA support to the HIV response began with the evaluation team reviewing in detail the ToR and supporting documents. This was followed by an interactive process of consultation and development through the following stages:

1. Individual and group interviews carried out during the evaluation kick-off workshop (first meeting of the evaluation reference group) in December 2018, including presentations by UNFPA headquarters, regional and national staff engaged in support to the HIV response
2. Review of documents
3. Follow-up interviews carried out with UNFPA and UNICEF headquarter staff in January 2019
4. Development of a preliminary overall theory of change by the evaluation team presented at the theory of change workshop
5. A one-day workshop held at UNFPA headquarters on Friday 22 February to review, revise and replace the preliminary theory of change with participation of UNFPA headquarters and regional staff engaged in HIV activities and programming, facilitated by the evaluation team and the Evaluation Office
6. Circulation to the ERG of a note containing draft overall and pathway theories of change
7. Revision of the draft overall theory of change by the evaluation team (figure 1).

The workshop resulted in a re-orientation of the theory of change to better link it explicitly to the *UNFPA Strategic Plan (2018-2021)*, while still identifying how UNFPA support contributes to the SRA of the UNAIDS UBRAF. The workshop also established that prevention of the sexual transmission of HIV as the primary focus and key role of UNFPA in supporting the HIV response. This is achieved through to related and interlinked outcomes:

- Achieving greater linkage between HIV and SRHR policies, systems, communities and integrated services

- The empowerment of adolescents and youth and women to secure their right to information and to services in HIV and SRHR freed from stigma, discrimination, coercion, violence and harmful practices.

While the main focus of UNFPA support is on adolescents and youth (youth and adolescents) and women, UNFPA work in support of the HIV response recognizes as a cross-cutting guiding principle to respond to the needs of populations left behind, the most-at-risk of infection (key populations), and the most vulnerable.

5. How to read the theory of change

The diagram presented in figure 1 depicts the **overall** theory of change for UNFPA support to the HIV response resulting from the consultation process (stages 1 through 6) mentioned above. The structure moves up the chain of effects from UNFPA activities and investments at the bottom of the figure to the overall goal of the UNFPA Strategic Plan on top.

It is important to note that, as a result of the theory of change workshop, **the primary role and function** of UNFPA support to the HIV response was determined to be **the prevention of sexual transmission of HIV** (identified in the second row from the top in figure 1). Similarly, it is worth noting that each of the outputs identified at country level (in the green boxes, in the middle of the figure) are explicitly linked to different UBRAF strategic results areas *by number* (see pink box). While the theory of change is structured around UNFPA strategic outcomes and goal, it retains the necessary link to UBRAF strategic results areas.

Other important features of the theory of change include:

- The overall goal of prevention is achieved through two important strategic outcomes which translate country level outputs into outcomes: **(a) Strengthened linkages between SRHR and HIV** at policy, system, community and service levels along with integrated delivery of HIV and SRHR services; **(b) Adolescents and youth and key populations, including people living with HIV, exercise their rights to access HIV-related information and services** free from coercion, stigma, discrimination, violence and harmful practices.
- However, in order for the activities and investments supported by UNFPA to contribute to the output and outcome level results depicted in the theory of change, the **key critical assumptions**, shaded in blue in figure 1, **will need to be realized**. These assumptions, described in detail for each evaluation area of investigation and related evaluation question (see evaluation matrix in Annex B) are an important focus of the evaluation.

ANNEX B: EVALUATION MATRIX

Area of Investigation One: Extent and scope of UNFPA support to the integration of HIV with other sexual and reproductive health and rights strategies and programmes	
<p>Evaluation Question 1: <i>To what extent has UNFPA contributed to establishing and strengthening bi-directional linkages (policies, systems, communities and services) between HIV and SRHR and to integrating HIV and SRHR service delivery?</i></p>	
Evaluation Criteria	<i>Relevance, Effectiveness, Efficiency</i>
Rationale	Strengthening linkages and bi-directional synergies between HIV and SRHR is an important strategy behind many of UNFPA efforts to support the response to HIV. At the level of service users, an important result of strengthened linkages should be more integrated delivery of HIV and SRHR services as well as integration of HIV and SRHR behaviour change communications efforts.
<p>Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> National HIV Strategy and SRHR Strategies, Roadmaps and Action Plans incorporate linkages between HIV and SRHR Health sector strategies and action plans incorporate linkages between HIV and SRHR National SRHR action plans and programmes, including family planning incorporate links to HIV prevention Operational guidelines, service protocols and manuals for health services staff incorporate linkages between HIV and SRHR services. Opinions of global and regional stakeholders on UNFPA role in supporting integration (and its overall level of influence) Extent to which HIV and SRHR strategies and policies address gender equality and HIV-related stigma and discrimination (gender and human rights components) 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> There is some disagreement or misunderstanding about the status of the <i>Draft National Strategy and Action Plan 2015-2019 HIV and AIDS Response in Indonesia</i>, produced in 2015. The plan was never formally adopted before the NAC was dissolved. However, for some stakeholders, it stands as the country's current national strategy. This strategy identifies the importance of linkages and integration: <p>‘The Continuum of Care (CoC) is intended to strengthen the integration of the health care system with community-based prevention services, such as the implementation of PSTHIV through close cooperation between the district/city government, health care managers, civil society, the community, key populations and PLHIV. Specifically, CoC aims to strengthen the integration of the health system with community-based systems in order to broaden the coverage of HIV-related promotion, prevention and treatment services, as described below:</p> 	<ul style="list-style-type: none"> National AIDS Commission, <i>Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia</i>, National AIDS Commission, 2015.

Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.

<ul style="list-style-type: none"> ○ Expand HIV-related services for key populations in primary and community health facilities, including services for TB, STI, sexual and reproductive health, victims of violence, and hepatitis. ○ Provide referral services from the community to service providers and back to the community. ○ Enhance health workers' responsiveness to HIV and AIDS programmes. ○ Scale up ART through decentralized service delivery. ○ Mitigate social and economic impacts. ○ Implement PSTHIV and SUFA within the conceptual framework of CoC. <p>Strong integration between the health care system and community-based prevention requires multisectoral planning to expand services, map out hotspots, develop outreach strategies and foster partnerships with key populations, and build the capacity of health care providers at the district/city level.' (p.25)</p> <ul style="list-style-type: none"> ● The strategy also states 'The integration of HIV and TB services should also be given special attention, both in hospitals and at the primary health care level.'(p.25) ● The strategy also highlights that 'Sound policies and comprehensive implementation of guidelines since 2012, including the integration of PMTCT into ANC services, have helped broaden coverage and strengthen the implementation of PMTCT, and improved detection of HIV-positive pregnant women.'(p.41) 	
<ul style="list-style-type: none"> ● Indonesia does not have a national policy or strategy for HIV<->SRHR<->GBV integration. 	<ul style="list-style-type: none"> ● Interagency Working Group on SRH and HIV Linkages, <i>HIV and SRHR Linkages Infographic Snapshot Indonesia</i>, IAWG, 2016 ● Interviews with UN agency staff, government officials and members of civil society organisations
<p>The UNFPA Country Action Plan highlights integration as follows:</p> <ul style="list-style-type: none"> ● 'Linking HIV and reproductive health in both concentrated and generalized epidemics is critical to synergize efforts addressing HIV, maternal health and family planning' (p.3) ● 'Outcome 1: Increased availability and use of integrated sexual and reproductive health services, including those related to family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access' (p.8) 	<ul style="list-style-type: none"> ● Government of the Republic of Indonesia and UNFPA, <i>Country Programme Action Plan 2016 – 2020 for the Programme of Cooperation between The Government of Indonesia and the United Nations Population Fund</i>, 2016.

Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.

<ul style="list-style-type: none"> Strategic interventions include: 'Provision of evidence-based advocacy for policies on the integration of HIV- SRH within the national programme on the prevention of HIV through sexual transmission (PMTS), and its linkages with maternal health and family planning programmes' (p.10) 	
<ul style="list-style-type: none"> In 2016 and 2017, the UBRAF funds of USD 55.000 and USD 25.086 respectively were allocated for salaries. On both occasions, the non-core funds request stated: 'In supporting the National Programme on the Prevention of HIV through Sexual Transmission, UNFPA's comparative advantage in strengthening HIV linkages will assist Government in developing and monitoring implementation of necessary protocols for an integrated HIV, maternal health and family planning programme'. The requests also noted that the anticipated impact was 'to contribute to linking HIV and reproductive health in both concentrated and generalised epidemics'. 	<ul style="list-style-type: none"> File: wp-ubraf2016 (1) File: ubraf wp august2017 (5) File: ubraf 2017 signed
<ul style="list-style-type: none"> In 2017, UNFPA reported a range of key achievements in the field of sexual reproductive health and rights, including supporting government to improve midwifery education standards, updating SRH-related SDG indicators, developing a costed national family planning implementation plan, and the adoption of the Minimum Implementation Service Package Operational Guidelines into national disaster preparedness policies. In addition, nearly 100,000 female sex workers were reached with HIV prevention through the GF financed programme. In the field of adolescent sexual reproductive health, a range of achievements were also noted, including the UNALA private sector initiative reaching over 2,500 young people with services and information, and making available Indonesia's first comprehensive and multisectoral National Action Plan on Youth Development (2017-2019). These initiatives display a varying degree of emphasis paid to linkages and integration. <ul style="list-style-type: none"> The work on midwifery education standards, updating SRH-related SDG indicators, and the costed national family planning implementation plan did not involve any significant component promoting or laying policy guidelines for HIV-SRH integration The Minimum Implementation Service Package (MISP) Guidelines were written to secure a high degree of integration of HIV<>ARH<>GBV services in humanitarian settings. UNFPA's work reaching FSW with HIV testing and treatment does not involve any significant component promoting or laying policy guidelines for HIV-SRH integration The UNALA initiative does not involve any significant component promoting or laying policy guidelines for HIV-SRH integration, the focus is more on reproductive health The National Action Plan on Youth Development does not involve any significant component promoting or laying policy guidelines for HIV-SRH integration (according to key informants; the document is not available in English for detailed review). 	<ul style="list-style-type: none"> The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2017 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated. Interviews with UNFPA staff, UN agency staff, government officials and members of civil society organisations

Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.

<ul style="list-style-type: none"> • The level of understanding of and commitment to linkages and integration among key stakeholders in Indonesia is reported to be low. There also seems to be some challenge within the UNFPA staff group to integration as a core UNFPA strategy in both generalised and concentrated epidemic settings. • UNFPA reported that integration is not discussed or proposed as a strategy at the national level in Indonesia. The focus is primarily on population groups and vertical approaches. UNFPA has achieved limited success pushing for integration in specific service contexts, such as adding HIV and STI to cervical cancer services. • One member of the UNFPA Indonesia team shared their view that ‘a comprehensive definition of “integration” only makes sense in the context of a generalised HIV epidemic. In a country like Indonesia, we need to focus on specific issues to integrate. Neither MoH nor the NAC in the past understand about integration. So we have identified specific elements that are relevant, such as talking to BKKBN on dual protection, access to condoms and lubes. With PMTCT we are trying to integrate by bringing in the issue of partner notification. But if we are assessed using integration checklist we will not pass the test. In Asia Pacific Region we need a specific checklist that is relevant to integration as it applies here.’ 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • ‘There’s not much happening on integration’. 	<ul style="list-style-type: none"> • Interviews with UN agency staff
<ul style="list-style-type: none"> • ‘We are keen to explore the integration of GBV and HIV services, but there is no consensus on integration among people working in HIV and among policy-makers. It seems to mean ‘referral systems’ to most, but I think it is deeper than this’. 	<ul style="list-style-type: none"> • Interviews with UN agency staff
<ul style="list-style-type: none"> • ‘In Indonesia, the main focus for integration is between family planning and HIV. For family planning, the strategy is the responsibility of BKKBN but implementation is through the MoH structures. At the moment coordination between these two structures is not optimal. The same happens with PMTCT, where communication and coordination between the two sub-directorates of the MoH is not optimal.’ 	<ul style="list-style-type: none"> • Interview with UNFPA Indonesia staff
<ul style="list-style-type: none"> • UNFPA report that the country’s current HIV programme has been designed without integration in mind and there is no particular interest in making systems more integrated. Over years there have been some small moves to try and integrate HIV and youth friendly services, and to integrate family planning into the PMTCT programme. UNFPA report that ‘we try to shape the programme and add our core values through evidence and lobbying and through the back door by influencing others’. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • In 2016, UNFPA recorded that it contributed to the ‘Establishment of a National cross-sector Coordination Team for integrated rights-based family planning programming’ (p.52) working with BAPPENAS, BKKBN and MOH. 	<ul style="list-style-type: none"> • UNFPA, <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to the Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.
<ul style="list-style-type: none"> • ‘Integration of family planning continuum of care across reproductive cycle: Family planning services play a key role throughout the reproductive cycle, enabling couples to have the number of children they want to have, at the age they want to have them, ensuring the elimination of unwanted pregnancies and births, as well as the need for abortions and their consequences, and the 	<ul style="list-style-type: none"> • Family Planning Strategy Working Group, <i>A Rights-Based Strategy for Accelerating Access to Integrated</i>

Assumption 1.1: At global, regional, and national level UNFPA has effectively supported and advocated initiatives for strengthening bi-directional linkages between HIV and SRHR policies, systems, communities and services.

<p>prevention of STIs and HIV via sexual transmission. The contribution of family planning services across the continuum of maternal and childcare to reducing mortality and improving health among mothers and children is well documented. The integration of family planning with maternal and child health services in particular is proven to be cost-efficient for clients and the health system.’ (p.28)</p> <ul style="list-style-type: none"> • The strategy also highlights that alongside clinical services, it is also essential to secure interlinked non clinical services, which they highlight as including ‘Sexual and Reproductive Health/SRH information for adolescents, pre-marital counselling for couples, STI and HIV prevention counselling, post-partum and post-abortion counselling’ (p.31) • The strategy highlights that a key activity is to ensure ‘Integration of FP messages with maternal and child health care messages as well as HIV and STI prevention messages’ and to incorporate ‘reproductive health and family planning messages ... during STI and HIV treatment’ (p.36). A key activity to achieve this is to ‘Review current FP services standards (counselling – for general and specific methods, instructions on use of a method, procedures, referrals, follow-up, STI/HIV screening, and dual protection) and revise as needed.’ (p.56) 	<p><i>Family Planning and Reproductive Health Services to Achieve Indonesia’s Development Goals.</i> Jakarta: UNFPA. (undated, but recorded as 2017)</p>
<ul style="list-style-type: none"> • Respondents reported that family planning and HIV are not well integrated at the service delivery level. Family planning is viewed as a service for married couples, whereas HIV services are viewed as services for key populations. This is also reflected at the national level, where there are separate supply chains for ‘family planning condoms’ and ‘HIV condoms’. 	<ul style="list-style-type: none"> • Interviews with UNFPA staff, UN agency staff, government officials and members of civil society organisations
<ul style="list-style-type: none"> • UNFPA staff (from the adolescent health team) provided the UNALA pilot project as an example of their work to integrate HIV into SRHR. UNALA started in 2016 in Yogyakarta as a public-private partnership initiative to provide young people with SRH information and link them to services. The initiative has received financial support from UNFPA and Canada. However, according to the organisation implementing UNALA ‘We are very closely supervised by MoH and BAPPENAS so we have to apply government policy to the letter of the law. So far we don’t get involved in HIV.’ 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff and members of civil society organisations
<ul style="list-style-type: none"> • The UNALA evaluation suggests that insufficient emphasis has been placed on HIV. Evaluation recommendations include ‘UNALA should identify ways to better target promotional activities to youth at risk of unwanted pregnancies, STI, and HIV/AIDS to increase overall project impact. This concerns sexually active unmarried and married youth, especially those who are in lower wealth quintiles, are out of school, live in villages, or are sex workers, street kids, or gang members.’ (p.14) 	<ul style="list-style-type: none"> • Kobilke and Majid, <i>Summary Executive - Evaluation Report. UNALA, Sexual and Reproductive Health Services Model for Youth in Yogyakarta, Indonesia, November 2016 to July 2018</i>, UNFPA, 2018.
<ul style="list-style-type: none"> • In 2017, UNFPA supported the MoH to develop operational guidelines for a Minimum Initial Service Package called the MISP for reproductive health in ‘health crisis’ i.e. humanitarian settings. The guidelines include requirements to create a reproductive health sub-cluster ‘headed by a coordinator who is responsible for coordinating the MISP for RH components, including the gender-based violence, prevention of HIV transmission, maternal and neonatal health, logistics, and adolescent reproductive health’. (p. 10) Once the initial ‘emergency phase’ is concluded, the guidelines state that ‘comprehensive reproductive health services should be available as in a non-crisis situation. Comprehensive reproductive health services focus on the provision of a full- 	<ul style="list-style-type: none"> • Ministry of Health Republic of Indonesia, <i>Operational Guideline on the Minimum Initial Service Package (MISP) for Reproductive Health Implementation in Health Crisis</i>, Ministry of Health The Republic of Indonesia, 2017

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<p>range of services in a life cycle approach to meet the need of fetuses, newborns, under 5 five-year-old children, adolescents, adults, and elderly. Services are provided in an integrated manner: promotive, preventive, curative, rehabilitative, and integrated with other programmes (e.g. MNH-FP, IMS-HIV, sexual violence, adolescent reproductive health, etc.). This is to ensure that reproductive health services in normal situations can deliver a one-stop service for a comprehensive intervention through the integrated reproductive health services’ (p.56).</p>	
<ul style="list-style-type: none"> • ‘We have been working in one humanitarian setting in Sulawesi Central through our implementing partner YKP. This is work to provide an emergency response in which HIV is integrated’. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • In 2015, The HIV and STIs National Action Plan for the health sector (NAP) was prepared by referring to the 2015-2019 National Mid-Term Development Plan (RPJMN) and the 2015-2019 MoH Strategic Plan where the issue of HIV and AIDS is part of the disease control and environmental health strategy. • This HIV and STIs NAP is a reference for developing strategies and their implementation in the government, private sector, working partners and the community in controlling HIV and AIDS in Indonesia by taking into account national priorities in strengthening overall health development by promoting competitive advantage according to cultural and social structures and quality human resources for fulfilment of the rights of the people of Indonesia in the field of health, especially HIV-AIDS and STIs in Indonesia (p.11). • The NAP describes systematically the forms of activities that are structured and in line with the National Action Plan on health and other non-health sectors (for example the National Strategy and Action Plan for HIV and AIDS Response, NAP Maternal and Child Health, NAP TB , Malaria NAP, NAP Reproductive health, and action plans in other sectors) to achieve the goal of reducing new HIV infections with a particular approach to key populations, special populations and community groups that are vulnerable to HIV-AIDS and STIs (p.39) • Referring to HIV and AIDS control strategies in Minister of Health Regulation no. 21/2013, it can be summarized two control strategies as follows: 1. Increase coverage of HIV-AIDS and STI services through CoC; 2. Strengthening the national health system in the implementation of CoC for HIV-AIDS and STIs (p.39) • In health services, STI management is part of the Integrated Reproductive Health Services (PKRT) activities. The scope of the PKRT is 1. MCH; 2. The Family Planning; 3. Adolescent Reproductive Health; 4. Management of STIs and HIV; 5. Elderly reproductive health (p.47) • However, during the evaluation process, this HIV NAP from health sector almost never mentioned or discussed by the key stakeholders, including member of the civil society organisation. 	<ul style="list-style-type: none"> • Ministry of Health Republic Indonesia, The HIV and STIs National Action Plan for the Health Sector 2015-2019, Ministry of Health The Republic of Indonesia,

Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV and SRHR have been implemented.	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Regional and national plans for linkage and integration adopted by health authorities • National health authorities confirm adoption of plans/programmes in support of linking and integration • National linkage plans and programmes address three components of IAWGL model: <ul style="list-style-type: none"> - Enabling environment - Stronger health systems - More integrated delivery of SRHR and HIV services • Linkage programmes supported by UNFPA at regional national level report on progress (including in integration) 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • In 2017, UNFPA reported a range of key achievements in the field of sexual reproductive health and rights, including supporting government to improve midwifery education standards, updating SRH-related SDG indicators, developing a costed national family planning implementation plan, and the adoption of the Minimum Implementation Service Package Operational Guidelines into national disaster preparedness policies. In addition, nearly 100,000 female sex workers were reached with HIV prevention through the GF financed programme. In the field of adolescent sexual reproductive health, a range of achievements were also noted, including the UNALA private sector initiative reaching over 2,500 young people with services and information, and making available Indonesia’s first comprehensive and multisectoral National Action Plan on Youth Development (2017-2019). • These initiatives display a varied degree of emphasis paid to linkages and integration. <ul style="list-style-type: none"> ○ The work on midwifery education standards, updating SRH-related SDG indicators, and the costed national family planning implementation plan did not involve any significant component promoting or laying policy guidelines for HIV-SRH integration ○ The Minimum Implementation Service Package (MISP) Guidelines were written to secure a high degree of integration of HIV<>ARH<>GBV services in humanitarian settings. ○ UNFPA’s work reaching FSW with HIV testing and treatment does not involve any significant component promoting or laying policy guidelines for HIV-SRH integration ○ The UNALA initiative does not involve any significant component promoting or laying policy guidelines for HIV-SRH integration, the focus is more on reproductive health ○ The National Action Plan on Youth Development does not involve any significant component promoting or laying policy guidelines for HIV-SRH integration (according to key informants; document is not available in English for detailed review). 	<ul style="list-style-type: none"> • The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2017 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated. • Interviews with UNFPA staff, UN agency staff, government officials and members of civil society organisations
<ul style="list-style-type: none"> • In 2017, UNFPA supported the MoH to develop operational guidelines for a Minimum Initial Service Package called the MISP for reproductive health in ‘health crisis’ i.e. humanitarian settings. The guidelines include requirements to create a reproductive health sub-cluster ‘headed by a coordinator who is responsible for coordinating the MISP for RH components, including the gender-based 	<ul style="list-style-type: none"> • Ministry of Health Republic of Indonesia, <i>Operational Guideline on the Minimum Initial Service Package (MISP)</i>

Assumption 1.2: UNFPA supported operational models/approaches for strengthening bi-directional linkages and integrating HIV and SRHR have been implemented.

