Scaling-up CVA for people living with HIV

UNFPA Indonesia was one of the first UNFPA country offices to integrate cash and voucher assistance (CVA) into its programmes, particularly using it to address needs of key populations such as people living with HIV (PLHIV). The provision of CVA to PLHIV is recommended by UNFPA in order to ensure that their access to SRH services is maintained in crisis situations, as CVA enables recipients to surmount some of the financial barriers they face when accessing critical support and treatment.

Cash assistance was provided conditionally against verified attendance to the ARV treatment visits and pick-up of medication as well as TB treatment, reproductive health checks, pregnancy check-ups, COVID-19 infection testing, and mental health counseling

As recipients became more comfortable with the project, in the second phase, there was a 59.42% increase of people claiming their cash transfers

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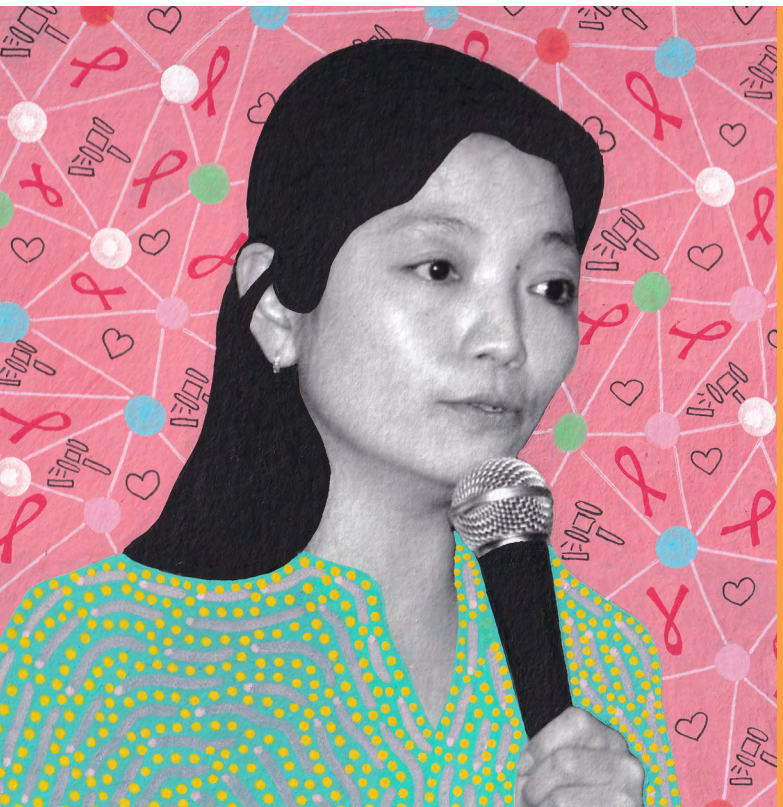


"Community alert mapping helps us see where female sex workers are working and living so they can be reached."

-Liana is a female sex worker living with HIV. She is the national coordinator of OPSI, a national network of sex workers in Indonesia. Together with UNFPA, and JIP, OPSI is developing an innovative model for reaching female sex workers with HIV in Indonesia.

Foreword

At UNFPA, we play a key role in preventing HIV, ensuring access to treatment, and integration with Sexual and Reproductive Health (SRH) programming for key populations such as men who have sex with men (MSM), transgender, sex workers, and people living with HIV.

The COVID-19 pandemic had disproportionately impacted people living with HIV, leaving these often marginalized individuals more vulnerable to high stigma and significant financial barriers in meeting their needs. In response to this situation, UNFPA Indonesia started to integrate Cash and Voucher Assistance (CVA) across its programmes in 2020. Being one of the first UNFPA country offices to pilot the CVA, we showed an innovative mindset in using cash assistance to support key populations at risk with improved access to services, ensuring their ability to continue antiretroviral treatment and to meet their sexual reproductive health needs.

Globally, UNFPA is highly committed towards scaling up CVA within its humanitarian, SRH, and Gender-Based Violence (GBV) programming, particularly for key populations. Making sure that our CVA programme component is adequately designed to meet the needs of the key populations is our priority.

In Indonesia, the initial CVA pilots also served as learning experiences for us. We have built our CVA experience, scaled up this existing approach, and started using cash as an assistance modality in our response to sudden-onset emergencies, which we have done successfully in 2022. We are now using CVA across multiple programmatic areas, including GBV programming. Our CVA is always integrated in a package of support to the recipient, as part of a holistic approach in our SRH and GBV programming.