<p>violence, prevention of HIV transmission, maternal and neonatal health, logistics, and adolescent reproductive health’. (p. 10) Once the initial ‘emergency phase’ is concluded, the guidelines state that ‘comprehensive reproductive health services should be available as in a non-crisis situation. Comprehensive reproductive health services focus on the provision of a full-range of services in a life cycle approach to meet the need of fetuses, newborns, under 5 five-year-old children, adolescents, adults, and elderly. Services are provided in an integrated manner: promotive, preventive, curative, rehabilitative, and integrated with other programmes (e.g. MNH-FP, IMS-HIV, sexual violence, adolescent reproductive health, etc.). This is to ensure that reproductive health services in normal situations can deliver a one-stop service for a comprehensive intervention through the integrated reproductive health services’ (p.56).</p> <ul style="list-style-type: none"> • Though defined in the definitions section (p. 71), the term ‘double protection’ is not used within the body of the MISP Operational Guideline. 	<p><i>for Reproductive Health Implementation in Health Crisis, Ministry of Health the Republic of Indonesia, 2017</i></p>
<ul style="list-style-type: none"> • ‘We have been working in one humanitarian setting in Central Sulawesi through our implementing partner YKP. This is work to provide an emergency response in which HIV is integrated’. • ‘During the humanitarian crisis in Lombok (West Nusa Tenggara) UNFPA CO worked together with Yayasan Inset (local PLHIV organization) to ensure availability and access to ARV as well as condom provision’. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • (2019) funding the National Development Planning Agency (BAPPENAS)(USD 295,970 for all years) in collaboration with BKKBN, Ministry of Health, Ministry of Youth and Sports, BPS, Research Institutions, NGOs, CSOs, youth networks and universities, to promote rights-based family planning through a more comprehensive and integrated planning and programming. This will include finalisation of a rights-based family planning advocacy strategy; continuing to pilot rights-based family planning in Malang, Lahat and West Aceh; and initiation of scale up and replication measures. 	<ul style="list-style-type: none"> • File: AWP Bappenas 2019 RFP, PDA, YPD_Final_Signed
<ul style="list-style-type: none"> • UNFPA has promoted the ‘case management’ approach within the GF-funded FSW programme. ‘Case management is the coordination of multiple services on behalf of a person who is considered a “case”’ (p.3), i.e. ways of trying to make non-integrated services feel more coordinated from the client’s perspective. 	<ul style="list-style-type: none"> • UNFPA, <i>HIV Case Management for Female Sex Workers in Indonesia, 2017. A Model of Practice</i>, UNFPA, 2017.
<ul style="list-style-type: none"> • In 2017, UNFPA supported MoH to develop an HIV pre-marital counselling module. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff

Assumption 1.3: As a result, HIV and SRHR services and interventions have been integrated both in health service delivery settings and in behaviour change and communications efforts, especially in relation to contraceptive services and family planning, including for eMTCT.

Indicators:

- Extent to which operational guidelines, service protocols and manuals that promote delivery of integrated HIV and SRHR services are reportedly used by health services staff
- Reported quality and clarity of operational models for integration
- Programme expenditures on integration
- Evaluation findings on integration initiatives
- Reported experience and views of national health authorities and other implementing partners
- Examples of successful/unsuccessful efforts to link HIV to SRHR services at operational level as confirmed by site visits/discussions with service providers

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- Data on aspects of service integration identified in the IAWG indicator list:
 - HIV counselling and testing and family planning integrated
 - Knowledge of HIV status
 - Met need for contraception
 - Sex worker access to services
 - MSM access to services

Observations	Sources of Evidence
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- In **2016, the Linkages project** summarised the Indonesia situation thus:

Question:	Answer:
Are there SRHR training materials and curricula that include HIV?	Yes (partial)
Are there HIV training materials and curricular that include SRHR?	Yes (partial)
To what extent is supportive supervision for SRHR and HIV integrated at the health service delivery level?	Partially integrated
Is there joint planning of HIV and SRHR?	No
Is there any collaboration between SRHR and HIV for programme management/implementation?	No
Health facilities provide HIV services integrated with other health services: HIV counselling and testing with SRH? EMTCT with antenatal care/maternal and child health?	Many
Schools that provided skills-based HIV and sexuality education in the previous academic year?	Data not available

- Interagency Working Group on SRHR and HIV Linkages, *HIV and SRHR Linkages Infographic Snapshot Indonesia*, IAWG, 2016

- ‘We are keen to explore the integration of GBV and HIV services, but **there is no consensus on integration** among people working in HIV and among policy-makers. **It seems to mean ‘referral systems’ to most**, but I think it is deeper than this’.

- Interviews with UN agency staff

- ‘In the **PMTCT** programme it has been a major **challenge to get the maternal health and the HIV teams at MoH to talk to each other**’.

- Interviews with UN agency staff

- The **case management approach UNFPA has promoted and developed for female sex workers** includes ‘assist with sexual and reproductive health needs ... Family planning may become an important added concern for newly HIV diagnosed female sex workers. Case managers assist clients to access dual methods of contraception and to access family planning support where requested and needed (p.10) ... Newly diagnosed clients may be diagnosed with STIs or TB. Determining the level of need in

- UNFPA, *HIV Case Management for Female Sex Workers in Indonesia, 2017. A Model of Practice*, UNFPA, 2017.

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relation to STI symptoms will allow caseworkers to decide whether urgent action on symptoms is required, as well as the sorts of actions to take.’(p.15)

- The evaluation team visited a **private clinic** (Angsamerah Clinic) known to be popular with members of key populations. This clinic operated a very discreet and **fully integrated model of service delivery** with the client staying in one room while s/he is provided with all relevant services. All staff had received training in HIV counselling and SRHR, gender diversity and sexuality issues.
- Among the services available were **STI screening, HIV counselling and testing and ART, SRH-related counselling, gynaecology, mental health, hormonal replacement treatment and PrEP**. The clinic also had a specialist psychiatrist/doctor who was knowledgeable on GBV, although **GBV case were referred** rather than treated in house. Condoms are available free in consulting rooms and the toilets. The clinic does not provide methadone therapy, but has a referral mechanism for those who need methadone.
- **All clients pay, however some clients that belong to KPs who can’t afford to pay receive a discount (funded by USAID)** negotiated through a partnership with certain CSOs. This clinic provided much of the inspiration and initial start-up support for the UNALA project later developed with support from UNFPA in Yogyakarta.
- The evaluation team also visited Puskesmas Jatinegara, i.e. public health centre. This was renowned to be one of the best examples of a puskesmas in the country as a whole. It was also chosen as a pilot institution for the new UNFPA partner notification project.
- **The puskesmas provides a very wide range of services (family planning, dentistry, maternal health, mental health, medical checks for pilgrims, non-communicable diseases, ophthalmology, etc.) spread across 23 service units.** Staff reported that **HIV counselling and testing are only provided in the specific HIV counselling and testing unit.** Elsewhere, doctors would only raise HIV issues if a patient presents with significant symptoms that might be relevant.
- The *Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia* highlighted that ‘The **integration of HIV and sexual and reproductive health services, including STI, in the context of PSTHIV needs special attention, notably at the primary healthcare level.** STI and HIV services must be integrated into sexual and reproductive healthcare, while HIV services should also be integrated into maternal and child healthcare and mental health services for the rehabilitation of drug users.’ (p.50)
- When asked about integration of services, **the puskesmas manager argued that her facility provided ‘one roof’ under which all needs could be met.** Staff reported that two doctors had received training on how to provide friendly services to young people and people from KPs. It was expected that these doctors would act as trainers for the wider staff group, but that had yet to occur.
- The puskesmas staff stated that **condoms** were freely available in the HIV and family planning consultation rooms, however the evaluation team did not find evidence of this supply. At some point in the past, the puskesmas had made condoms available at the security post at the entrance, however this was highlighted and criticised in the media and the clinic managers removed this provision for fear of security issues.

- Site visits to public and private sector clinics and interviews with clinic managers and health workers
- National AIDS Commission, *Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia*, National AIDS Commission, 2015.

Assumption 1.3: As a result, HIV and SRHR services and interventions have been integrated both in health service delivery settings and in behaviour change and communications efforts, especially in relation to contraceptive services and family planning, including for eMTCT.

<ul style="list-style-type: none"> • Among the health workers interviewed at the puskesmas was a volunteer peer support worker, tasked to follow up and support people newly diagnosed HIV positive. Working on her own, this young woman was responsible for supporting around 300 PLHIV in the community. She reported many PLHIV dropping their treatment, and had found it useful to tell people that their ART would keep PLHIV handsome/beautiful. 	
<ul style="list-style-type: none"> • For the Ministry of Health, their ‘triple elimination’ work provides a good example of integration in action. This provides pregnant women with testing for hepatitis, syphilis and HIV. In reality, this is more akin to combined testing than an integrated service since any resulting treatments would be directed to different services/service providers. 	<ul style="list-style-type: none"> • Interviews with Ministry of Health
<ul style="list-style-type: none"> • In efforts to prevent transmission of HIV and syphilis from mother to child, PMTCT services and prevention of congenital syphilis are integrated with maternal and child health services (MCH) (p.1) • Until the end of 2011, there were only 94 PMTCT services (Ministry of Health, 2011), which only covered around 7% of the estimated number of pregnant women who needed PMTCT services. To expand the reach and access to services for the community, the PPIA Program was also implemented by several community institutions (p.7). Of all PMTCT services, the number of services per province reporting in 2019 was 88 services. • ‘almost all of PMTCT services suggest caesarean and infant formula to pregnant women with HIV. Only one doctor who allows “normal” birth and breastfeeding. VL and CD4 test is not performed routinely in pregnant women with HIV so that doctors do not want to take the risk, as well as lactation counselling. Also, unfortunately, puskesmas generally refer pregnant women with HIV to the provincial referral hospital for delivering the baby and even for ARV treatment.” • ‘This makes it difficult for pregnant women who live far from the provincial capital. The complicated postnatal process, including EID test and prophylaxis for infants, has created challenges for women living with HIV who live in the district level. In efforts to prevent transmission of HIV and syphilis from mother to child, PMTCT services and prevention of congenital syphilis are integrated with maternal and child health services (MCH) (p.1) 	<ul style="list-style-type: none"> • Ministry of Health Republic of Indonesia, <i>Program management guidelines for prevention of HIV transmission and syphilis from mother to child</i>, Ministry of Health Republic of Indonesia, 2015 • Ministry of Health Republic of Indonesia, <i>Report on the progress of HIV AIDS and sexually transmitted infections in the first quarter of 2019</i> • Interviews with member of community organisation

Assumption 1.4: UNFPA has supported effective efforts to strengthen the management of supply chains for male and female condoms and lubricants (including in humanitarian settings).

<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Key informant experience and opinion regarding extent to which national capacity in supply chain management (SCM) for HIV-related SRHR commodities (e.g. male and female condoms and lubricants and STI medications) has been enhanced • Reported results on UNFPA support to SCM – including volumes of procurement over time • Experience and views of supply chain managers at national and district level

Assumption 1.4: UNFPA has supported effective efforts to strengthen the management of supply chains for male and female condoms and lubricants (including in humanitarian settings).

Observations	Sources of Evidence
<ul style="list-style-type: none"> • UNFPA Indonesia does not procure condoms nor play an integral role in the condom supply chain for either family planning or HIV prevention. • Since the NAC was dissolved, procurement and distribution of condoms for family planning is the responsibility of BKKBN and procurement and distribution of condoms for HIV has been listed as a role for UNFPA. However, UNFPA has not able to fulfil this role. Initially, UNFPA believed it could procure condoms using its usual channels and procedures, through the Copenhagen office. However, Indonesian regulations made this route impossible. As a result of discussions between UNFPA and MoH, the plan is now to move responsibility for ‘HIV condom’ procurement to the GF PR Spiritia. • During the period covered by the evaluation, UNFPA’s only role re: the HIV condom supply chain has been: <ul style="list-style-type: none"> ○ Fund and support work in 2016 and 2017 to review and then strengthen guidelines for Supply Chain Management (SCM) modelling in 9 districts: Banyuwangi, Pamekasan, Lamongan (East Java) and Kupang Municipality, Kupang District, Sikka, West Manggarai, West Sumba, and Sabu Raijua (East Nusa Tenggara). This work involved partnership with the International Council on Management of Population Programmes (ICOMP) in collaboration with BAPPENAS, IFPPD, Setneg, FBOs, Universities and CSOs. ○ Fund and support the National Population and Family Planning Board (USD195,001 total in 2018) to work in collaboration with Bappenas, IFPPD, Setneg, FBOs, Universities and CSOs to produce a policy brief on improved supply chain modelling. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff, UN agency staff, government officials and members of civil society organisations • File: AWP_ICOMP_2016 • File: AWP BKKBN FINAL – 8 Mar 2018
<ul style="list-style-type: none"> • 2016 ‘Are there integrated supply systems? Fully integrated. Are there integrated ordering systems? Not integrated. Are there integrated monitoring systems? Data not available’ 	<ul style="list-style-type: none"> • Interagency Working Group on SRH and HIV Linkages, <i>HIV and SRHR Linkages Infographic Snapshot Indonesia</i>, IAWG, 2016
<ul style="list-style-type: none"> • UNFPA was working with the NAC to develop a strategy on dual protection. This had reached draft MoU stage by the time the NAC was dissolved. Since then, UNFPA has been unable to progress this issue. • In the current system, the main contribution of UNFPA to improving the condom supply chain is to disseminate information to their GF SSRs to inform relevant authorities across the country that condoms are available and inform them how condoms can be accessed. In September 2019 a different strategy, led by UNAIDS, will begin with an assessment on comprehensive condom programming and then a workshop held in collaboration with the national family planning association (BKKBN) to promote a total market solution in Indonesia. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff

<p>Assumption 1.5: UNFPA has effectively supported efforts to operationalise comprehensive condom programming at global, national and sub-national levels, with emphasis on promotion of the triple protection (HIV, STI and unwanted pregnancies) while encouraging engagement by the private sector – and these have been linked to other initiatives and programmes in HIV such as HIV testing and counselling.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • National HIV and SRHR strategies include reference to Comprehensive Condom Programming (CCP) and its goals/targets • National programmes and strategies address the enabling political and social environment for demand, access and utilization of male and female condoms • Results reports and evaluation findings on CCP programmes in case-study countries • Views of national health authorities • Views/experience of non-governmental service providers, including private sector firms • Views of service providers in government health facilities • Experience of selected clients • Trends in condom use • Met need for family planning both in general teams (percentage of women of reproductive age accessing modern methods) and, where available, more specific indicators such as: • Percentage of adolescents and youth, especially adolescent girls and young women, reporting the use of a condom during their last intercourse) • Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse • Percentage of sex workers reporting the use of a condom with their most recent client • Percentage of men reporting the use of a condom the last time they had anal sex with a male partner 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • See also observations presented under assumption 1.4 above. 	
<ul style="list-style-type: none"> • No documents were provided by UNFPA on comprehensive condom programming. 	<ul style="list-style-type: none"> • Google Drive records
<ul style="list-style-type: none"> • Indonesia’s most recent IBBS data has not been released. The latest available data is from the 2013 IBBS. 	<ul style="list-style-type: none"> • Interviews with UNFPA staff and government officials
<ul style="list-style-type: none"> • The <i>Draft National Strategy and Action Plan 2015-2019 HIV and AIDS Response in Indonesia</i> presents the following data on HIV among sex workers: ‘Behavior change is a challenge among FSW group. The average number of clients of DFSW tends to increase in the 2011 IBBS and 2013 HIV serosurveillance/rapid behaviour survey. The condom use at last commercial sex varies in various places on both surveys. A significant decrease occurs in the proportion of condom use in last commercial sex among DFSW in Denpasar, from 90% to 76.5%, but in the same time period generally a significant increase occurs in the proportion of condom use at last sex in the location of the survey, from 49.6% to 65.5%. There is also a significant reduction of this proportion in Bandung, from 35.1% to 12.5%, and in Malang from 44.9% to 24.2%.’ (p.8) 	<ul style="list-style-type: none"> • National AIDS Commission, <i>Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia</i>, National AIDS Commission, 2015.
<ul style="list-style-type: none"> • It is reported that police sometimes treat possession of a condom as evidence that the person is a sex worker. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff and members of civil society organisations

Assumption 1.5: UNFPA has effectively supported efforts to operationalise comprehensive condom programming at global, national and sub-national levels, with emphasis on promotion of the triple protection (HIV, STI and unwanted pregnancies) while encouraging engagement by the private sector – and these have been linked to other initiatives and programmes in HIV such as HIV testing and counselling.

<ul style="list-style-type: none"> • ‘...the amendment of Indonesia Penal Code as a result of a meeting between the government and the Parliament states that any person without rights and without being asked expressly displays a tool to prevent pregnancy, offers, broadcasts writings or shows to be able to obtain a pessary, can be convicted...’ • ‘...only authorized personnel can demonstrate the prevention of pregnancy in the context of implementing family planning, prevention of communicable diseases, the importance of education and health education’. 	
<ul style="list-style-type: none"> • The <i>Draft National Strategy and Action Plan 2015-2019 HIV and AIDS Response in Indonesia</i> presents the following data on HIV among MSM: <ul style="list-style-type: none"> ○ ‘low consistency of condom use during last anal sex as shown in Surabaya, from 75.9% (IBBS 2011) to 53% (HIV serosurveillance/rapid behaviour survey 2013)’ (p.7) ○ MSM in Papua: ‘Condom use at last commercial sex among men experienced a significant increase from 14.1% (2006 IBBS) to 40.3% (2013 IBBS). This indicates a positive increase in safer sexual behavior.’ (p.9) 	<ul style="list-style-type: none"> • National AIDS Commission, <i>Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia</i>, National AIDS Commission, 2015.
<ul style="list-style-type: none"> • The <i>Draft National Strategy and Action Plan 2015-2019 HIV and AIDS Response in Indonesia</i> does not mention ‘comprehensive condom programming’, ‘triple protection’, ‘dual protection’, ‘female condoms’ or ‘UNFPA’. 	<ul style="list-style-type: none"> • National AIDS Commission, <i>Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia</i>, National AIDS Commission, 2015.
<ul style="list-style-type: none"> • Government of Indonesia’s <i>Family Planning 2020 Commitment</i> does not mention ‘comprehensive condom programming’, ‘triple protection’, ‘dual protection’ or ‘female condoms’ or ‘condoms’. 	<ul style="list-style-type: none"> • Government of Indonesia, <i>Family Planning 2020 Commitment</i>, Government of Indonesia, 2017.
<ul style="list-style-type: none"> • ‘I don’t think condom supply is the issue. There are millions of condoms in the national warehouse. But due to decentralisation the districts need to request the condoms. It seems that many districts do not request or they don’t have the necessary warehouse facilities to store condoms at the district level, or they are not committed to ensure condom supply’. (Note this refers to ‘HIV condoms’ which follow a different supply chain to ‘family planning condoms’). 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • In 2017, when UNFPA was asked to take on the role of SR for the FSW work in the Global Fund programme, UNFPA was also asked to take on responsibility for condom supply for all key populations, i.e. what are sometimes referred to as the ‘HIV condoms’ to distinguish them from condoms distributed through family planning channels. Condom distribution remained in the UNFPA workplan but never took shape due to a clash between UNFPA procurement rules and Indonesian government procurement regulations. It was reported to the evaluation team that the role will transfer to Spiritia, which is already a PR in the Global Fund programme. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff

Assumption 1.5: UNFPA has effectively supported efforts to operationalise comprehensive condom programming at global, national and sub-national levels, with emphasis on promotion of the triple protection (HIV, STI and unwanted pregnancies) while encouraging engagement by the private sector – and these have been linked to other initiatives and programmes in HIV such as HIV testing and counselling.

- The joint assessment visit of the Global Prevention Coalition found that Indonesia had placed emphasis on outreach and HIV testing, but paid ‘limited attention to increasing access and demand’ for condoms’ and across the country there was ‘limited use of contact points with KP to promote condoms.’ (slide 26)

- Global Prevention Coalition, *Joint HIV Prevention Assessment Indonesia*, presentation, Jakarta, 29 September 2017

Assumption 1.6: UNFPA has effectively supported knowledge development and dissemination at global, regional and national level as well as supporting lessons learning and south-south cooperation on strengthening bi-directional linkages between HIV and SRHR and integrating HIV and SRHR services.

Indicators:

- Quantity and type of knowledge products at global, regional levels
- Quality of global knowledge products
- Dissemination activities: volume and frequency; reach
- Reported use of global knowledge products at regional/country level
- Extent of collaboration with HIV research community

Observations

• **UNFPA Indonesia have not supported any activities or produced any products focusing on bi-directional linkages between HIV and SRHR and integrating HIV and SRHR services.**

• In 2016, UNFPA and UNAIDS organised a **visit to Mysore in India to learn about HIV prevention among FSW** with an SRH component. OPSI and BKKBI were involved and were shown ways of reaching SW in the street, and training programmes for SW. In 2017, the Indian organisation visited UNFPA Indonesia partners in Jakarta.

• In 2018, UNFPA made funding available to the **BKKBN (National Population and Family Planning Board)** (USD195,001 total in 2018) in collaboration with BAPPENAS, IFPPD, Setneg, FBOs, Universities and CSOs, for work towards outputs including ‘strengthening right-based, equitable, and quality family planning policies and programmes utilising regional and international partnerships, including south-south co-operation’. This included strategic intervention 3 for UNFPA Indonesia to ‘continue to provide technical assistance to BKKBN, Ministry of State Secretariat, and Faculty of Medicine, Gadjah Mada University to implement South-South and Triangular Cooperation (SSTC) on four main focus, i.e. Strategic Partnership with Muslim Religious Leaders in Family Planning, International Training on Comprehensive Rights Based Family Planning Services, under the Universal Health Coverage (UHC), and Bilateral Cooperation between the Philippines and Indonesia on Family Planning Related issues’.

Sources of Evidence

- Interviews with UNFPA Indonesia staff
- Google Drive records
- Interviews with UNFPA Indonesia staff
- File: AWP BKKBN FINAL - 8 Mar 2018

Assumption 1.7: Linkage and integration of HIV and SRHR has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably key populations. Including in humanitarian settings.

Indicators:

- Observed improvements in client centred services as reported by key informants

<p>Assumption 1.7: Linkage and integration of HIV and SRHR has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably key populations. Including in humanitarian settings.</p>	
<ul style="list-style-type: none"> • Client centred service observed during site visits to service delivery points • Experience/views of organisations representing women, adolescents and youth and key populations • Improvements in access monitored in programme results reports • Increased use of services reported in health information statistics systems (DHIS2) • Client satisfaction survey results such as the UNFPA Supplies annual surveys • Where available, secondary data on aspects of service integration identified in the IAWG indicator list: <ul style="list-style-type: none"> - HIV counselling and testing and family planning integrated - Knowledge of HIV status - Met need for contraception - Sex worker access to services - MSM access to services 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • 'In 2008, the Ministry of Health of the Republic of Indonesia developed a programme for reproductive health (RH) services in disaster situations which was then implemented throughout Indonesia. At that time, the implementation was based on the guideline on reproductive health in disaster situations, translated from the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises international guideline. Since 2014, the guideline has been adapted to suit Indonesia's context with the publication of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations. This MISP for RH guideline was developed based on field experiences and practices in the provision of reproductive health services in crisis situations from the tsunami that struck Aceh in 2004 until more recent disasters in 2017.' (p.2) • In 2017, UNFPA supported the government to update the Operational Guidelines for the MISP. • UNFPA reports that initially, issues for FSW and MSM were not included in the MISP, however they and their partner organisation OPSI are advocating for their inclusion. As a sign of progress, FSW and MSM are now mentioned in the technical guidance. 	<ul style="list-style-type: none"> • https://indonesia.unfpa.org/en/publications/operational-guideline-minimum-initial-service-package-misp-reproductive-health • Ministry of Health Republic of Indonesia, <i>Operational Guideline on the Minimum Initial Service Package (MISP) for Reproductive Health Implementation in Health Crisis</i>, Ministry of Health The Republic of Indonesia, 2017 • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • In 2017, UNFPA reported a range of key achievements in the field of sexual reproductive health and rights, including the adoption of the Minimum Implementation Service Package (MISP) Operational Guidelines into national disaster preparedness policies. The MISP guidelines were written to secure a high degree of integration of HIV<>ARH<>GBV services in humanitarian settings. 	<ul style="list-style-type: none"> • The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2017 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated. • Interviews with UNFPA staff, UN agency staff, government officials and members of civil society organisations
<ul style="list-style-type: none"> • In 2017, UNFPA supported the MoH to develop operational guidelines for a Minimum Initial Service Package called the MISP for reproductive health in 'health crisis', i.e. humanitarian settings. The guidelines include requirements to create a reproductive 	<ul style="list-style-type: none"> • Ministry of Health Republic of Indonesia, <i>Operational Guideline on the Minimum</i>

Assumption 1.7: Linkage and integration of HIV and SRHR has contributed to improved quality-focused and client-centred services and has resulted in increased access by the most-at risk, marginalized and vulnerable, and notably key populations. Including in humanitarian settings.	
health sub-cluster 'headed by a coordinator who is responsible for coordinating the MISP for RH components, including the gender-based violence, prevention of HIV transmission, maternal and neonatal health, logistics, and adolescent reproductive health'. (p. 10) Once the initial 'emergency phase' is concluded, the guidelines state that 'comprehensive reproductive health services should be available as in a non-crisis situation. Comprehensive reproductive health services focus on the provision of a full-range of services in a life cycle approach to meet the need of fetuses, newborns, under 5 five-year-old children, adolescents, adults, and elderly. Services are provided in an integrated manner: promotive, preventive, curative, rehabilitative, and integrated with other programmes (e.g. MNH-FP, IMS-HIV, sexual violence, adolescent reproductive health, etc.). This is to ensure that reproductive health services in normal situations can deliver a one-stop service for a comprehensive intervention through the integrated reproductive health services' (p.56).	<i>Initial Service Package (MISP) for Reproductive Health Implementation in Health Crisis, Ministry of Health The Republic of Indonesia, 2017</i>

Area of Investigation Two: Extent UNFPA support to the HIV response corresponds to the needs of most vulnerable and at risk populations	
Evaluation Question 2: To what extent has UNFPA support to HIV strategies and programmes contributed to meeting the needs of at risk, most vulnerable and marginalized people especially (but not exclusively) adolescents and youth, key populations, women and persons with disabilities?	
Evaluation Criteria	<i>Relevance, Effectiveness, Efficiency</i>
Rationale	UNFPA has joint leadership under the UNAIDS division of labour for the prevention of HIV infection among adolescents and youth and key populations. In addition, UNFPA Strategic Plan, 2018 - 2021) and the guiding principles for UNFPA action in HIV emphasize the principle of No-One Left Behind, and the requirement to focus on meeting the needs of those at risk of HIV infection and most vulnerable.
Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> National HIV strategies, action plans and programmes incorporate policies and promote approaches prioritizing needs of adolescents and youth, women and key populations Operational guidelines for HIV and SRHR programming include measures specifically targeted to meeting needs of adolescents and youth/women/key populations for HIV prevention National strategies and programme documents make specific reference to the evolving nature of the epidemic and its implications for changing needs of adolescents and youth/women/key populations Where available, reported changes in national strategies, action plans, programmes and service guidelines to reflect changes in the epidemic 	

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.

Observations	Sources of Evidence
<ul style="list-style-type: none"> • 'The comprehensive PMTS programme is a model used in the prevention of sexual transmission in a comprehensive, integrated and effective manner in all populations with high vulnerability. It is implemented by deploying the force of the Government (regional work unit), private sector and communities, oriented toward the empowerment of populations with high vulnerability for their self-reliance in HIV prevention'. (p.15) 	<ul style="list-style-type: none"> • Komisi Penanggulangan AIDS, <i>PMTS Paripurna (Comprehensive HIV Prevention Through Sexual Transmission Guidelines) Partnership between Government, Private Sector, Communities and Media</i>, Komisi Penanggulangan AIDS, 2014.
<ul style="list-style-type: none"> • Components of the comprehensive PMTS Paripurna programme are as follows: Component 1: Increased Positive Role of Stakeholders ; Component 2: Behaviour Change Communication ; Component 3: Condoms and Lubricant Supply Management ; Component 4: Management of STIs and HIV (p.19) • After NAC was dissolved, PMTS was partially implemented because the first component which was the responsibility of NAC could not be implemented. 	<ul style="list-style-type: none"> • Komisi Penanggulangan AIDS, <i>PMTS Paripurna (Comprehensive HIV Prevention Through Sexual Transmission Guidelines) Partnership between Government, Private Sector, Communities and Media</i>, Komisi Penanggulangan AIDS, 2014.
<ul style="list-style-type: none"> • The <i>Draft National Strategy and Action Plan 2015-2019 HIV and AIDS Response in Indonesia</i>, which has an uncertain status, contained a clear focus on HIV prevention prioritising the needs of KPs: 'The spread of HIV is curbed by the scaling up of effective prevention programmes. These should cover high-risk sexual relations and the use of non-sterile injecting equipment. Special attention should also be given to preventing new HIV infections among MSM. HIV prevention in key populations in several high-performance regions has been made possible by a combination of the following factors: a) individual commitment; b) client-friendly services; c) stakeholder engagement; d) active participation by the local health office and primary health centres (puskesmas) at the provincial and district/city level and cooperation with law enforcement agencies and key figures in brothel complexes or targeted locations; e) NGO and CSO engagement in the promotion of condom use and monitoring programmes aimed at increasing condom use; and f) community mobilization through peer-based interventions.'(p.31) 	<ul style="list-style-type: none"> • National AIDS Commission, <i>Draft National Strategy and Action Plan 2015-2019: HIV and AIDS Response in Indonesia</i>, National AIDS Commission, 2015.
<ul style="list-style-type: none"> • 'The new phase of Global Fund HIV funding that commences in early 2016 is focused on supporting the National HIV Strategy and Action Plan 2015-2019. The new Strategy aims to more tightly focus Indonesia's HIV efforts (outside Tanah Papua) on the key populations – sex workers, men who have sex with men and transgender people, people who inject drugs – and on the early treatment, care and support for all PLHIV' (p.2) 	<ul style="list-style-type: none"> • <i>UNFPA Project Document: Maternal Health, HIV SRH Linkages, and MISIP (IDN09MHJH) (File Global Fund 2016-2017)</i>, 2017.
<ul style="list-style-type: none"> • 'Almost all our efforts in the area of HIV are covered by the Global Fund project' 	<ul style="list-style-type: none"> • Interview with UNFPA Indonesia staff

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.

<ul style="list-style-type: none"> • UNFPA’s main activity relating to HIV prevention during the period covered by the evaluation is implementation of the female sex workers (FSW) strategy under the Global Fund – New Funding Model (NFM) programme for 2016 – 2017 and New Funding Model Continue (NFMc) 2018 – 2020. This role began through an agreement with the National AIDS Commission (up to 2017) and subsequently continued with UNFPA acting as a sub-recipient to the MOH. The FSW strategy has the following outputs: <ol style="list-style-type: none"> 4) Technical capacity delivered across the Sub-Recipients (SRs) and Implementation Units (IUs) for the implementation of the Sex Workers Strategy and new outreach model – National Level, Provincial and District level 5) TA/Mentoring delivered to the SRs in the development of the testing and mentoring model and HIV – SRH linkages for IUs, Peer Leaders (PLs) and Peer Educators (PEs) 6) Support provided to the high functioning IUs (Districts) and establish them as learning sites to foster scale-up’ • The FSW work also requires UNFPA to manage grants to 4 sub-sub-recipients (SSRs) namely PKBI Jakarta, Kalandara Foundation in Semarang, Central java, Kerti Praja foundation in Bali and PKBI Papua • The FSW programme is implemented in 88 districts (out of a national total of 514 districts) and across 56 implementation units by OPSI, the sex workers network organisation. • Programmatically, the FSW strategy is narrow. It targets FSW (and not other KPs) and focuses on ‘test and treat’, i.e. recruiting FSW for HIV testing and treatment for FSW testing HIV+. It does not constitute a national HIV prevention strategy itself, is not part of a comprehensive national HIV prevention strategy, and is not part of a strategy to ensure access to integrated HIV and SRHR services for adolescents and youth, key populations and women. 	<ul style="list-style-type: none"> • Outcome 02: Prevention of STIs and HIV infection—among sex workers and their clients, men who have sex with men and people who inject drugs—reduced with better outreach and more effective behavior change delivered through CIDHS (File: UBRAF Reporting 2016_25Jan (2) asr_osm) • <i>Indonesia Country Update</i> provided by UNFPA
<ul style="list-style-type: none"> • During the period 2016-18, UNFPA agreed to support MoH with the following interventions: <ul style="list-style-type: none"> ○ ‘Technical capacity delivered across MoH, Sub-Recipients (SRs) and Implementation Units (IUs) for the implementation of the Sex Workers Strategy and the new outreach model – at national, provincial, and district levels ○ Technical assistance provided to SRs in the development of the testing and mentoring model and HIV – SRH linkages for IUs, Peer Leaders (PLs) and Peer Educators (PEs) ○ Support provided to high functioning IUs (Districts) to establish them as learning sites to foster scale-up ○ Support the transition of NAC to MoH for the implementation of FSW programme.’ (p.2) • ‘UNFPA interventions to the implementation of the Female Sex Workers programme in Indonesia are mainstreamed in the activities executed by 4 SRs (PKBI DKI Jakarta – Region 1, Yayasan Kalandara – Region 2, Yayasan Kerti Praja – Region 3, PKBI Papua – Region 4). The activities for this programme are defined yearly between MoH, UNFPA, SSRs with adjustment to the updated local needs to implement the peer to peer approach for key affected population’. (p2) 	<ul style="list-style-type: none"> • UNFPA Indonesia, <i>Final Report January - December 2018 Technical Assistance and Capacity Development to Support Implementation of the Global Fund Programme on Female Sex Workers</i> (Files: GF_MOH_2018_Annual Report_TimShared with Annex_2019_03_20_All)

<p>Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.</p>	
<ul style="list-style-type: none"> In 2018, it was reported that ‘Together with MoH, the HIV prevention programme implemented in 88 districts/municipalities across 30 provinces in Indonesia for key-affected population reached 82,702 female sex workers with 34,009 FSWs tested (yielding 1,241 case findings and 490 FSWs accessed ARV treatment)’. (p.52) 	<ul style="list-style-type: none"> UNFPA, <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.
<ul style="list-style-type: none"> Linked to and based around the Global Fund FSW programme, UNFPA Indonesia has attempted to improve the HIV prevention footprint of the programme by: <ul style="list-style-type: none"> In 2016, UNFPA supported a study by the AIDS Research Centre at Atma Jaya University on intimate partner notification, i.e. PLHIV telling their partners of their status. This evolved into a programme of work with civil society partners to develop guidelines and models for partner notification. The goal of this programming is to encourage index patients to disclose their HIV status and encourage partners to test themselves and/or take appropriate steps to avoid infection, and to improve adherence on ART for PLHIV. ‘Provision of evidence on HIV transmission to intimate partners resulted in a government-led pilot to improve outreach policies and programmes among key affected populations’ in 2016 (<i>The Government of the Republic of Indonesia and UNFPA: 2016 Key Achievements</i> p.2) In 2017, UNFPA published a lessons learnt document. This was based on a study of the peer outreach programme supported by UNFPA to reach women in sex work with HIV testing and HIV prevention, and to link newly diagnosed HIV+ sex workers to treatment care and support. The fifth lesson learnt focused on partner notification: ‘Partner notification may be neglected when case management is separated from HIV prevention outreach. Women in sex work newly diagnosed with HIV need to consider partner notification as a key part of the adjustment to living successfully with HIV. When the ‘back-end’ of the HIV services cascade is neglected in HIV prevention outreach, the issue of partner notification is also neglected. When the HIV services cascade is separated by organization (i.e. that HIV case management is provided by a separate organization to the HIV prevention outreach activity) this means that partner notification is neglected. At present, it is unclear how partner notification is managed in the national HIV program for sex workers. The lesson learned is that case management needs to be integrated into HIV prevention outreach services so that partner notification can be managed as a priority.’ (<i>A New Approach to HIV Prevention for Women in Sex Work in Indonesia: Lessons Learned from Implementation</i>, p.10.) Making progress towards ‘National guideline on the Prevention of HIV/STI among intimate partner is endorsed. Endorsement for the Implementation Manual on the prevention of HIV/STI among intimate partner’ in 2017 (File: Updated2018_Annex_2b_CPAP_PMME All Final p.5) 	<ul style="list-style-type: none"> The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2016 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated. AIDS Research Centre, <i>Field Study Report. Risk Factors and Protection against HIV Transmission in Heterosexual Intimate Couples in Indonesia</i>, Universitas Katolik Indonesia, 2016. UNFPA Indonesia, <i>A New Approach to HIV Prevention for Women in Sex Work in Indonesia: Lessons Learned from Implementation</i>, Jakarta: Indonesia, 2017. File: Updated2018_Annex_2b_CPAP_PMME All Final UNFPA, <i>HIV Case Management for Female Sex Workers in Indonesia, 2017. A Model of Practice</i>, UNFPA, 2017. <i>UBRAF Country Summary Report 2018 Indonesia</i> Interviews with UNFPA Indonesia staff and members of civil society organisations

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.

<ul style="list-style-type: none"> ○ In 2017, developing ‘a model of HIV case management or casework to be used in Indonesia’s Ministry for Health’s HIV programming response to the sexual and reproductive health needs of female sex workers. The document is a guide to support community sector partners in the delivery of HIV case management training, supervision and service delivery to newly diagnosed female sex workers across Indonesia.’ (<i>HIV Case Management for Female Sex Workers in Indonesia, 2017. A Model of Practice</i> p.3) ○ Supporting the development of an ‘outreach implementation manual for FSW. Through technical assistance and programme implementation, UNFPA significantly increased HIV testing and treatment to FSW’ (<i>UBRAF Country Summary Report 2018 Indonesia</i> p.1) ○ In 2019, UNFPA will start working with JIP, the organisation representing PLHIV in Indonesia, to trial the guidelines produced for intimate partner notification. The piloting will take place in 5 cities and focus on the partners of FSW, PLHIV and the female partners of MSM. According to JIP, the focus of the Indonesian response to HIV has been KPs for a decade, but the partners have tended to be forgotten. They note that it was UNFPA that raised the issue of partner notification. 	
<ul style="list-style-type: none"> ● Since 2017, UNFPA Indonesia has been supporting Yayasan Kerti Praja Bali as part of the GF Financed programme. YKP is one of the sub-sub-recipients of UNFPA. UNFPA supports YKP in terms of planning, technical inputs into implementation, strengthening governance, financial management, M&E systems development, and have worked closely with them to develop a new outreach model for FSW. YKP assess this support package to be relevant and good quality, although they advocate more of a differentiated approach. ‘UNFPA should take account of differences in capacity and structures and conditions. We cannot have the same approach across all districts’. 	<ul style="list-style-type: none"> ● Interviews with members of civil society organisations
<ul style="list-style-type: none"> ● UNFPA started with the NAC in 2015 on the issue of male involvement in the PMTS Paripurna (<i>Comprehensive HIV Prevention Through Sexual Transmission</i>) programme. In particular, male involvement targeted seafarers and the clients of sex workers, both high risk groups of men. Implementation of the model started in 2016, and the <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i> noted that ‘... with support from UNFPA, the National Framework on Male Involvement was developed and endorsed by MoWECF and has been used as a guidance for male engagement in various sectoral programmes on GBV prevention and SRHR.’ (p.71) However, implementation stalled in 2017 when the NAC was abolished. UNFPA point out that they have an agreed model ready to use but currently, in the absence of the NAC, there is no suitable implementing structure. In discussions linked to the Global Prevention Coalition, UNFPA and UNAIDS have agreed to try and persuade MoH to take full ownership of this policy and re-start implementation. 	<ul style="list-style-type: none"> ● Interviews with UNFPA Indonesia staff ● UNFPA, <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.
<ul style="list-style-type: none"> ● In 2016, UNFPA recorded a series of achievements linked to GBV. These included: <ul style="list-style-type: none"> ○ Producing a ‘Policy brief on mechanism of health sector response to GBV’ (p.22) 	<ul style="list-style-type: none"> ● File: Updated2017_Annex_2b_CPAP_PMME

Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.