We are thankful to our implementing partners, Jaringan Indonesia Positif (JIP), Organisasi Perubahan Sosial Indonesia (OPSI), and PKBI DKI Jakarta who have worked with us along the way in making the CVA initiative a success. We are thankful for the support and involvement of our Government partners, in particular Directorate General of Prevention Diseases Control, Ministry of Health. I would also like to warmly thank our donors, the Government of Japan and the Australian Government Department of Foreign Affairs and Trade for their trust and continued support, without whom the CVA initiative would not have been possible.

We are hopeful that we can replicate our CVA approach, integrate it into social protection programmes, and ensure a wider inclusion of marginalized groups so that no one is left behind in our future programming.

Anjali Sen
UNFPA Representative in Indonesia

Executive summary

UNFPA Indonesia first provided cash assistance in 2020, working with implementing partner Indonesian Organization for Social Change (OPSI), a national network of sex workers that is trusted and well-known by sex workers at district level, to provide cash support to 155 female sex workers living with HIV. The initial pilot programme with OPSI in 2020 coincided with the early stages of the COVID-19 pandemic, during which it was found that women living with HIV (WLHIV) and living with partners with HIV in Indonesia were facing increased economic vulnerability that was affecting their ability to access their HIV treatments and obtain other healthcare when needed.

In order to respond to these new challenges and scale-up its experience with the 2020 pilot with OPSI, in 2021 UNFPA Indonesia began to work with Jaringan Indonesia Positif (JIP), a national network that works to advocate for the rights of PLHIV in Indonesia, to develop a cash assistance component within its comprehensive programme of support to PLHIV in the country. Through this programme, PLHIV received cash assistance that was intended to reimburse their transportation costs to access ARV treatment. In the first phase of the programme in 2021, UNFPA Indonesia and JIP provided cash assistance to WLHIV, young PLHIV, and people with disabilities living with HIV in nine provinces.

Then, based on successful learnings, in 2022 UNFPA Indonesia began the second phase of its programme with CVA for PLHIV in which it enlarged its targeting criteria and substantially expanded its geographical coverage, introducing cash assistance to seven new provinces. So far, from October 2021 to June 2022, the country office has used cash assistance to reach 782 PLHIV across 16 provinces and is continuing to do so. At the time of the writing of this report the second phase of the programme was still in progress.

The CVA was provided in the form of cash assistance through mobile e-wallet transfers. It was provided conditionally against verified attendance to the ARV treatment visits and pick-up of medication as well as to other SRH and GBV services such as TB treatment, reproductive health checks, pregnancy check-ups, COVID-19 infection testing, and mental health counseling. The programme has been largely funded by the Government of Japan. Based on this experience, UNFPA Indonesia is working to develop CVA interventions specifically geared toward adolescents and youth living with HIV but also with other characteristics and needs.

The project was built on the involvement of existing networks and sought to further strengthen them such as the provincial Initiator Groups and peer support groups who played a key role, and continue to do so, in the dissemination of key information and support for the programme. The project also directly stimulated the building of local knowledge and capacity on CVA. This approach was very successful in shifting power and knowledge as today, it is implementing partners like JIP who are the ones sharing their CVA knowledge and experience with partners working for PLHIV as well as for other programme areas. This report demonstrates UNFPA Indonesia's ongoing efforts to collaborate with local and community-based partners to continue to improve and expand its projects for PLHIV and beyond. Furthermore, keeping sustainability for this approach in mind, UNFPA Indonesia and its partners worked closely with the Government of Indonesia to show them how to replicate assistance modalities to reach the furthest left behind finding a high level of interest and engagement from national counterparts.

This report outlines UNFPA Indonesia's scale-up of CVA for PLHIV and highlights the key learnings gained throughout that process. Building upon UNFPA's August 2021 case study on the initial pilot for CVA for female sex workers in Indonesia, this report documents the learning journey and decision-making that took place throughout the programme expansion.

Introduction

Indonesia has contended with HIV since its first cases were reported in 1987, with 436,948 reported active HIV cases at the time of writing. According to the most recent data published by the Ministry of Health, 149,614 (28%) of PLHIV currently in Indonesia are receiving antiretroviral (ARV) treatment. ARV treatment is a vital part of healthcare for PLHIV, helping to prevent the damage that HIV causes to the body and helping to significantly prolong the lives of PLHIV. According to modeling data from 2021, the number of new HIV cases has decreased in all key population, except for men who have sex with men. However, modeling additionally indicates that reported new cases are increasingly occurring in non-key populations. Furthermore, the COVID-19 pandemic has exacerbated Indonesia's already precarious socio-economic situation, particularly among the most marginalized groups such as PLHIV, making access to health services increasingly difficult for some.