<ul style="list-style-type: none"> ○ Conducting a ‘Gap analysis on male involvement in SRH and GBV’ (p.26) ○ Investing in a pilot for the ‘P4P’ in Papua by developing ‘manuals on engaging young people to change social norms and promote gender equitable relationships available’ and training facilitators to facilitate sessions based on the manuals. (p.26) ○ ‘Final draft of the situational analysis on the existing GBV prevention and response that will be used as the main reference to develop technical guidelines for GBV prevention and response in humanitarian crisis is available’ (p.27) 	
<ul style="list-style-type: none"> ● The Asia Pacific regional initiative on Partners for Prevention (P4P), involves UNFPA, UNDP, UNWOMEN and UNV, working with boys and men to prevent gender-based violence. In Indonesia, UNFPA was involved in developing and implementing the programme, working with UN partners as well as with the national implementing partners and agencies. HIV issues were incorporated into the boys and men prevention module on GBV. 	<ul style="list-style-type: none"> ● Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> ● In 2018, UNFPA reported that ‘Together with MoH, the HIV Prevention programme implemented in 88 districts/municipalities across 30 provinces in Indonesia through the peer-to-peer outreach model for key-affected populations (female sex workers), reaching 82,702 FSWs and resulting in 34,009 FSWs who have been tested. These results yielded 1,241 FSW HIV case findings, 490 FSWs accessed ARV treatment.’ (p.2) 	<ul style="list-style-type: none"> ● The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2018 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated.
<ul style="list-style-type: none"> ● In 2018, UNFPA reported the key achievement that ‘In collaboration with MoH, local government, and private sector in Yogyakarta, UNALA provided youth-friendly SRH services to fill the gap in access to services through providing youth-friendly services in the private sector, reaching over 3,400 youths aged 15-24’ (p.3) It is important to note that the design and operation of the UNALA initiative does not address HIV. 	<ul style="list-style-type: none"> ● The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2018 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated. ● Interviews with UNFPA Indonesia staff and members of civil society organisations
<ul style="list-style-type: none"> ● UNFPA lobbied for and supported the development of the intimate partner transmission guidelines. This began as a pilot but was subsequently endorsed as a national strategy. In December 2017, MoH changed counselling guidelines to take into account partner notification. For UNFPA this broadens their ongoing FSW work to bring others into the circle covered by HIV prevention initiatives. In particular, the push for intimate partner notification targets women at risk of HIV who are partners of men living with HIV (i.e. primarily PLHIV or MSM). It also seeks to target the male partners of FSW and male partners of women living with HIV. UNFPA present this as a good example of a pilot initiative arising from current work, which is then brought upstream to national policy. 	<ul style="list-style-type: none"> ● Interviews with UNFPA Indonesia staff

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<ul style="list-style-type: none"> UNFPA documentation reported a partnership in 2016-17 with the Directorate General of Public Health, MoH, Ministry of Education and Culture, Ministry of Women’s Empowerment and Child Protection (MoWCEP) in collaboration with civil society organisations and diverse other stakeholders for ‘mapping of policies, practise, and data availability on SRHR among persons with disabilities’ and ‘secondary analysis of national data sets on SRHR among persons with disabilities’. (p.2) The status of these initiatives is unclear, they were not know to staff interviewed. 	<ul style="list-style-type: none"> <i>UNFPA Project Document: Maternal Health, HIV-SRHR Linkages, and MISP</i> (File: Final MYWP Dirgen Public Health MOH 2016-2017) Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> UNFPA Indonesia’s 2016 Annual Report summarised their work as follows: ‘UNFPA interventions are focused to address the high maternal mortality ratio, stagnating family planning programme, high rate of HIV/AIDS cases in key populations, adolescent pregnancies, and unacceptable gender-based violence and harmful practices (including relatively high child marriage and female genital mutilation)’. (p.2) 	<ul style="list-style-type: none"> <i>UNFPA, Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020, Annual Report 2016</i>, UNFPA, 2017.
<ul style="list-style-type: none"> In 2016, the results of the new outreach model under the GF-funded FSW programme were reported as follows (quoted verbatim): <ul style="list-style-type: none"> ‘Stressed Female Sex Worker community empowerment & mobilizing their active role for HIV response. Used a coaching approach by national NGOs toward peer leaders and peer educators, as opposed to the top-down managerial approach. Encouraged high-risk populations FSWs and clients to actively do HIV tests & seek services. Undertook real time mapping of FSW mobility – who were now scattered across the supported cities following the closure of establishment localization sites. Reaching out to these FSWs helped ensure they had access to comprehensive services’. (p.13) 	<ul style="list-style-type: none"> <i>UNFPA, Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020, Annual Report 2016</i>, UNFPA, 2017.
<ul style="list-style-type: none"> UNFPA has advocated for the integration of HIV and SRH with cervical cancer initiatives. The MoH has a maternal health strategy including cervical cancer. UNFPA is advocating for SOPs for service providers to link cervical cancer and HIV and STIs. Cervical cancer could then provide an entry point to STI/HIV diagnosis and treatment. Under the GF financed programme, FSW are allowed to access a cervical cancer test for free in puskesmas. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> ‘UNFPA has been able to advocate the government to increase their attention and commitment to sensitive issues including provision of SRH information and services for young people although this is not an area that is considered in line with GoI’s policy.’ (p.44) 	<ul style="list-style-type: none"> <i>UNFPA, Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.
<ul style="list-style-type: none"> ‘Overall, MTR finds that CP9 is: “highly relevant to the needs of the target group members and UNFPA has been successful in developing effective partnerships with partner government and NGOs. UNFPA is successful in aligning CP9 with relevant SDGs, ICPD agenda, national development goals, plans and priorities of the country” ‘ (p.36) 	<ul style="list-style-type: none"> <i>UNFPA, Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of</i>

<p>Assumption 2.1: UNFPA has been effective in promoting and supporting national HIV strategies and programmes which prioritize the needs of adolescents and youth, key populations and women for access to integrated HIV and SRHR services (while recognizing the changing nature of the epidemic and its implications) and emphasize the use of quality condoms and lubricants for HIV prevention. This includes meeting the needs of those marginalized for social and economic reasons other than age, gender or membership in a key population.</p>	
	<p><i>Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.</p>
<ul style="list-style-type: none"> • ‘We really don’t have national guidelines for the HIV programme overall. Most of the work is related to the Global Fund project. We don’t have a national prevention package’. 	<ul style="list-style-type: none"> • Interviews with UN agency staff
<ul style="list-style-type: none"> • UNFPA is trying to improve PMTCT by advocacy to MoH. In Indonesia, PMTCT as such focuses on prong 3 (prevention of HIV transmission from HIV positive mothers to the infants), so in 2016, UNFPA was partnering with Indonesian Positive Women’s Association (IPPI) and the sex worker network OPSI that other 2 prongs are also important (i.e. primary prevention of HIV infection among women of child bearing age and prevention of unintended pregnancies among HIV-positive women). 	<ul style="list-style-type: none"> • Interviews with UNFPA staff
<p>Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Where available, survey results regarding changing knowledge of HIV causes and prevention among adolescents and youth (e.g. percentage of women and men aged 15-24 who correctly identify both ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission) • Experience and view of partners implementing interventions targeting adolescents and youth – including ministry of education staff responsible for formal and non-formal education • Guidelines and teacher training curricula for comprehensive sexuality education include HIV prevention components • Observation of adolescents and youth friendly service outlets for HIV prevention and SRHR • Experience and views of adolescents and youth attending service outlets 	
<p>Observations</p>	<p>Sources of Evidence</p>
<ul style="list-style-type: none"> • Adolescents aged 15-19 who have comprehensive knowledge of HIV: 9% females, 4% males (2016). • Schools that provided skills-based HIV and sexuality education in the previous academic year: Data not available (2016). 	<ul style="list-style-type: none"> • Interagency Working Group on SRH and HIV Linkages, <i>HIV and SRHR Linkages Infographic Snapshot Indonesia</i>, IAWG, 2016
<ul style="list-style-type: none"> • ‘In partnership with MoH, UNFPA contributed to formulating the 2017 – 2019 NAP on School Aged Children and Adolescent Health, to address specific health needs of young people and to carry out evidence-based advocacy to the Ministry of Education and Culture for the inclusion of SRH education in the national curriculum. To ensure youth well-being in humanitarian settings, UNFPA helped develop the National Guideline on SRH and Youth Involvement in Humanitarian Settings for service providers.’ (p.15) 	<ul style="list-style-type: none"> • UNFPA, <i>Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020, Annual Report 2016</i>, UNFPA, 2017.
<ul style="list-style-type: none"> • In 2018, UNFPA Indonesia’s adolescent sexual and reproductive health team supported the Ministry of Health to review the module on adolescent reproductive health (ARH) for teachers and develop a national action plan on adolescent health (document and official title are in local language). UNFPA advocated for HIV prevention and comprehensive sexual education to 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff

Assumption 2.2: UNFPA has been able to advocate for and support the implementation of Comprehensive Sexuality Education for in-school and out-of-school adolescents and youth (adolescents and youth) alongside behaviour change communications efforts aimed at adolescents and youth with the goal of preventing HIV infections.

<p>be included. The ‘adolescent reproductive health’ section of the action plan which passed approval by the MoH, Ministry of Religious Affairs and the Ministry of Education is based on the <i>International technical guidance on sexuality education An evidence-informed approach revised edition</i>, published by UNESCO in 2018. This means that many SRHR and HIV and GBV issues are covered, including body image, HIV prevention, anatomy, gender equality, how to say “no”, GBV, stigma and discrimination and some contraceptive information for students in senior high school.</p> <ul style="list-style-type: none"> • The Indonesian adolescent health action plan does not cover issues of sexual orientation and gender identity. This was as a result of a backlash from teachers and religious leaders A UNFPA staff member noted ‘People tend to panic if we use the word “sexual”. • The action plan targets adolescents in-school. UNFPA plans to work with government to address the needs of out-of-school adolescents in 2020. 	
<ul style="list-style-type: none"> • ‘We have all been too soft in recent years. UNFPA must be brave to talk to government. They have been doing scattered things, but there is no clear strategy. This is true of the UN system more generally. We must all use evidence and science to make arguments’. 	<ul style="list-style-type: none"> • Interviews with members of civil society organisations
<ul style="list-style-type: none"> • In 2019, the UNFPA youth and adolescent sexual health team plan to work on a CSE for out of schools concept note. They expect to receive support from the regional APRO for this work out of school and plan to develop the work in partnership with Inti Muda, a civil society organisation formed by and focusing on the needs of young KPs. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff

Assumption 2.3: National governments respond positively to UNFPA advocacy and technical support efforts by allocating resources, altering policies and implementing programmes intended to ensure access to effective HIV and SRHR services that meet the needs of adolescents and youth, key populations, women – and other at risk and marginalized groups (also applies to evaluation question 3).

<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Experience and view of partners implementing interventions targeting adolescents and youth/women/key populations • Guidelines, service protocols and manuals for HIV prevention services integrated into SRHR address needs of adolescents and youth/women/key populations • Level of national government funds allocated to comprehensive sexuality education for adolescents and youth. • Examples of changes in policies and laws to include provisions for quality and human-rights-based HIV and SRHR services that meet the needs of adolescents and youth, key populations and women • Observation of adolescents and youth friendly service outlets for HIV prevention and SRHR • Experience and views of adolescents and youth attending service outlets • Observation of integrated HIV and SRHR services targeted to adolescents and youth/women/key populations • Experience and views of organisations representing (and led by) adolescents and youth/women/key populations)

Assumption 2.3: National governments respond positively to UNFPA advocacy and technical support efforts by allocating resources, altering policies and implementing programmes intended to ensure access to effective HIV and SRHR services that meet the needs of adolescents and youth, key populations, women – and other at risk and marginalized groups (also applies to evaluation question 3).	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • 'The Community-Led Mapping Technical Guideline was developed by a national team that consisted of MoH, NAC, UNFPA, UNAIDS, OPSI, and IPPA DKI Jakarta. The main objective of this activity was to identify new hot spots and to develop a profile of these new hot spots to be used to plan interventions. Based on SR reports in the fourth semester national evaluation, the community-led mapping method was useful for identifying, and reaching new hot spots' • The guideline was developed in 2017 and implementation started in 2018. 	<ul style="list-style-type: none"> • <i>Indonesia Country Update</i> provided by UNFPA
<ul style="list-style-type: none"> • In 2018, UNFPA reported a key achievement that 'Together with CSOs and BKKBN, multi-sector dialogue conducted to advocate for revisions towards the draft Penal Code particularly on issues that will severely hamper sexual and reproductive health (including maternal health, family planning, and HIV prevention).' • 'Together with KOMNAS Perempuan, policy advice provided to parliamentarians and CSOs, to advocate for revisions towards the draft Penal Code on issues that will hamper gender equality specifically on sexual violence'. (p.4) • One of the proposed revisions to the penal code, which UNFPA has advocated to strike out, would make it illegal for anyone other than a recognised health official to engage in condom promotion. • At the time of the country case study mission to Indonesia, the revisions to the penal code had not been finalised by parliament. It was, however, reported that revisions could be ratified as early as September 2019. 	<ul style="list-style-type: none"> • The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2018 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated. • Interviews with UNFPA Indonesia staff and members of civil society organisations
<ul style="list-style-type: none"> • In 2019, UNFPA will partner with the Directorate General of Disease Prevention and Control (P2PML) in the MoH and CSOs to finalise guidelines on prevention HIV among intimate partners and begin pilot implementation of the planned approach for HIV prevention among intimate partners. 	<ul style="list-style-type: none"> • File: 2019_WP_P2P_Final
<ul style="list-style-type: none"> • One respondent argued that in Indonesia 'advocacy has become completely reactive. It is now all about harm reduction, not about the positive changes we would like to see'. 	<ul style="list-style-type: none"> • Interviews with members of civil society organisations
<ul style="list-style-type: none"> • UNFPA 2018 workplans include a partnership with MoH (USD76,388 allocated in 2018), in collaboration with CSOs, Universities, IBI, other UN Agencies, Ministry of Education and Culture, NGOs and youth networks working to achieve output of 'improved policies and programmes to fulfil the rights and needs of adolescents and youth, including in humanitarian settings'. The programme of work includes targets to conduct 'annual review of the implementation of the National Action Plan on School Aged Child and Adolescent Health 2017-2019', 'annual review of the use of the Module on Adolescent Reproductive Health (ARH) for teachers', 'concept note on public private partnerships to improve adolescent reproductive health through UNALA available' 'partnerships with local government, CSOs, and private sector in 5 districts (Yogyakarta City, Sleman District, Bantul District, Kulon Progo District and Gunung Kidul District) for UNALA established', and 'UNALA model implemented in 5 districts (Yogyakarta City, Sleman District, Bantul District, Kulon Progo District and Gunung Kidul District)'. 	<ul style="list-style-type: none"> • File: AWP MOH FINAL - 8 Mar 2018

Assumption 2.3: National governments respond positively to UNFPA advocacy and technical support efforts by allocating resources, altering policies and implementing programmes intended to ensure access to effective HIV and SRHR services that meet the needs of adolescents and youth, key populations, women – and other at risk and marginalized groups (also applies to evaluation question 3).

<ul style="list-style-type: none"> It should be noted that these collaborations do not contain any substantial focus on HIV as a standalone topic, integration of HIV<>SRH<>GBV, or a strong rights focus for adolescents and youth. 	
<ul style="list-style-type: none"> 'In 2008, the Ministry of Health of the Republic of Indonesia developed a programme for reproductive health (RH) services in disaster situations which was then implemented throughout Indonesia. At that time, the implementation was based on the guideline on reproductive health in disaster situations, translated from the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises international guideline. Since 2014, the guideline has been adapted to suit Indonesia's context with the publication of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations. This MISP for RH guideline was developed based on field experiences and practices in the provision of reproductive health services in crisis situations from the tsunami that struck Aceh in 2004 until more recent disasters in 2017.' (p.2) In 2017, UNFPA supported the government to update the Operational Guidelines for the MISP. UNFPA reports that initially, issues for FSW and MSM were not included in the MISP, however they and their partner organisation OPSI are advocating for their inclusion. As a sign of progress, FSW and MSM are now mentioned in the technical guidance. 	<ul style="list-style-type: none"> https://indonesia.unfpa.org/en/publications/operational-guideline-minimum-initial-service-package-misp-reproductive-health Ministry of Health Republic of Indonesia, <i>Operational Guideline on the Minimum Initial Service Package (MISP) for Reproductive Health Implementation in Health Crisis</i>, Ministry of Health The Republic of Indonesia, 2017 Interviews with UNFPA Indonesia staff

Assumption 2.4: UNFPA has effectively supported coalitions and networks of adolescents and youth, key populations and women to engage meaningfully and advocate for national policies and programmes which prioritize access to effective integrated HIV and SRHR services (also applies to evaluation question 3).

<p><u>Indicators:</u></p>	
<ul style="list-style-type: none"> Workplans illustrate direct support of networks Narrative reports of network activities illustrate role of UNFPA support Examples of network advocacy for integrated HIV and SRHR services Experience and views of UNFPA staff/network representatives/national authorities 	

Observations	Sources of Evidence
<ul style="list-style-type: none"> In its role as a sub-recipient of a GF grant, UNFPA on-grants to OPSI, the sex workers' network organisation. UNFPA's financial and technical support is greatly appreciated by OPSI. Over time, UNFPA has supported OPSI on the integration of a human rights-based approach in their work through regular mentoring, through help with proposal writing, and by supplying interpreters. UNFPA has helped OPSI to provide input to their community research assessing health service providers providing SRH including HIV services to FSW. This was key populations research, funded by the regional network of sex workers. Mentoring from UNFPA has also helped to make sure that OPSI is fluent on sexual orientation and gender identity issues and have integrated SOIG issues into their SRH training materials, which is highly relevant because they represent TG and MSW as well as FSW. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff Interviews with members of civil society organisations

Assumption 2.4: UNFPA has effectively supported coalitions and networks of adolescents and youth, key populations and women to engage meaningfully and advocate for national policies and programmes which prioritize access to effective integrated HIV and SRHR services (also applies to evaluation question 3).

<ul style="list-style-type: none"> • In 2018, UNFPA supported OPSI to develop an advocacy plan to react to government action closing brothels. This used evidence from a review that had been conducted into the impact of on HIV and health and security issues for sex workers the brothel closure initiative. • However, OPSI reported that its main support to build advocacy capacity and to undertake advocacy comes from the Partnership to Inspire, Transform and Connect the HIV response (known as the PITCH programme) and from Bridging the Gaps (both initiatives primarily funded by the Netherlands Ministry of Foreign Affairs) and from Aidsfonds, a Dutch international NGO. • A representative of OPSI stated ‘UNFPA really put us in a strategic position. They really empower us and involve us. They know the MOH really want us to be involved and they make that happen’. • In 2018, UNFPA supported OPSI to develop booklet of HIV and SRHR and also booklet of GBV, HIV and Human Rights. 	
<ul style="list-style-type: none"> • UNFPA staff have close relationships with many of the other coalitions and networks of key populations (including PLHIV, female sex workers, young key populations, gay men and MSM organisation). These relationships are primarily at a personal level rather than organised as part of the UNFPA country programme implementation and they do not seem to be explicitly focused on building advocacy capacity, but rather provision of emotional and technical support. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff and members of civil society organisations
<ul style="list-style-type: none"> • One senior manager of a civil society organisation noted that many UN agencies have become sub-recipients of the GF financed programme. This, he argued, places UN agencies working closely with government, but not necessarily close to the key communities and community groups in the HIV response. His concern is that once GF money ends, support to the community response will collapse and that Indonesia is short of actors willing and able to engage in advocacy to government on tricky issues such as stigma reduction, challenging discrimination, decriminalisation and the role and value of the community response within an explicitly multisectoral response. His argument is that this is a critical time for building advocacy capacity among coalitions and networks of adolescents and youth, key populations and women. 	<ul style="list-style-type: none"> • Interviews with members of civil society organisations
<ul style="list-style-type: none"> • ‘In 2008, the Ministry of Health of the Republic of Indonesia developed a programme for reproductive health (RH) services in disaster situations which was then implemented throughout Indonesia. At that time, the implementation was based on the guideline on reproductive health in disaster situations, translated from the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises international guideline. Since 2014, the guideline has been adapted to suit Indonesia’s context with the publication of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations. This MISP for RH guideline was developed based on field experiences and practices in the provision of reproductive health services in crisis situations from the tsunami that struck Aceh in 2004 until more recent disasters in 2017.’ (p.2) • In 2017, UNFPA supported the government to update the Operational Guidelines for the MISP. • UNFPA reports that initially, issues for FSW and MSM were not included in the MISP, however they and their partner organisation OPSI are advocating for their inclusion. As a sign of progress, FSW and MSM are now mentioned in the technical guidance. 	<ul style="list-style-type: none"> • https://indonesia.unfpa.org/en/publications/operational-guideline-minimum-initial-service-package-misp-reproductive-health • Ministry of Health Republic of Indonesia, <i>Operational Guideline on the Minimum Initial Service Package (MISP) for Reproductive Health Implementation in Health Crisis</i>, Ministry of Health The Republic of Indonesia, 2017 • Interviews with UNFPA Indonesia staff

<p>Assumption 2.5: UNFPA has been effective in supporting the implementation of programming tools for provision of accessible and effective HIV and SRHR services for adolescents and youth, key populations and women (<i>also supports evaluation question 3</i>). Further, service providers have the capacity to provide these services.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> Quantity and content of programming tools Examples of dissemination/training efforts for health facility staff using the programming tools supported by UNFPA Evidence that training in linking and integrating HIV into SRHR has been accompanied by measures addressing incentives, equipment, supplies and infrastructure as needed. 	
<p>Observations</p>	<p>Sources of Evidence</p>
<ul style="list-style-type: none"> In its first iteration, the FSW programme noted a gap between numbers of FSW knowing their HIV positive status, and numbers of FSW starting on ART. To try and close this gap, UNFPA worked with stakeholders to design a new case management approach. This seeks to better coordinate relevant services and stakeholders to simplify and speed up initiation of ART, and to support retention in care and continuation of treatment. 	<ul style="list-style-type: none"> Interview with UNFPA Indonesia staff UNFPA, <i>HIV Case Management for Female Sex Workers in Indonesia, 2017. A Model of Practice</i>, UNFPA, 2017.
<ul style="list-style-type: none"> As noted above, the Indonesian Government plans that all brothels will be closed before 2020. This means that the traditional strategies for reaching sex workers – at their place of work - are increasingly ineffective. As sex workers shift to working in new ways – reportedly focused on use of social media and mobile phones, UNFPA has been involved in discussions with partners to change strategy. The result was the development of an outreach implementation manual for FSW. UNFPA report significantly increased HIV testing and treatment to FSW as a result of their technical assistance and programme implementation using the new manual. The new approach is to increase the number of sex workers among the outreach workers, to create a more peer-led approach. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff and members of civil society organisations UBRAF <i>Country Summary Report 2018 Indonesia</i> UNFPA, <i>Outreach Implementation Manual for Female Sex Workers Programme in Indonesia</i>. Final Version. UNFPA (undated)
<ul style="list-style-type: none"> 'In 2008, the Ministry of Health of the Republic of Indonesia developed a programme for reproductive health (RH) services in disaster situations which was then implemented throughout Indonesia. At that time, the implementation was based on the guideline on reproductive health in disaster situations, translated from the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises international guideline. Since 2014, the guideline has been adapted to suit Indonesia's context with the publication of the Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations. This MISP for RH guideline was developed based on field experiences and practices in the provision of reproductive health services in crisis situations from the tsunami that struck Aceh in 2004 until more recent disasters in 2017.' (p.2) In 2017, UNFPA supported the government to update the Operational Guidelines for the MISP. UNFPA reports that initially, issues for FSW and MSM were not included in the MISP, however they and their partner organisation OPSI are advocating for their inclusion. As a sign of progress, FSW and MSM are now mentioned in the technical guidance. 	<ul style="list-style-type: none"> https://indonesia.unfpa.org/en/publications/operational-guideline-minimum-initial-service-package-misp-reproductive-health Ministry of Health Republic of Indonesia, <i>Operational Guideline on the Minimum Initial Service Package (MISP) for Reproductive Health Implementation in Health Crisis</i>, Ministry of Health The Republic of Indonesia, 2017 Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> In 2015 UNFPA developed an SRH and HIV booklet for sex workers as well as a booklet covering issues of GBV and HIV and human rights. These booklets are still being used by OPSI, the sex worker network organisation, in the training they provide. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff and members of civil society organisations

Assumption 2.5: UNFPA has been effective in supporting the implementation of programming tools for provision of accessible and effective HIV and SRHR services for adolescents and youth, key populations and women (*also supports evaluation question 3*). Further, service providers have the capacity to provide these services.

<ul style="list-style-type: none"> In light of government efforts to close all brothels, UNFPA gave OPSI (the sex worker network) a tool to use in community led mapping to identify where FSW are now working, and hence how they can be reached. 	
<ul style="list-style-type: none"> UNFPA worked with NAC to develop the intimate partner transmission model. SOPs were developed in Indonesian language. UNFPA also worked with NAC to develop guidelines on male involvement. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> Initially the outreach for the FSW programme was undertaken by ‘professionals’, i.e. people from the general population recruited for the role. This did not prove very effective. UNFPA then worked with representatives of the sex worker community to explore a peer-led approach. This was before UNFPA took on its role as an SR in the Global Fund programme managing the FSW component; the exploration was funded with UBRAF money. As it showed signs of success, the peer model was advocated to NAC and in 2016 the NAC as a Global Fund PR agreed to fund UNFPA to provide technical support to scale up the peer-led approach to outreach. UNFPA developed guidelines and delivered field support and monitoring to implementing partners in the field to assist CSOs to identify and recruit peer SW outreach workers. Over the course of 18 months we increased the percentage of outreach workers who were from the sex worker community from 20% to 60%. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> ‘Our role and success implementing the FSW programme gives us a strong position to influence both the government and the Global Fund mechanism’. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> In 2016, UNFPA in collaboration with the Ministry of Health and the Atma Jaya AIDS Research Center conducted an assessment on HIV prevention among intimate partners in 5 cities in Indonesia (West Jakarta, Bandung, Denpasar, Surabaya and Makassar). This study addresses explicitly and analyzes existing outreach model programs for key populations that target the transmission of intimate partners and identifies their challenges in accessing health services. To follow up on the results and recommendations of this assessment, and to improve prevention programs for key populations, including prevention of HIV transmission in intimate partner relationships is needed in this country. UNFPA Indonesia then funded the development of Outreach and Peer Support guidelines with support from the Ministry of Health and Spiritia Foundation. It aims to provide a detailed strategy for preventing HIV transmission among intimate partners of key population and PLHIV. In mid-2019, UNFPA Indonesia will work with JIP, The national network of PLHIV and JIP constituents in the implementation of this guideline in 5 cities (West Jakarta, Bandung, Denpasar, Surabaya and Makassar). UNFPA is collaborating with MoH, WHO, UNAIDS, UN Women, Spiritia, OPSI, GWL-INA, IPPI as the advisory team and also facilitators in the implementation of the pilot test. UN Women then contributed to the implementation of the guideline by developing standard operating procedures (SOPs) to address the issue of violence and prevent it from occurring in intimate partner relationships in key populations and PLHIV. Standard operational procedures become an integrated part of the guideline. 	<ul style="list-style-type: none"> UNFPA, <i>Guidelines for HIV prevention programs for intimate partners of key populations and PLHIV</i>, UNFPA 2018 Interviews with member of civil society organisation UN Women, <i>SOP: Prevention and rapid response programs related to intimate partner violence against people living with HIV (as part of Guidelines for HIV prevention Programs for Intimate Partners of Key Populations and PLHIV, UNFPA 2018)</i>, UN Women 2018

Area of Investigation Three: Extent of UNFPA promotion of human rights in the context of HIV

Evaluation Question 3: To what extent has UNFPA support contributed to engage and empower communities (including but not only, adolescents and youth, key populations and women) to understand and claim their rights while also effectively advocating for policies and laws affecting human rights, gender equality and access to HIV and SRHR services?

Evaluation Criteria	<i>Relevance, Effectiveness, Efficiency</i>	
Rationale	As well as access for marginalized people, a key dimension of UNFPA support to the HIV response is its intended focus on empowerment and rights protection, including gender equality.	
Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.		
Indicators:		
<ul style="list-style-type: none"> • UNFPA guidelines on human rights-based approaches (HRBA) to HIV and SRHR services – in use at CO level • Extent to which implementing partners are aware and knowledgeable about the content of the Guidelines on HRBA and HIV and SRHR • HIV and SRHR service guidelines incorporate some or all components of HRBA • Experience and views of service providers and clients 		
Observations	Sources of Evidence	
<ul style="list-style-type: none"> • Work plan activities towards output of ‘improved policies and programmes to address barriers in the prevention and responses to gender based violence and harmful practices, including in humanitarian settings’, including : <ul style="list-style-type: none"> • 2016-18 - collaborating with and funding (USD183,295 in 2016, 178,664 in 2017, 174,593 in 2018) Ministry of Women’s Empowerment and Child Protection, National Commission on Violence Against Women, Ministry of Health, BPS-Statistical Indonesia and NGOs on strengthening the role of MoWECP in the health sector, evidence based advocacy to eliminate harmful practices, policy and advocacy initiatives on male involvement in SRH and GBV prevention, and development of national guidelines on preventing GBV in humanitarian settings • 2016-18 - collaborating with and funding (USD45,469 in 2016, 176,867 in 2017, 44,000 in 2018) National Commission on Violence Against Women, Ministry of Women’s Empowerment and Child Protection, and NGOs on evidence based advocacy and policy advice on GBV prevention with a focus on the health sector response to GBV • 2017 funding Pusat Studi Kependudukan dan Kebijakan Universitas Gadjah Mada (USD147,502 in 2017) to collaborate with National Commission on Violence Against Women to strengthen evidence based advocacy by conducting a FGM study • The Mid-Term Evaluation report for the UNFPA 9th Country Programme listed ‘Incorporation of rights-based and gender-sensitive elements into the national strategy on family planning’ as an achievement in 2016. However work is ongoing as of 2019. This is strategy development, hence UNFPA is working with MoH, especially the Directorate of Family Health and BKKBN. The first year of implementation focused on orienting key stakeholders to the strategy. The current programme of work involves implementing the model in Aceh, Lahat (S. Sumatra) and Malang (E. Java). 	<ul style="list-style-type: none"> • Files: <ul style="list-style-type: none"> ○ Updated2018_Annex_2b_CPAP_P MME All Final ○ File: AWP NCVAW FINAL - 8 Mar 2018 ○ File: PSKK UGM - 2017 Signed • UNFPA, <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA. p. 52 • Interviews with UNFPA Indonesia staff 	

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.

<ul style="list-style-type: none"> • The strategy does mention HIV; it recommends that FP and HIV services should be integrated. However, several concerns are noted re: issues of HIV, rights-based programming and integration. <ul style="list-style-type: none"> ○ The family planning system is very decentralised. Regardless of the strategy, implementation may be quite different across different districts and facilities. ○ The HIV component of the strategy development was developed by the UNFPA reproductive health team with family planning representatives in government and BKKBN. It is reported that the UNFPA HIV team was not consulted or involved (teams within the country office are reported to operate in their own ‘silos’) and there was no collaboration with the STI unit of MoH (communication and collaboration are reported to be sub-optimal between the family health and CDC sub directorates of MOH) ○ UNFPA report that it has been difficult to make progress integrating FP and maternal health strategy and service delivery. At district level, family planning comes under the auspices of the family planning dept, whereas maternal health is under the maternal health district office. As above, communication and collaboration are reported to be sub-optimal between these structures of government. 	<ul style="list-style-type: none"> • Interviews with members of civil society organisations and government officials
<ul style="list-style-type: none"> • UNFPA is able to use rights language – i.e. mention ‘human rights’ and ‘rights based’ approaches - in discussions with government, however many aspects of human rights and many of the most basic practical implications of adopting a rights-based approach are not to be raised. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff and government officials
<ul style="list-style-type: none"> • In 2018, UNFPA ‘policy advice to MoWECP resulted in a National Guideline to Engage Men and Boys in the Prevention of GBV and SRH, operationalized through a MoWECP work plan on male involvement; this guideline will enable the development of national standard protocols under the leadership of MoWECP’ and ‘Together with MoWECP and MoH, two advocacy strategies were developed and adopted on the elimination of FGM/C for CSOs (family-based advocacy) and for FGM/C prevention through the health sector. Partnerships with religious leaders (men and women ulama), youth, and health service providers, were established to complement policy efforts.’ (p.4) 	<ul style="list-style-type: none"> • The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2018 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated.
<ul style="list-style-type: none"> • UNFPA has supported OPSI, the SW network, to build their capacity in human rights. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • ‘UNFPA will support the Government in fulfilling the rights and needs of youth and adolescents, to support the RPJMN 2015-2019, by developing an integrated and comprehensive National Action Plan on Youth Development and a Youth Development Index for Indonesia that capitalizes on the demographic dividend and improves the lives of young people in Indonesia. UNFPA will also provide support to strengthen the National Action Plan on School-Aged Child and Adolescent Health through providing reviews and policy briefs on ASRH education in schools and access to youth-friendly services, including via the private sector’. (p.13) 	<ul style="list-style-type: none"> • Government of the Republic of Indonesia and UNFPA, <i>Country Programme Action Plan 2016 – 2020 for the Programme of Cooperation between The Government of Indonesia and the United Nations Population Fund, 2016</i>.
<ul style="list-style-type: none"> • ‘UNFPA in partnership with UNICEF has currently launched a joint programme: “BERANI” (Better Reproductive Health and Rights for All in Indonesia). The Outcome of the joint programme is “Improved health and fulfilment of sexual and reproductive health.”’. The programme launched in December 2018. (p.71) 	<ul style="list-style-type: none"> • UNFPA, Mid Term Review Evaluation Report, <i>UNFPA 9th Country Programme of Assistance to The Government of</i>

Assumption 3.1: UNFPA staff and key partners have a shared understanding of the meaning and importance of human rights and gender equality in the context of HIV.	
	<i>Indonesia (GOI) 2016 – 2020. Dated February 20, 2019. UNFPA.</i>
Assumption 3.2: Networks representing adolescents and youth, women and key populations have the capacity to meaningfully participate in and influence national dialogue and prompt changes in national policies and programmes to reduce stigma and discrimination for their members, including people living with HIV. Further, they are able to assert their right to hold service providers accountable.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> • Examples of changes in national policies, laws, strategies and programmes which explicitly recognize and respond to the needs of adolescents and youth, key populations, and women (for example, anti-discrimination laws protecting people living with HIV in place, decriminalization of HIV transmission, universal access to SRHR and HIV services etc.) • Experience and views of network staff • Experience and views of national health authorities • Experience and views of policy makers in areas effecting stigma and discrimination including criminal justice, education and health among others 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • 2016-17 collaboration in Yogyakarta with Yayasan Siklus Sehat Indonesia over the UNALA initiative, including targets to establish ‘at least two formal collaborations with the existing youth networks/civil organisation to support the provision of SRH information and promoting UNALA’ in 2016 and 6 in 2017. However, it should be noted that the UNALA initiative does not have direct focus on HIV. 	<ul style="list-style-type: none"> • File: MYWP 2016-2017 YSSI • <i>UNFPA, The Concept: UNALA - an innovation in making investing in youth sustainable, UNFPA, undated.</i>
<ul style="list-style-type: none"> • In its role as a sub-recipient of a GF grant, UNFPA on-grants to OPSI, the sex workers’ network organisation. UNFPA’s financial and technical support is greatly appreciated by OPSI. • Over time, UNFPA has supported OPSI on the integration of a human rights-based approach in their work through regular mentoring, through help with proposal writing, and by supplying interpreters. UNFPA has helped OPSI to provide input to their community research assessing health service providers providing SRH including HIV services to FSW. This was key populations research, funded by the regional network of sex workers. Mentoring from UNFPA has also helped to make sure that OPSI is fluent on sexual orientation and gender identity issues and have integrated SOIG issues into their SRH training materials, which is highly relevant because they represent TG and MSW as well as FSW. • In 2018, UNFPA supported OPSI to develop an advocacy plan to react to government action closing brothels. This used evidence from a review that had been conducted into the impact of on HIV and health and security issues for sex workers the brothel closure initiative. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • Since 2016, UNFPA has been supporting IPPI, the women living with HIV network. They have helped IPPI organise a workshop on HIV and SRH for women with HIV, and helped with the costs of printing materials developed in light of the workshop. The materials had been developed with aid from other donors in 2011. The workshop helped IPPI review and update the model/materials in light of changes in context over time, including bringing FP issues and dual protection up to date. UNFPA also supported IPPI to develop short video on HIV prevention for women. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff

Assumption 3.2: Networks representing adolescents and youth, women and key populations have the capacity to meaningfully participate in and influence national dialogue and prompt changes in national policies and programmes to reduce stigma and discrimination for their members, including people living with HIV. Further, they are able to assert their right to hold service providers accountable.

<ul style="list-style-type: none"> UNFPA has provided encouragement, technical support, organisational development support, and funding to OPSI, the sex worker network organisation. OPSI particularly appreciate the coaching in proposal writing that they have received. 	<ul style="list-style-type: none"> Interviews with members of civil society organisations
<ul style="list-style-type: none"> UNFPA has provided technical assistance, particularly on financial and grant management to Indonesia AIDS Coalition (IAC) to become a new PR of GF grant project. In addition, UNFPA is also preparing IAC to be able to replace the role of UNFPA in running the FSW program. For this reason, IAC has recruited a special staff to prepare the FSW program. 	<ul style="list-style-type: none"> Interviews with members of civil society organisations

Assumption 3.3: UNFPA has contributed to developing the capacity of health workers to deliver HIV prevention services (including access to rights-based family planning) in a manner free from stigma and discrimination with services more accessible to adolescents and youth (sometimes called youth friendly SRHR), key populations, women and those with disabilities.

<p><u>Indicators:</u></p>	
<ul style="list-style-type: none"> Evidence that training in linking and integrating HIV into SRHR has been accompanied by measures addressing incentives, equipment, supplies and infrastructure as needed Extent to which training for health staff integrates avoidance of stigma and discrimination, gender sensitivity, attitudes towards key populations, youth-friendly service delivery, and sexual and reproductive rights and choices Experience and views of national health authorities Experience and views of health workers Experience and views of adolescents and youth, key populations and women on HIV and SRHR services Where survey data reports it, percentage of people living with HIV who report experiences of HIV-related discrimination in health care settings Views of staff of organisations and networks representing HIV and SRHR needs of adolescents and youth, key populations and women 	

Observations	Sources of Evidence
<ul style="list-style-type: none"> Output 2 of the UNFPA 9th country programme in Indonesia was ‘Strengthened rights-based, equitable and quality family planning policies and programmes, utilizing regional and international partnerships, including South-South Cooperation.’ (p.10) 	<ul style="list-style-type: none"> Government of the Republic of Indonesia and UNFPA, <i>Country Programme Action Plan 2016 – 2020 for the Programme of Cooperation between The Government of Indonesia and the United Nations Population Fund, 2016.</i>
<ul style="list-style-type: none"> In the UNFPA 2016 Annual Report, the results of the new outreach model under the GF-funded FSW programme were reported. Linked to this development, UNFPA had built capacity among staff and volunteers involved in the initiative: ‘Technical capacity development was undertaken for national and community partners to implement the strategy and to adopt the new outreach model in their everyday practice. In 2016, a module for HIV PMTS was developed. Trainings for core team and 33 trainers from DKI Jakarta, Semarang, Bali and Jayapura as members of master trainers were conducted. These trainers provided training on proper implementation of the new outreach model for 113 peer leaders (PLs) and peer educators (PEs) from 54 organizations who directly worked with FSWs in their respective areas. For community empowerment, the PLs and PEs are recruited from the FSWs› 	<ul style="list-style-type: none"> UNFPA, <i>Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020, Annual Report 2016</i>, UNFPA, 2017.

Assumption 3.3: UNFPA has contributed to developing the capacity of health workers to deliver HIV prevention services (including access to rights-based family planning) in a manner free from stigma and discrimination with services more accessible to adolescents and youth (sometimes called youth friendly SRHR), key populations, women and those with disabilities.

<p>community and they can reach FSWs in their respective areas. Coaching and mentoring to local PLs and PEs by national partners ensures proper adoption and implementation of the new outreach model'. (p.14)</p>	
<ul style="list-style-type: none"> In 2016, UNFPA was involved in an activity under the GF financed programme to train health care providers on reducing stigma and discrimination for FSW. The training was originally planned to focus specifically on FSW, but MoH were keen to expand it to cover MSM as well. So UNFPA reprogrammed the training and it became known as the IPSD programme (Indonesian acronym, translated as 'implementation of reduction of stigma and discrimination'). This training is still used by Linkages, UNAIDS, UNFPA, WHO, MOH. It is currently being implemented by MOH with GF money and Linkages in Jakarta. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> In 2018, UNFPA provided financial (USD7,714 in 2018) and technical support to the Board for Health Workforce Development and Empowerment (BPPSDMK) in the Ministry of Health to 'increase availability and use of integrated sexual and reproductive health services, including family planning, maternal health, and HIV, that are gender-responsive and meet human rights standards for quality of care and quality in access' involving strategic intervention aimed at the 'improvement of capacity of midwifery workforce particularly in enhancing the midwifery education and services.' The capacity building of midwifery did not focus on HIV or SRHR. 	<ul style="list-style-type: none"> File: AWP BPPSDMK FINAL 8 Mar 2018 Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> In 2018, UNFPA reported that as part of its work in humanitarian settings, in this case in Central Sulawesi, <ul style="list-style-type: none"> '60 facilitators trained on psychosocial support 228 humanitarian workers of various organizations trained on PSEA and GBV 80 partners from women and youth NGOs in disaster affected West Nusa Tenggara and Central Sulawesi joined training on PSEA and GBV in emergencies (GBViE).' (p.7) 	<ul style="list-style-type: none"> UNFPA, <i>Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020 Annual Report 2018</i>, Jakarta: UNFPA, undated.
<ul style="list-style-type: none"> In 2019, UNFPA committed to trying to include a new component in the intimate partner notification programme. In the 2019 UNFPA workplan there is support to MoH to provide capacity building for health providers on partner notification. One section is that health care workers need to be friendly for KPs and their partners. UNFPA have developed a case study targeting these sensitive issues and trialled it with MSM community. The issue is: when doing health and risk assessments, health workers always say that MSM are reluctant to bring their female partners when they are married. It is reported that the MSM are more concerned about disclosure of their sexual orientation than their HIV positive status. The case study and UNFPA's proposed new component in the intimate partner notification programme therefore focuses on asking clients about risk behaviour with past partners without mentioning the sex of those partners or asking for information about the sex of those partners. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff

Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.

Indicators:

<p>Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.</p>	
<ul style="list-style-type: none"> • Percentage of women aged 15-49 years who experience physical or sexual violence from a male intimate partner (12 months) • Reported trends (where available) in early marriage (as context) • Where survey data reports it (as in recent DHS), proportion of women and men who say that wife beating is an acceptable way for husbands to discipline their wives • National strategies and programmes developed and implemented with goal of preventing/reducing GBV – with specific reference to preventing HIV • National HIV strategies/roadmaps/ workplans incorporate efforts to protect women and girls from GBV and from coercion with its impact on HIV • Presence of laws, policies and regulations that protect adolescents and youth, key populations, women and PLIHV against GBV • Staff of facilities report that post-GBV clinical care integrates HIV and SRHR • Views of national health and HIV authorities • Views and experience of networks and organisations engaged in protecting women and girls from GBV, including in relation to HIV prevention 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • '1 in 3 (33.4%) women aged 15-64 years old have ever experienced physical and/or sexual violence perpetrated by their partner or non-partner in her lifetime. Around 9.4% women have experienced it in the last 12 months' (p.1) 	<ul style="list-style-type: none"> • 2016 Indonesian National Women's Life Experience Survey, <i>Study on Violence Against Women and Girls Key Findings</i>, (UNFPA logo on second page; undated)
<ul style="list-style-type: none"> • 'Around 1 in 9 girls are married before age 18.' (p.4) • '49% of girls aged under 11 years old have undergone Female Genital Mutilation/Cutting (FGM/ C) with higher rates in rural areas' (p.4) 	<ul style="list-style-type: none"> • UNFPA, <i>Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020 Annual Report 2018</i>, Jakarta: UNFPA, undated.
<ul style="list-style-type: none"> • Apart from the foreword by the UNFPA Representative, and the acknowledgements page, the 2015 UNFPA monograph 'Women and Girls in Indonesia' contained no reference to gender-based violence (though physical abuse of migrants was mentioned). The report also contained no reference to HIV (apart from in the title of one reference) and no reference to harmful practices, FGM or cutting. 	<ul style="list-style-type: none"> • UNFPA, <i>Women and Girls in Indonesia: Progress and Challenges. UNFPA Indonesia Monograph Series 5</i>, Jakarta: UNFPA, 2015.
<ul style="list-style-type: none"> • In contrast to the above UNFPA (2015) <i>Women and Girls in Indonesia: Progress and Challenges</i>, the 2016 <i>Field Study Report. Risk Factors and Protection against HIV Transmission in Heterosexual Intimate Couples in Indonesia</i> mentions violence over one hundred times, and concludes that 'It is apparent that the social constructions of sexual interactions between the key populations and their sexual partners still reflect the culture and values that put men in a stronger position within the romantic relationship. Although female respondents are aware of this unequal relationship, there is not much they can do to address this inequality compared with female respondent with traditional view. It seems that disparity in this power relation may have led to acts of violence that put women at risk of contracting HIV in this asymmetric sexual interaction.' (p.59) 	<ul style="list-style-type: none"> • AIDS Research Centre, <i>Field Study Report. Risk Factors and Protection against HIV Transmission in Heterosexual Intimate Couples in Indonesia</i>, Universitas Katolik Indonesia, 2016.
<ul style="list-style-type: none"> • In the UNFPA 9th Country Programme two outcomes focus on young women and girls and prevention of violence and harmful practices: 	<ul style="list-style-type: none"> • Government of the Republic of Indonesia and UNFPA, <i>Country Programme Action Plan 2016 – 2020 for</i>

<p>Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.</p>	
<ul style="list-style-type: none"> ○ 'Outcome 3: Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth' ○ 'Outcome 4: Improved policies and programmes to address barriers in the prevention and responses to gender-based violence and harmful practices, including in humanitarian settings.' (p.14) 	<p><i>the Programme of Cooperation between The Government of Indonesia and the United Nations Population Fund, 2016.</i></p>
<ul style="list-style-type: none"> • <i>The UNFPA 2016 Annual Report</i> (p.4) shared five results relating to efforts to protect young women and girls: <ul style="list-style-type: none"> ○ 'Evidence-based advocacy and policy dialogue on harmful practices resulted in the inclusion of child marriage and others into the national Ministry of Women's and Child Protection (MoWECP) priority agenda. The dialogue re-opened discussions for inclusion of these harmful practices in Indonesia's reported SDG indicators. ○ Improved coordination for health sector response to domestic and gender-based violence as well as the inclusion of male involvement approaches in the National Framework on GBV prevention and SRHR. ○ Improved quality assurance for the Indonesia's first Violence Against Women survey and strengthened coordination among related ministries in the conduct of the survey. ○ Improved national GBV prevention and response programme referencing the situation analysis on GBV in humanitarian settings in Indonesia. ○ Improved capacity of local partners in the integration of men and boys engagement approach in GBV prevention to contribute to the National Framework of Male Involvement' 	<ul style="list-style-type: none"> • The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2016 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated.
<ul style="list-style-type: none"> • The <i>2017 UNFPA Annual Report</i> (p.4) reported key achievements in regard to gender equality. To support advocacy work on harmful practices, a policy brief was produced and a lessons learnt document and implementation model was prepared for preventing child marriage. In addition, a pilot was conducted in Papua entitled Partners for Prevention (P4P). Achievements were: <ul style="list-style-type: none"> ○ Approximately 75% of 80 participants (adolescents) trained have increasingly significant attitude change on gender equitable relationships ○ Approximately 75% of 60 participants (caregivers) trained have increasingly significant attitude change on gender equitable relationships ○ Evaluation report of the P4P pilot available. 	<ul style="list-style-type: none"> • The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2017 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated.
<ul style="list-style-type: none"> • In 2018, UNFPA reported that as part of its work in humanitarian settings, in this case in Central Sulawesi, <ul style="list-style-type: none"> ○ '43,918 women, youth received GBV information through community education ○ 60 facilitators trained on psychosocial support ○ 228 humanitarian workers of various organizations trained on PSEA and GBV 	<ul style="list-style-type: none"> • UNFPA, <i>Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020 Annual Report 2018</i>, Jakarta: UNFPA, undated.

Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.

<ul style="list-style-type: none"> ○ 80 partners from women and youth NGOs in disaster affected West Nusa Tenggara and Central Sulawesi joined training on PSEA and GBV in emergencies (GBViE).’ (p.7) 	
<ul style="list-style-type: none"> ● In 2018, UNFPA key achievements in regard to gender equality, including <ul style="list-style-type: none"> ○ ‘8,465 people (7,191 females and 1,274 males) received services through RH and GBV outreach ○ 1,704 people have participated in Focus Group Discussions on GBV ○ An orientation of the global Clinical Management of Rape (CMR) protocol was organized for the RH subcluster in Jakarta ○ 20 non-health volunteers trained on Prevention of GBV in emergencies by UNFPA, central PKBI & Yayasan Pulih ○ GBV training materials developed and 45 GBV focal points, local government officials, women NGOs and volunteers in North Lombok received training using the materials.’ (p.8) <p>Also:</p> <ul style="list-style-type: none"> ○ The Background Paper of RPJMN on Gender Equality and Women Empowerment 2020-2024 ○ A revised Manual of TOT on GBV Case Management for National Facilitator and Health Service Providers ○ Guidelines on Prevention of FGM/C for Health Service Providers and the Abandonment of FGM/C for CSO using a Family Approach ○ A Modelling Strategy of Child Marriage Prevention ○ Bogor Declaration of strengthened commitment of Religious Leaders on the Abandonment of FGM/C through a National Meeting of Ulema and Pesantren Based Dialogues in 4 provinces on the abandonment of FGM/C ○ Youth Facilitators Networks on the Abandonment of FGM/C and 4 Youth Dialogues in 2 Child Forums and 2 High Schools.’ (p.21) 	<ul style="list-style-type: none"> ● UNFPA, <i>Government of Indonesia – UNFPA Strategic Partnership Ninth Country Programme 2016-2020 Annual Report 2018</i>, Jakarta: UNFPA, undated.
<ul style="list-style-type: none"> ● In 2018, ‘1,281 girls received, with support from UNFPA, prevention, protection services, and/or care related to child, early, and forced marriage’ and ‘1,036 girls and women received, with support from UNFPA, prevention, protection services, and/or care related to female genital mutilation’ (p.1) 	<ul style="list-style-type: none"> ● File: ID_UNFPA_Results_05_30
<ul style="list-style-type: none"> ● The <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i> (p.67) noted achievements of: <ul style="list-style-type: none"> ○ In 2016: ‘Situation Analysis on GBV with a set of recommendations to strengthen the National Coordination Mechanism of GB/VAW prevention and response; Concept Paper on GBV in Health Sector Response; Policy dialogue based on a policy brief on GBV and SRHR, covering 9 issues: VAW, child marriage, FGM/C, trafficking in persons, sexual minority and adolescent)’ 	<ul style="list-style-type: none"> ● UNFPA, <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.

Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.

<ul style="list-style-type: none"> ○ In 2017: ‘Development of Recommendations and Follow up Actions Matrix based on the Concept Paper on GBV in Health Sector Response’ and (2018) ‘Piloting strengthening GBV HSR in 1 district, which include conducting capacity assessment; revising and developing TOT manual; conducting GBV training for Health Service Providers and integrating data on GBV’ ○ In 2018: ‘Advocacy on GBV related laws: 1. Draft Sexual Violence Law; 2. Draft Penal Code Revision Law’ 	
<ul style="list-style-type: none"> ● In 2019, UNFPA supported the Ministry of Women’s Empowerment and Child Protection (USD 234,288 for all years) in collaboration with National Commission on Violence Against Women, Ministry of Health and NGOs to develop a road map and action plan for FGM/C abandonment, developing a background paper on increasing the age of marriage, holding a national dialogue on male involvement within national policies and programmes, making available SOPs of the National Framework on Male Involvement in SRHR and GBV prevention at the national and sub level, developing guidelines on the prevention of sexual and gender based violence in humanitarian settings. 	<ul style="list-style-type: none"> ● File: AWP MOWECP GEN_HUM 2019 Final
<ul style="list-style-type: none"> ● UNFPA sub-sub-recipient partner OPSI has trained CSOs (which work as Implementing Units for the FSW programme) on gender-based violence as it relates to the FSW GF financed programme. 	<ul style="list-style-type: none"> ● Interview with member of civil society organisation
<ul style="list-style-type: none"> ● UNFPA reports that in general ‘no-one in Indonesia wants to talk about female genital mutilation’; UNFPA is proud that it does raise the issue. 	<ul style="list-style-type: none"> ● Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> ● When UNFPA developed their intimate partner notification model, they realised the GBV component was missing. They knew GBV issues were a major concern for intimate partners disclosing their status. UNFPA did not have money to address this, but collaborated with UNWOMEN. UNWOMEN had UNBRAAF money available and allocated USD 35,000 USD into the collaboration to pay for consultants and a workshop. Collaboration with UNWOMEN enables UNFPA to bring in good inputs from key gender stakeholders. ‘We had the concept and they had the stakeholders and the money to make this possible’. In addition, UNFPA report that UNWOMEN have not yet established a strong relationship with MOH, so this collaboration has helped them ease their way into the working group on partner notification and thus created an entry point to form a UNWOMEN-MOH relationship (which had been missing since the NAC was dissolved). 	<ul style="list-style-type: none"> ● Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> ● In February 2019, UNFPA, UN Women and UNICEF issued a Joint Statement ‘Take action to eliminate female genital mutilation by 2030’. HIV was not mentioned in the statement. 	<ul style="list-style-type: none"> ● https://indonesia.unfpa.org/en/news/joint-statement-take-action-eliminate-female-genital-mutilation-2030
<ul style="list-style-type: none"> ● The evaluation team did not hear of any national initiatives targeting GBV related to HIV. 	
<ul style="list-style-type: none"> ● In 2015, UNFPA had paid NAC (which hired one of the current UNFPA staff as a consultant) to develop a referral system for GBV in collaboration with MoWECP. The consultant worked with the gender team in NAC, looking at ways to integrate HIV and GBV. They subsequently trained service providers and government officials in the MoH in GBV. This work was still at the sensitisation phase, 	<ul style="list-style-type: none"> ● Interviews with UNFPA Indonesia staff

Assumption 3.4: UNFPA has contributed to effective efforts to protect young women and girls, including those at risk of early marriage, from gender-based violence especially in relation to HIV prevention; and to provide young women and girls with information leading to empowerment through knowledge and behaviour change for HIV prevention. Further, HIV prevention has been integrated into efforts to improve clinical and other services for survivors of GBV.

<p>building awareness in both NAC and MoWECF when the NAC was dissolved. Since the NAC was dissolved, MoH has not continued the work.</p>	
<ul style="list-style-type: none"> UNFPA is working with WHO and UNWOMEN to develop proposals for a pilot initiative for 2020. ‘There is growing evidence that the relationship between violence against women and HIV infection in women and girls may be indirectly mediated by HIV risk-taking behaviours. Studies show that women’s experience of violence is linked to increased risk-taking including having multiple partners, nonprimary partners (or partnerships outside marriage) or engaging in transactional sex. The links between intimate partner violence and HIV/AIDS are explained by biological as well as sociocultural and economic factors. UN Women has jointly contributed to support the implementation of Partner Notification in particular by developing SOP for addressing the violence and how to prevent it from occurring in the intimate partner relations. The SOP will be an integral part of the Partner Notification both in health care and community settings. UN Women already recruited a national consultant to conduct review of the existing tools such as global and national guidelines and develop contextualized SOP based on the review.’ (p.4) 	<ul style="list-style-type: none"> UNFPA, <i>Concept Note Support for Pilot Implementation of Partner Notification in Health Care and Community Setting in Indonesia</i>. WHO, UNFPA AND UN WOMEN. 2019 – 2020.
<ul style="list-style-type: none"> ‘What does the government need to be confronted about? They key things are human rights and legal barriers. The National Commission on Violence against Women have discovered over 100 legal instruments at local government level that discriminate against women. The UN needs to use diplomacy skill to tackle these and other legal barriers in order to improve results on 90:90:90’. 	<ul style="list-style-type: none"> Interviews with UN agency staff

Area of Investigation Four: Extent of UNFPA efforts as a broker to facilitate the participation of a broad spectrum of actors and contribute to forging partnerships

Evaluation Question 4: *To what extent has UNFPA been effective at global, regional and country level in forging and/or supporting networks, coalitions and partnerships to ensure meaningful participation of governments, civil society (especially adolescents and youth and key populations) and the private sector in dialogue and action on HIV prevention – including participation in programme design, planning and implementation?*

<p>Evaluation Criteria</p>	<p><i>Effectiveness, sustainability, coordination</i></p>
<p>Rationale</p>	<p>In order for those at risk and vulnerable, notably adolescents and youth and key populations to have access to effective integrated HIV and SRHR services and to secure their rights to information and services free from stigma, discrimination and violence, it is important they participate meaningfully in regional, national and local dialogues and influence decision making on HIV prevention. Networks, coalitions and partnerships are effective mechanisms for engaging these groups in critically important debates on HIV policies and services.</p>

Assumption 4.1: UNFPA has effectively supported platforms for south-south cooperation and joint lessons learning on strengthening bi-directional linkages and integrating HIV and SRHR (also applies to assumption 1.6).

Indicators:

Assumption 4.1: UNFPA has effectively supported platforms for south-south cooperation and joint lessons learning on strengthening bi-directional linkages and integrating HIV and SRHR (also applies to assumption 1.6).

- Type and number of platforms and mechanisms for south-south consultation and cooperation supported by UNFPA
- Frequency of south-south meetings/workshops/interactions on linkages/integration
- Reported utility of south-south cooperative efforts on linkages/ integration supported by UNFPA

Observations	Sources of Evidence
<ul style="list-style-type: none"> • The <i>UNFPA 2016 Annual Report</i> mentions 'Knowledge sharing through South-South and Triangular Cooperation with 12 Asian and African countries on strategic partnerships for family planning with Muslim religious leaders (MRLs); comprehensive, rights-based clinical family planning; bridging leadership with district leaders; and Islamic youth leaders in adolescent reproductive health, in partnership with Ministry of State Secretariat, National Population and Family Planning Board (BKKBN) and University of Gadjah Mada (UGM).' (p. 2) 	<ul style="list-style-type: none"> • The Government of the Republic of Indonesia and UNFPA, <i>The Government of the Republic of Indonesia and UNFPA: 2016 Key Achievements</i>, Jakarta: BAPPENAS and UNFPA, undated.
<ul style="list-style-type: none"> • The UNFPA, <i>Mid Term Review Evaluation Report</i> (p.52) noted achievements of: <ul style="list-style-type: none"> ○ In 2016: 'South-South Cooperation with 12 Asian and African countries on the role of Muslim Leaders in FP, on comprehensive, rights-based clinical family planning, the role of Islamic Youth Leaders in adolescent reproductive health.' ○ In 2017: 'Continued South-South Cooperation through the international training programme and the bilateral programme with the Philippines (government co-financing/financial contribution)' ○ In 2018: 'Continued South-South Cooperation through the international training programme and the bilateral programme with the Philippines (government co-financing/financial contribution)' 	<ul style="list-style-type: none"> • UNFPA, <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA. p.52
<ul style="list-style-type: none"> • The south-south work with Muslim leaders contains components of SRHR - i.e. equitable and equity access to contraceptives and HIV prevention with condom as dual protection. However, it was not specific to marginalized groups, more to HIV prevention in general. 	<ul style="list-style-type: none"> •

Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.

Indicators:

- Inter-governmental statements of policies and strategies for HIV and SRHR reflect need for integration and protection of rights of adolescents and youth/women/ key populations
- HIV prevention re-positioned as high priority in global and regional intergovernmental HIV strategies and policies
- Views of national health authorities and national HIV commissions
- Views of members of global, national HIV prevention coalitions

Assumption 4.2: The support provided by UNFPA to global, regional and national partnerships (including for example HIV prevention coalitions) has contributed to more and better joint policy development and programming on HIV prevention. UNFPA support has also contributed to re-positioning HIV prevention as an essential component of SRHR with broad participation.

Observations	Sources of Evidence
<ul style="list-style-type: none"> The report of the Mid Term Review of the UNFPA Indonesia 9th Country Programme does not mention the term ‘HIV’ in either the conclusions or the recommendations. 	<ul style="list-style-type: none"> UNFPA, Mid Term Review Evaluation Report, <i>UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.
<ul style="list-style-type: none"> UNFPA Indonesia believe that their role within the GF financed programme, including fulfilling a role requested by government, membership of the CCM/HIV Technical Working Group, and contractual relationships with their sub-sub-recipients, provides them with frequent opportunities to meet and liaise with, and attempt to influence key stakeholders. Prior to acting as a Global Fund sub-recipient, UNFPA report being more challenged to achieve influence and leverage. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> ‘Even before the Global Fund programme began, UNFPA already had a role influencing policy in specific areas. We were able to persuade government that it was also important to consider HIV prevention for the intimate partners of sex workers and other KPs. Now we have government buy in and have a pilot in 5 cities funded through UBRAF and growing interest from the Global Fund. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> There is little evidence that UNFPA has attempted to position HIV prevention as a priority issue for Indonesia beyond its work on the FSW and partner notification. The evaluation team asked whether UNFPA has contributed to positioning HIV prevention as an essential component of SRHR with broad participation. We were told ‘Working in the background is the best way. Be silent but effective. You have to be super-skilful to work with government’ UNFPA does not give a clear message that HIV is an essential component of SRHR. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff, government officials and members of civil society organisations
<ul style="list-style-type: none"> UNFPA is working with WHO and UNWOMEN to develop proposals for a pilot initiative for 2020. ‘WHO has recommended partner testing since 2012, the assisted HIV partner notification is in line with and builds on existing WHO recommendations supporting couples and partner testing, including offering HIV testing to the households, family members and partners of people who are HIV-positive. The voluntary assisted HIV partner notification services is part of a comprehensive package of testing and care offered to people living with HIV. ... The CO in collaboration with the MoH will engage an institution to work on the pilot implementation of the HIV prevention among intimate partner in 5 cities in Indonesia (West Jakarta, Bandung, Denpasar, Surabaya, Makassar). This consultancy work will look into HIV prevention programme particularly on outreach targeting key population and psychosocial support programme for PLHIV, strategy formulation to reach intimate partners including data collection and reporting, and increase the capacity of NGOs to prevent sexual transmission among intimate partners. As for mentoring and coaching in the local level, the national team which consist of UNFPA, UN Women, Yayasan Spiritia and the pilot institution will visit the 5 piloting districts every quarter’. (pp.1-3) 	<ul style="list-style-type: none"> UNFPA, <i>Concept Note Support for Pilot Implementation of Partner Notification in Health Care and Community Setting in Indonesia</i>. WHO, UNFPA AND UN WOMEN. 2019 – 2020.

<p>Assumption 4.3: The development of policies and programmes for HIV prevention is characterized by the participation of diverse actors as advocated by UNFPA– especially organisations representing and led by adolescents and youth, key populations and women. This may include private sector participation in a total market approach to distribution of condoms for HIV prevention.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • Extent and frequency of national consultations on HIV prevention policy • Extent and frequency of participation by organisations representing and led by adolescents and youth, women and key populations in national forums and platforms for HIV prevention • Reported involvement of private sector actors in consultations on national HIV prevention strategies and programmes • Experience and views of national health authorities • Experience and views of staff of organisations representing adolescents and youth/women/key populations • Experience and views of organisations representing social marketing agencies and private sector firms engaged in distribution and sale of family planning products including condoms and lubricants 	
<p>Observations</p>	<p>Sources of Evidence</p>
<ul style="list-style-type: none"> • UNFPA ensured wide participation of key groups when developing guidelines for FSW programme outreach. ‘The workshop to develop guidelines for basic outreach was ... attended by 20 participants from the SSRs (PKBI DKI Jakarta, Yayasan Kalandara, Yayasan Kerti Praja, PKBI Papua), the Ministry of Health, OPSI Network, Indonesia AIDS Coalition and UNFPA. During the workshop, participants provided input to the guidelines (The Outreach Implementation Manual for Female Sex Workers Programme in Indonesia) and on-site revision was conducted.’ (p.10) 	<ul style="list-style-type: none"> • UNFPA Indonesia, <i>Final Report January - December 2018 Technical Assistance and Capacity Development to Support Implementation of the Global Fund Programme on Female Sex Workers</i> (Files: GF_MOH_2018_Annual Report_TimShared with Annex_2019_03_20_All) • UNFPA, <i>Outreach Implementation Manual for Female Sex Workers Programme in Indonesia. Final Version.</i> UNFPA (undated)
<ul style="list-style-type: none"> • ‘UNFPA CO and OPSI have demonstrated constructive collaboration since the development of concept note of the New Funding Model (NFM) FSW programme. To strengthen the FSW programme within this NFM and to increase sex worker community role, participation, and accountability in the national FSW programme, the CO is developing a technical assistance plan to build technical capacity of OPSI for the implementation of the FSW strategy and community led outreach model, including simple case management.’ (p.1) 	<ul style="list-style-type: none"> • <i>Terms of Reference. Technical Assistance Plan for OPSI (Indonesia Sex Worker National Network) to Support the Global Fund National Female Sex Worker Programme 2019 – 2020</i> (File: ToR TA PLAN OPSI – Final (1))
<ul style="list-style-type: none"> • ‘UNALA is an innovative social franchising model, led by the private sector, to deliver high-quality, youth-friendly, and stigma-free sexual and reproductive health (SRH) information and services for young people. ... UNALA is part of UNFPA’s overall technical and financial support to the Indonesian government and included in the current 9th Country Program Action Plan (CPAP) 2016–2020.’ (p.2) 	<ul style="list-style-type: none"> • Kobilke and Majid, <i>Summary Executive - Evaluation Report. UNALA, Sexual and Reproductive Health Services Model for Youth in Yogyakarta, Indonesia,</i>

<p>Assumption 4.3: The development of policies and programmes for HIV prevention is characterized by the participation of diverse actors as advocated by UNFPA– especially organisations representing and led by adolescents and youth, key populations and women. This may include private sector participation in a total market approach to distribution of condoms for HIV prevention.</p>	
<ul style="list-style-type: none"> ‘UNALA has been a successful introduction of a fractional social franchise model. The fact that private health care providers have joined the UNALA network and agreed to provide SRH services to unmarried youth is a major milestone’. (p.9) 	<p>November 2016 to July 2018, UNFPA, 2018.</p>
<ul style="list-style-type: none"> The Global Fund programme plays a central role in the national response. Development of other national policies and programmes for HIV prevention has to a large extent been overtaken by emphasis on the need to successfully implement and subsequently renew the GF financed programme (which has a particular emphasis on a test and treat approach, and does not have strategise for many of the other necessary activities to ensure that HIV prevention policies and programmes are comprehensive at national level). 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff, government officials, members of civil society organisations
<p>Assumption 4.4: National governments have been responsive to UNFPA advocacy for and support of meaningful participation of non-governmental actors in dialogue on HIV prevention policies and programmes including in programme development, implementation and accountability.</p>	
<p>Indicators: As per assumption 4.3</p>	
<p>Observations</p>	<p>Sources of Evidence</p>
<ul style="list-style-type: none"> ‘UNFPA has been able to advocate the government to increase their attention and commitment to sensitive issues including provision of SRH information and services for young people although this is not an area that is considered in line with Gol’s policy.’ (p.44) 	<ul style="list-style-type: none"> UNFPA, <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.
<ul style="list-style-type: none"> ‘When we became a major player in the Global Fund work, it kind of tied our hands to talk about sensitive issues such as human rights. Our approach changed from “professional” to “co-worker” in which there was pressure not to confront sensitive issues. we no longer had the distance necessary to advocate and leverage on issues. Before we didn’t have such strong relationships, but we could be more risky in challenging on issues. Now we have to stay more in line and use the Representative or the KP communities to raise the more sensitive issues with government’. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> At the time of the evaluation field visit, draft amendments to Indonesia’s Penal Code were before parliament. Among others, these amendments, if passed, would criminalise sex outside of marriage and limit the ability of people other than professional health service providers from distributing condoms, among other limitations on the HIV prevention response. This was predicted to have wide ranging implications for access to services for KPs and young people in particular, as well as for the general public. 	<ul style="list-style-type: none"> Interviews with UN agency staff
<ul style="list-style-type: none"> One respondent worked in an organisation focusing specifically on advocacy. They believe that most HIV and SRHR advocacy tends to be technical in nature and tends to target the MoH. In contrast, they believe that advocacy should target the Ministry of Internal Affairs, because that ministry oversees all the local structures through which policy is amended and implemented (or not) at local level. 	<ul style="list-style-type: none"> Interview with members of civil society organisation

Area of Investigation Five: Extent UNFPA has optimized its comparative advantage within the UNAIDS division of labour and has contributed to the collective strength of the cosponsors

Evaluation Question 5: To what extent has UNFPA been able to ensure its comparative advantages at global, regional and national levels are recognized within its roles and responsibilities under the UNAIDS division of labour?

Evaluation Criteria	<i>Coordination, Efficiency, Effectiveness</i>
Rationale	It is essential that UNFPA is able to accept and carry out functions at global, regional and national level which reflect its comparative advantages among the UNAIDS cosponsors

Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the Joint United Nations Team on AIDS (JUNTA) organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.

<u>Indicators:</u>	
<ul style="list-style-type: none"> • Variation in roles taken on by UNFPA (under the UNAIDS cosponsor division of labour at country level) matched with changes in context of the epidemic and UNFPA technical capacity and mandate • Experience and views of UNFPA CO staff • Experience and views of national health and HIV authorities • Experience and views of members of the JUNTA at country level • Experience and views of implementing partners 	

Observations	Sources of Evidence
<ul style="list-style-type: none"> • Among the UN agencies there is general agreement that in most cases roles are divided according to KP group: <ul style="list-style-type: none"> ○ UNFPA are generally held to be focused on female sex workers, because of their function as a sub-recipient of the GF financed programme. In the future they are also tasked with focusing on young KPs. ○ UNICEF used to focus on young KPs, but is relinquishing this. Their focus is on PMTCT primarily. ○ UNDP are intended to focus on MSM and the transgender communities, but encountered challenges when their actions were deemed to contravene government wishes; UNDP has largely stepped back from working with MSM as a result ○ UNODC focus on PWUD and prisoners ○ UNWOMEN focus on GBV ○ WHO focus on technical/clinical guidelines, provide technical support to MoH ○ UNESCO does not have a national office presence in Indonesia. In practise, responsibility for CSE is reported to be shared between UNFPA, UNICEF and UNESCO. • UN agency staff report that no agency is explicitly responsible for advocating the integration of HIV and SRHR and GBV for KPs in the general public health system, or for advocating the value of integration in services for the general population. 	<ul style="list-style-type: none"> • Interviews with staff from UNFPA, UNICEF, UNDP, UNAIDS

<p>Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the Joint United Nations Team on AIDS (JUNTA) organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.</p>	
<ul style="list-style-type: none"> In the current division of labour in the JUNTA, UNFPA focuses primarily on female sex workers and to as much lesser extent women most at risk of HIV. In terms of future roles, the evaluation team heard different plans/proposals. One stakeholder stated that the focus would be expanded soon to include young key populations (previously the focus for UNICEF) whereas a different stakeholder stated that UNFPA would take a new, non-KP-specific role focusing on access to comprehensive HIV prevention. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff and UN agency staff
<ul style="list-style-type: none"> Early in 2017, when the NAC was dissolved, MoH asked UNFPA to take on the FSW programme implementation as a SR in the Global Fund mechanism. This was major commitment involving a large budget. The UNFPA Regional Office approved the country office to take on this implementing role, even though Indonesia was designated as a yellow quadrant country. One UNFPA CO staff member stated that ‘senior management consider this is not a long-term strategy’. This commitment to implementing the FSW programme has come to shape UNFPA’s role within the UN division of labour and its focus in terms of HIV prevention. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> ‘I feel that UNFPA working directly on outreach to KPs may not be the correct role. I would have thought they would focus on the strategy level. I’m really not sure how UNFPA ended up focusing on FSW rather than reproductive health’. 	<ul style="list-style-type: none"> Interviews with UN agency staff
<ul style="list-style-type: none"> The UNFPA Indonesia country office has a number of different teams relevant to HIV. These teams include maternal health and FP, population and data, gender, humanitarian, adolescent SRH and youth, advocacy, HIV. Among the UNFPA staff there appears to be consensus that working across teams proves challenging and their work is therefore not integrated. Staff report that it is hard to bring people together and agree shared initiatives and targets across the teams. 	<ul style="list-style-type: none"> Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> ‘I have been involved in a lot of joint UN meetings. The JUNTA here in Indonesia is one of most effective and active UN meetings I have seen. UNAIDS makes it successful. They even involve the community representatives every two months. As for partnership among JUNTA members, we have exchanged some ideas with UNFPA and will work together on GBV and HIV issues. Gradually we are working more closely together on partner notification’. 	<ul style="list-style-type: none"> Interviews with UN agency staff
<ul style="list-style-type: none"> Whereas the UN Joint Team on AIDS Programme of Support for 2017-2019 was structured according to overall objectives, objectives and outputs, with contributions from all UN agencies located within a single joint plan, the revised version of the JUNTA plan 2018-19 takes the form of a simple list of disparate activities. It is structured by UN agency and lists activities under each organisational heading, with no attempt to highlight potential synergies or actual collaboration by partners. 	<ul style="list-style-type: none"> <i>UN Joint Team on AIDS Programme of Support for 2017-2019</i> <i>Joint Plan 2018-2019 revision</i>
<ul style="list-style-type: none"> ‘I find it really useful to work jointly with other UN programmes. By combining resources we achieve more together. We have benefitted a lot from the technical expertise of UNFPA, and their expertise working at community level.’ 	<ul style="list-style-type: none"> Interviews with UN agency staff
<ul style="list-style-type: none"> ‘UNFPA’s special focus on youth and development aligns closely with and complements the work of other UN Agencies such as UNICEF and WHO. Since 2013, task division between UN Agencies under UNFPA for youth and development has been in place in the form of United Nations Inter-Agency Network on Youth Development (IANYD).’ (p.64) 	<ul style="list-style-type: none"> <i>UNFPA, Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020. Dated February 20, 2019. UNFPA.</i>

<p>Assumption 5.1: At global, regional and country level, UNFPA has been able to match its comparative advantages in mandate, brand recognition, and technical capacity to the tasks it takes on under the UNAIDS UBRAF. At country level, specifically, the Joint United Nations Team on AIDS (JUNTA) organisational structure and programming process recognizes and encourages a division of labour that assigns to UNFPA the role and responsibilities that capitalize on its distinctive advantages.</p>	
<ul style="list-style-type: none"> • ‘We don’t have any specific efforts to improve SRHR within the PMTCT programme. WHO and UNFPA haven’t discussed how to raise this with the national programme’. 	<ul style="list-style-type: none"> • Interviews with UN agency staff
<ul style="list-style-type: none"> • ‘UNESCO is present in Indonesia, but not working on HIV. In the JUNTA we have not unpacked who is responsible for CSE (not since 2013 as far as I can remember). We have only discussed young KPs. UNICEF has been the lead. But we will soon have a new platform called the UN Youth Working Group with UNICEF and UNFPA as co chairs).’ 	<ul style="list-style-type: none"> • Interviews with UNFPA staff
<ul style="list-style-type: none"> • ‘UNFPA’s comparative advantage should be in family planning commodities’. 	<ul style="list-style-type: none"> • Interviews with UN agency staff
<ul style="list-style-type: none"> • UNFPA is working with WHO and UNWOMEN to develop proposals for a pilot initiative for 2020. ‘WHO has recommended partner testing since 2012, the assisted HIV partner notification is in line with and builds on existing WHO recommendations supporting couples and partner testing, including offering HIV testing to the households, family members and partners of people who are HIV-positive. The voluntary assisted HIV partner notification services is part of a comprehensive package of testing and care offered to people living with HIV. ... The CO in collaboration with the MoH will engage an institution to work on the pilot implementation of the HIV prevention among intimate partner in 5 cities in Indonesia (West Jakarta, Bandung, Denpasar, Surabaya, Makassar). This consultancy work will look into HIV prevention programme particularly on outreach targeting key population and psychosocial support programme for PLHIV, strategy formulation to reach intimate partners including data collection and reporting, and increase the capacity of NGOs to prevent sexual transmission among intimate partners. As for mentoring and coaching in the local level, the national team which consist of UNFPA, UN Women, Yayasan Spiritia and the pilot institution will visit the 5 piloting districts every quarter’. (pp. 1, 3) 	<ul style="list-style-type: none"> • UNFPA, <i>Concept Note Support for Pilot Implementation of Partner Notification in Health Care and Community Setting in Indonesia</i>. WHO, UNFPA AND UN WOMEN. 2019 – 2020.
<p>Assumption 5.2: UNFPA supported activities and investments are strategically important to the HIV response, at global, regional and national level.</p>	
<p><u>Indicators:</u></p> <ul style="list-style-type: none"> • National HIV strategies/roadmaps/action/plans/ programmes reflect advocacy and policy engagement by UNFPA (and cosponsors) • UNFPA supported activities concentrated in functional areas designated as high priority in national HIV strategies and programmes • UNFPA supported activities in HIV prevention and rights protection positioned to influence national policies and programmes going forward • Experience and views of national health and HIV authorities • Experience and views of members of the JUNTA at country level and bilateral agencies supporting the HIV response 	
<p>Observations</p> <ul style="list-style-type: none"> • ‘As requested by the Ministry of Health (MoH), starting April 2016, UNFPA provided support to the transition of the merging of the role of NAC to the MoH, by implementing the FSW programme while providing technical assistance for the programme, including at seaports. UNFPA managed programme implementation as well as grant management to four (4) national SRs that covered 88 districts, in direct coordination with MoH as the current FSW programme primary recipient (PR).’ (p.2) 	<p>Sources of Evidence</p> <ul style="list-style-type: none"> • UNFPA Indonesia, <i>Final Report January - December 2018 Technical Assistance and Capacity Development to Support Implementation of the Global Fund Programme on Female Sex Workers</i> (Files: GF_MOH_2018_Annual

Assumption 5.2: UNFPA supported activities and investments are strategically important to the HIV response, at global, regional and national level.	
	Report_TimShared with Annex_2019_03_20_All)
<ul style="list-style-type: none"> • 'In broad overview, the performance of the UNFPA in supporting the FSW component of the National HIV and AIDS program appears to have been satisfactory and in some respects exemplary. UNFPA was put in a difficult position, but seems to have "held the ship steady" during the transition period and led what appears to have been a successful transition to a new, potentially more effective HIV outreach model for FSW.' (p.32) 	<ul style="list-style-type: none"> • Magnani, Sutrisna and Indrasar, <i>Evaluation Report, Global Fund Program Evaluation, UNFPA Technical Assistance and Capacity Development to Support Implementation of the Indonesia National AIDS Commission's Global Fund TA and Training Plan 2016 – 2017</i>, UNFPA, 2018
<ul style="list-style-type: none"> • In 2016, the <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i> reported that 'Provision of evidence on HIV transmission to intimate partners resulted in government-led pilot to improve outreach and policies among Key-Affected Populations' (p.52) 	<ul style="list-style-type: none"> • UNFPA, <i>Mid Term Review Evaluation Report, UNFPA 9th Country Programme of Assistance to The Government of Indonesia (GOI) 2016 – 2020</i>. Dated February 20, 2019. UNFPA.
<ul style="list-style-type: none"> • UNFPA's ongoing work to implement the FSW programme, and its linked work on intimate partner notification are important components of the national HIV prevention response in Indonesia. However, according to many respondents, a fundamental challenge of working with the GF financed programme is that success is defined in terms of numbers not quality. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff, UN agency staff, government officials and members of civil society organisations
<ul style="list-style-type: none"> • UN Women and UNFPA report 'Activities addressing linkage of HIV and violence against women including the Papua Province, and including prevention of intimate partner violence in IPT module' (p.3) 	<ul style="list-style-type: none"> • <i>UBRAF Country Summary Report 2018 Indonesia</i>
<ul style="list-style-type: none"> • In 2018 UNFPA supported the development of an outreach implementation manual for FSW. It is reported that this led to increased HIV testing and access to treatment for FSW. 	<ul style="list-style-type: none"> • <i>UBRAF Country Summary Report 2018 Indonesia</i>
<ul style="list-style-type: none"> • 'Here there is no modality for government to fund NGOs, so it is very difficult for civil society organisations to operate. So UNFPA are playing an important role'. 	<ul style="list-style-type: none"> • Interviews with UN agency staff
<ul style="list-style-type: none"> • Small projects funded through UBRAF are used to supplement the activities undertaken under the GF financed programme. • A civil society representative, who also sits on the UNAIDS Programme Coordinating Board argued that most UBRAF money was being spent to support the initiatives already funded through the Global Fund programme of work (which is heavily focused on treat and treat). He argued that UBRAF funds should really be targeted on other areas, particularly gender, GBV and SRHR. 'It's not that improved case management and intimate partner notification are not important. it's just that nobody is talking about SRHR at school and out of school and we can't achieve our prevention targets unless we do that'. 	<ul style="list-style-type: none"> • Interviews with members of civil society organisations

Assumption 5.3: UNFPA maintains the technical capacity required to carry out effectively the tasks assigned to it at global, regional and national levels as part of the UNAIDS consortium.

Indicators:

- See Assumption 5.1

Observations	Sources of Evidence
<ul style="list-style-type: none"> • UNAIDS report that UNFPA is performing well. It is proactive, trusted by government and CSOs, and ‘there when needed’. 	<ul style="list-style-type: none"> • Interviews with UNAIDS Country Director
<ul style="list-style-type: none"> • No respondent questioned UNFPA’s technical capacity to carry out its tasks with regard to HIV or HIV<>SRHR<>GBV linkages and integration. However, it is a concern that UNFPA staff contended that HIV<>SRHR<>GBV linkages and integration is only relevant to generalised, and not concentrated epidemics (therefore not relevant in general to Indonesia). 	<ul style="list-style-type: none"> •

Area of Investigation Six: Extent of UNFPA efforts to support the coordination of actions and resources to strengthen national leadership in the HIV response

Evaluation Question 6: To what extent has UNFPA effectively supported and participated in platforms for coordinating and sustaining resources and programmes aimed at preventing HIV?

Evaluation Criteria	<i>Coordination, Sustainability</i>
Rationale	UNFPA and its partners are engaged in a common effort to encourage national leadership to increase sustainable national investments in HIV prevention over time. This requires concerted and coordinated efforts advocacy and associated financial and technical support along with responsive national authorities capable of making and realizing associated commitments.

Assumption 6.1: Global, regional and national coordination platforms (including the JUNTA) have been effective in identifying how external partners may most effectively contribute to nationally led policies and programmes for HIV prevention and coordinating subsequent external support.

Indicators:

- See assumption 5.1 above

Observations	Sources of Evidence
<ul style="list-style-type: none"> • In mid-2016 the Presidential office raised the possibility of dissolving the country’s National AIDS Commission (NAC). Dissolution then occurred in 2017 Presidential decree no 124/2016, established on 31 December 2016, and states that the NAC completes its work no later than 31 December 2017 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • The HIV Technical Working Group, organised as part of the Global Fund mechanism, has become very important for coordination and leadership since the NAC was dissolved. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
<ul style="list-style-type: none"> • The UN Joint Team meets monthly for updates. In 2018, UNFPA, WHO, Linkages and MoH were working together on developing the partner notification guidelines. 	<ul style="list-style-type: none"> • Interviews with UN agency staff

Assumption 6.2: Platforms and structures for coordinating support to the HIV response do not duplicate the work of other structures for coordinating action in HIV and SRHR.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> • Frequency of meetings of platforms for coordinating the HIV response and related platforms for coordination of other SRHR interventions (including mother and child health and family planning) • Overlapping mandates (or not) of HIV and SRHR related coordinating platforms • Cross-membership in platforms for coordinating action in HIV and in SRHR • Reported overlap or duplication of effort among coordinating platforms as reported by participants 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • The NAC in Indonesia acted as a government body and also as an agent for civil society. It played a relatively progressive role in the national HIV response and provided overall leadership and coordination. The NAC strongly pushed community groups to stand up and link with official stakeholders for service delivery, research and advocacy. When the NAC was dissolved, the leadership role has not yet been taken up by government. More than one respondent in the HIV evaluation commented that in Indonesia the national response to HIV is currently on ‘autopilot’. • A member of a civil society organisation told the evaluation team ‘we are on autopilot. We don’t have any leadership on HIV prevention in Indonesia. we – like others – are working without a clear vision of where we are going’. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff, UN agency staff and members of civil society organisations
<ul style="list-style-type: none"> • The country’s main coordinating platform/structure for support to the HIV, TB and Malaria response is a Country Coordinating Mechanism or CCM formed under the auspices of the Global Fund grant project. The HIV Technical Working Group which consist of member and non-member of CCM have more technical roles to develop TWG annual work plan; lead, assist and monitor the GF project proposal development; to determine proposal’ content and focuses; to propose the new PRs; to offer budget location among PRs and to monitoring PRs’ performance and provide recommendation action. • The country currently does not have a standalone National AIDS Commission; functions of the NAC were held by Coordinating Ministry of Human Development and Culture. • After the NAC dissolved in 2017, Ministry of Health no longer has responsibility as the secretariat of NAC 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff • Presidential Decree No 124/2016 on National AIDS Commission
<ul style="list-style-type: none"> • One member of a civil society organisation commented on the lack of leadership and coordination since the NAC was dissolved. They told the evaluation team of plans to create a new coordinating structure across civil society organisations. However, the respondent noted ‘we (i.e. civil society) don’t have a good track record in trusting each other. We tend to work in silos. The priority is to reclaim trust. There could be a role for UNFPA to help us’. 	<ul style="list-style-type: none"> • Interviews with members of civil society organisations
<ul style="list-style-type: none"> • UNFPA and UNAIDS have discussed the need to create a national technical working group on human rights. The ambit of this TWG would go beyond HIV. 	<ul style="list-style-type: none"> • Interviews with UNFPA Indonesia staff
Assumption 6.3: External partners, including UNFPA, have worked in concert to promote institutionalization of sustainable national investments in the HIV response that are appropriate to the evolving and emerging challenges and needs posed by the epidemic in that country.	
<u>Indicators:</u>	
<ul style="list-style-type: none"> • Agreed strategies and approaches among UNAIDS cosponsors and multilateral and bilateral partners regarding promotion of national investment in HIV response • Trends over time in national investment in the HIV response both in absolute terms and in relation to external support 	

Assumption 6.3: External partners, including UNFPA, have worked in concert to promote institutionalization of sustainable national investments in the HIV response that are appropriate to the evolving and emerging challenges and needs posed by the epidemic in that country.

- Changes in national budget procedures and criteria which institutionalize investments in HIV: i.e. commencing a specific, regular budget line for HIV budgets at national, regional, district level
- Integration of HIV budgeting and resource allocation into efforts to put national health systems on a sustainable footing including development of national health insurance schemes/programmes
- Efforts to encourage private insurers and/or private, for profit, firms to invest in national and local HIV response

Observations

- The role of **UNFPA as a sub-recipient of the Global Fund grant** is openly described as a temporary arrangement, giving time for the capacity of one of their sub-sub recipients (IAC) to grow and take over any future similar role.
- The role implementing the FSW programme **does not include any significant focus on sustainability** of the funded interventions in the absence of GF finance.
- Since the **GF financed programme focuses primarily on test and treat**, rather than the much wider range of strategies, services and initiatives required to secure a comprehensive HIV response, **UNFPA’s continued primary focus on the FSW programme may have significant opportunity costs** in terms of work required to ‘promote institutionalization of sustainable national investments in the HIV response that are appropriate to the evolving and emerging challenges and needs posed by the epidemic in that country’.

Sources of Evidence

- Interviews with UNFPA Indonesia staff, government officials and members of civil society organisations

Assumption 6.4: National governments have both the interest and the capacity to respond effectively to coordinated efforts to institutionalize and render more sustainable the national HIV response.

Indicators:

- As in 6.3 plus:
- Views of national budget authorities
- Views of Staff of UNAIDS cosponsors
- Views of UN CO staff
- Views of bilateral agencies supporting HIV prevention

Observations

- The **NAC in Indonesia acted as a government body and also as an agent for civil society**. It played a relatively progressive role in the national HIV response and provided overall leadership and coordination. The NAC strongly pushed community groups to stand up and link with official stakeholders for service delivery, research and advocacy. When the NAC was dissolved, the leadership role has not yet been taken up by government. More than one respondent in the HIV evaluation commented that in Indonesia the national response to HIV is currently on ‘autopilot’.
- A member of a civil society organisation told the evaluation team ‘we are on autopilot. We don’t have any leadership on HIV prevention in Indonesia. we – like others – are working without a clear vision of where we are going’.

Sources of Evidence

- Interviews with UNFPA Indonesia staff, UN agency staff and members of civil society organisations

ANNEX C: KEY INFORMANTS INTERVIEWED

Name	Organization	Position
Ahmadova, Shalala	WHO	Medical Officer (Communicable Diseases)
Almuna, Iriantoni	UN Women	National Programme Officer
Andriyani, Lia	Organisasi Perubahan Sosial Indonesia	National Coordinator
Apriliasari, Priska	UNFPA	Programme Finance Assistant – HIV
Ardiansyah, Sepimaulana	Inti Muda	National Coordinator
Ariastuti, Putu	Yayasan Kerti Praja Bali	Program Coordinator SSR Region III GFNMc
Assifi, Najib	UNFPA	Representative a.i.
Basri, Carmelia	Country Coordinating Mechanism Indonesia	Vice Chair
Benny	Organisasi Perubahan Sosial Indonesia	Programme Manager
Boonto, Krittayawan	UNAIDS	Country Director
Budiman, Samsu	Persaudaraan Korban Napza Indonesia (PKNI) (network of people who inject drugs)	National Coordinator
Camelia, Artha	UNICEF	Health Specialist – Child Survival and Development
Dr Astrid Seikka	Angsamerah Clinic (private clinic)	Doctor
Dr Sedy Dwisangka	Sub Directorate HIV and STI, MOH	Head of sub-directorate HIV AIDS and STI
Erlinda, Fera	Yayasan Kotex Mandiri	Peer Support Worker (for PLHIV)
Evrinarti, Rika	Suku Dinas Kesehatan JakTim (District Health Office)	Penfolatt HIV JT
Fikran, Ade	Inti Muda	Program Manager
Fithriah, Fiena	Suku Dinas Kesehatan JakTim (District Health Office)	Kepala Seksi P2P JT
Gunawan, Hendra	Angsamerah Clinic (private clinic)	Doctor
Halida, Merthia	Puskesmas Jatinegara (public health centre)	Kasatpel UKP
Harahap, Dikot	UNFPA	M&E Analyst
Hartini	Ikatan Perempuan Positive Indonesia (IPPI) (Indonesian Positive Womens Association)	Project Officer
Hidayat, Melania	UNFPA	Assistant Representative
Imma Batubara	UNFPA Indonesia	Programme Specialist for Reproductive Health
Januraga, Pande Putu	Yayasan Kerti Praja Bali	Program Manager SSR Region III GFNMc
Junniar, Linna	Puskesmas Jatinegara (public health centre)	Coordinator, HIV
Kori, Risya	UNFPA	Gender Programme Specialist
Kristono, Yacobus	Yayasan Kalandara	Executive Director
Lenny	YSS	Director
Mahatmi, Tiara	WHO	Professional Officer HIV and AIDS

Name	Organization	Position
Male patient living with HIV	Puskesmas Jatinegara (public health centre)	
Marguari, Daniel	Yayasan Spiritia	Director
Maryati, Eki	Suku Dinas Kesehatan JakTim (District Health Office)	Staff P2P JT
Merliana, Bonita	PKBI Jakarta	Regional Executive Director
Mihari, Tengku	Gaya Warna Lentera (Indonesian Network GWL-INA)	Executive Director
Mukuan, Oldri	UNFPA	HIV Officer
Muliayanto, Teguh	Yayasan Kalandara	M&E Officer
Mustafairah, Aftina	National Commission on Violence Against Women	Staff
Prabawanti, Ciptasari	Yayasan Siklus Sehat Indonesia	Director
Prameswari, Hellen Dewi	Sub Directorate HIV and STI, MOH	Staff of sub-directorate HIV AIDS and STI
Pronyk, Paul	UNICEF	Chief, Child Survival and Development Cluster
Puspa	Angsamerah Clinic (private clinic)	Operational Manager
Putra, Arry	UNDP	National Project Manager
Rina, Katarina	Yayasan Kalandara	Programme Coordinator
Rivona, Baby	Ikatan Perempuan Positive Indonesia (IPPI) (Indonesian Positive Womens Association)	National Coordinator
Sabam	Indonesia AIDS Coalition (IAC)	Programme Officer
Sapayo, Indriyati	National Commission on Violence Against Women	Commissioner
Saragih, Gloria	UNFPA	National Programme Associate
Sasha, Ellen	UNFPA	M&E Assistant - HIV
Setiabudi, Cahyo	UNFPA	Logistics and Data Assistant
Setiawah, Andy	Yayasan Kalandara	Finance Officer
Silitonga, Nurlan	Angsamerah Clinic (private clinic)	Founder / Director
Stiyani, Endang	UNFPA	Programme Assistant
Sukmaningrum, Evi	AIDS Research Centre	Director
Taslim, Aditia	Rumah Cemara	Director
Transgender woman living with HIV	Puskesmas Jatinegara (public health centre)	
Umar, Ann	Directorate General of Disease Prevention and Control (P2P), MOH	Head of Section HIV
Verdy	Jaringan Indonesian Positive (JIP)	Research Manager
Vina, Kanzha	(SWARA)	Coordinator
Wahrani, Budi	National Commission on Violence Against Women	Commissioner
Wardhana, Aditya	Indonesia AIDS Coalition (IAC)	Executive Director
Waskito, Norcahyo	UNFPA	Gender Programme Specialist
Widiastuti, Asti	UNFPA	FSW Officer
Woworuntu, Wiendra	Directorate General of Disease Prevention and Control (P2P), MOH	Director

ANNEX D: MAIN ELEMENTS OF BIBLIOGRAPHY

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ANNEX E: STANDARD OPERATING PROCEDURE FOR FIELD OUTREACH TO SEX WORKERS

Extracted from: UNFPA, *Outreach Implementation Manual for Female Sex Workers Programme in Indonesia. Final Version*. UNFPA (undated)

A. Outreach

1. A standard package for the outreach programme to female sex workers include face-to-face outreach, condom promotion and distribution (1 outreach pack consist of 8 condoms and 2 lubricants), IEC materials, and vouchers to access HIV/STI testing and treatment services.
2. A PL is responsible for the completion of the client profile form after conducting each outreach activity
3. "Face to face" outreach refers to occasions when a PL or PE (PL/PE) personally visit a FSW at a hotspot or any other venue which is mutually agreed upon; provided that these venues are located in a project location corresponding to results from the hotspot mapping process. The PL or PE will introduce herself, explain the roles and responsibilities of a PL/PE in a friendly manner.
4. A PL/PE will provide basic information on HIV/AIDS and STI; the importance of condom and lubricant use, promoting safe sex behaviour; and provide details on how and where to access prevention commodities (including condom outlets); and how and where a FSW can access health services, including testing for HIV, STI, TB and antiretroviral therapy (ART).
5. PL/PE and FSW can use mobile phone applications such as Whatsapp, Whatsapp group, Line, SMS and other voice applications to share information related to HIV/AIDS, STI; invite them to a group discussions or meetings, send out HIV and STI test reminders, provide general health information (particularly on condom promotion) and to update information on the availability of condom and lubricants.
6. A PL/PE will conduct outreach to each client at a minimum, once per semester (i.e. once in 6 months).
7. The FSW who was reached in a current semester will be considered and counted as a new outreach target in the following semester.

B. Referral to HIV Testing

1. A PL/PE who refers a FSW for a HIV test will accompany her to the health facility and stay with her until the test result is released.
2. At the point of testing for HIV, propose STI, Hep-B and TB tests as well.
3. HIV test target is considered as "achieved" when a FSW has been tested for HIV and received the result.
4. The PL/PE is responsible for the completion of details in the referral vouchers provided. (Annex 4: Vouchers A, B and C)
5. There are 3 components to the referral vouchers:
 - a. Voucher A: The Consent to Testing Voucher is to be completed by PL/PE, acknowledged, and signed by the FSW and kept by the PL/PE for filing.
 - b. Voucher B: The Referral Voucher is to be completed and signed by PL/PE; and given to the FSW as reference. This form will be handed over to the healthcare worker when the FSW presents herself for HIV testing.
 - c. Voucher C: The Test Results Voucher is to be completed by PL/PE; and given to the FSW with voucher B. Voucher C must be stamped and signed by a healthcare worker at the HIV test facility after the test is done. Once results from the test is issued, the FSW will also sign

Voucher C before submitting Voucher C to the PL/PE as evidence to support her transportation claim (also known as incentive payment).

6. The PE will hand over Voucher C to her PL for verification purposes, before reporting the HIV test as a target achieved. The PL will check against health facility data to ensure accuracy of the information.
7. If the test results can be released on the same day, the FSW requested to wait for the results at the health facility.
8. If the test results cannot be released on the same day, the FSW must return to the health facility personally to collect the results. Collection of HIV test result cannot be authorised to someone else.
9. If a negative result is received, the FSW is encouraged to access HIV testing every 3 months and motivated to continue practicing safe sex. Note that HIV test targets is only recorded once in a semester regardless of how many times each FSW access HIV tests.

C. Referral to Anti-Retroviral Treatment (ART)

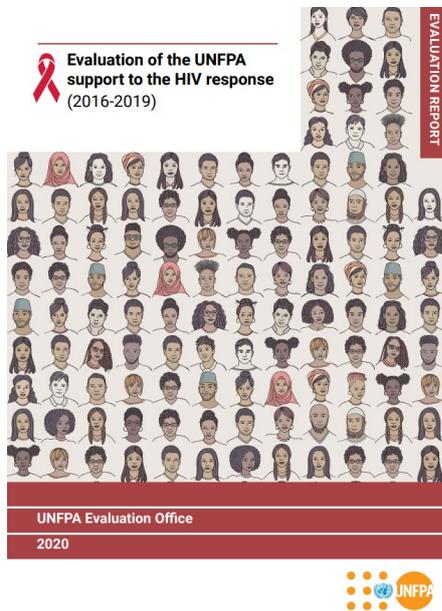
1. If the HIV test result is positive, the FSW will receive post-test counselling and provided a referral for follow up appointments at the clinic to access anti-retroviral treatment.
2. The PL must ensure the completion of ARV referral forms as follows:
 - a. Voucher D (ARV referral) is for the PL's reference. It must be signed and stamped by the healthcare provider who is referring the patient to ART.
 - b. Vouchers F (ARV Initiation) must be signed and stamped by the healthcare provider who is initiating the patient on ART.
3. To ensure ART adherence and minimise loss to follow up, the FSW is encouraged to continue engaging with the same PL when starting ART, unless the client chooses to be accompanied by someone else. It is important that a community led support system is available for a newly diagnosed patient.
4. Once the FSW is retained in treatment and care for 3 months, the designated PL will complete a "Stay on ARV" Voucher. This voucher must be stamped and signed by a health service provider as evidence to support the patient's transportation claims (incentive).
5. Payment for incentive earned by PEs (according to the number of FSWs tested for HIV and received test results) will be made between the 28th to 30th of each month by the finance department upon verification by the PL/IU coordinator and the healthcare facility. The verification process is conducted weekly (at a minimum, every two weeks) while payment is made on the monthly basis.
6. After 1 month, and with the consent of the newly diagnosed FSW, the PL will introduce her to the Peer Support Group programme. If the patient is not ready to be referred to the peer support programme, the PL will continue to provide care and support to the patient on voluntarily basis.

D. Networking

1. If a "Pokja Lokasi" (Local Working Groups) or "Pokja PMTS" is available at the project location, the IU Coordinator will encourage all PL and PE to be actively involved in the working groups.
2. Each IU is encouraged to network with other CSOs, which provide relevant services to FSWs such as LBHM and organisations providing health and social services for women.
3. For districts/project locations, which have referral mechanisms in place and financed by other sources of funding, the transport reimbursement mechanism will be made based on an agreement between the IU and relevant stakeholders by observing the evidence of liability that DINKES has specified with justification.
4. All PL, PE and FSW are encouraged to persuade their clients and intimate partners of FSWs to access the HIV and STI services. Note that these referrals will not be counted as targets achieved.

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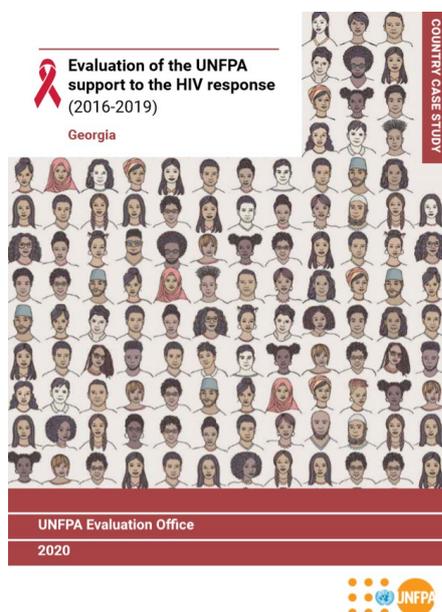
Read all the other publications on the UNFPA Evaluation Office [website](https://www.unfpa.org/evaluation).



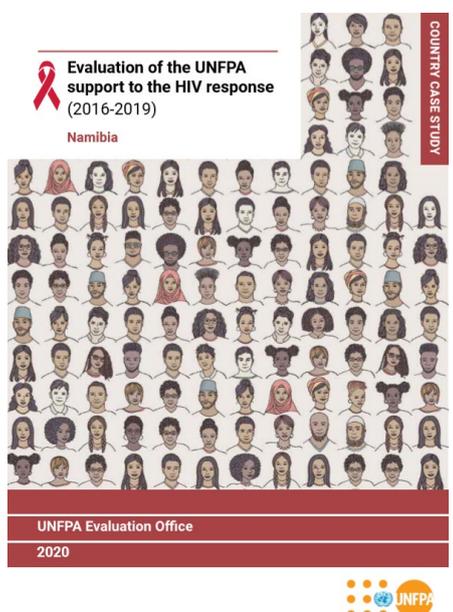
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Evaluation brief of the UNFPA support to the HIV response (2016-2019)



Georgia case study



Namibia case study



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