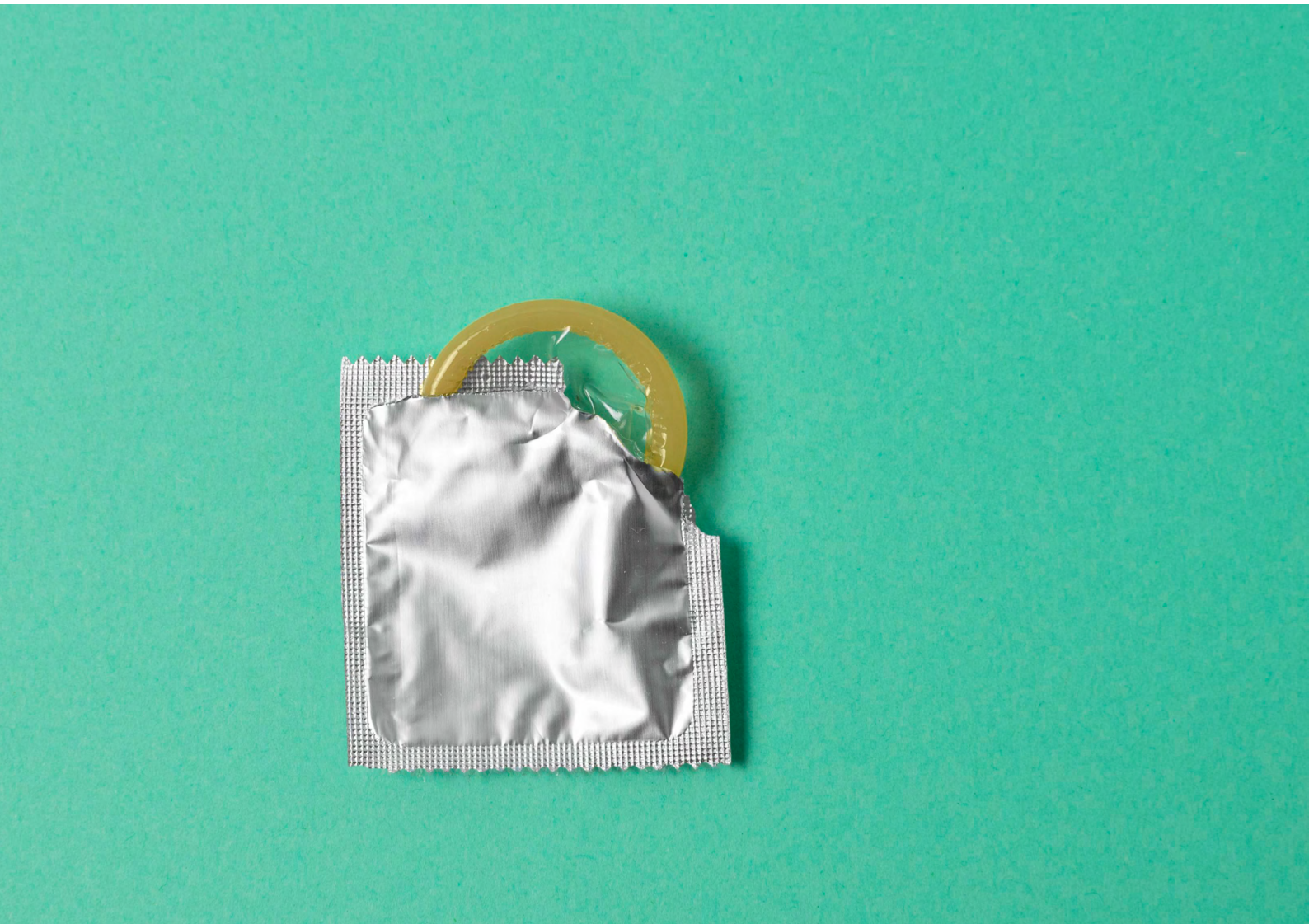
According to a survey on the socio-economic impact of COVID-19 on Indonesian households conducted by UNICEF, UNDP, PROSPERA, and the SMERU Research Institute, 74.3% of households interviewed in October-November 2020 reported earning significantly less than they had in January 2020. In households with children, this figure was even higher (75.3%). A substantial number of households (24.4%) also faced the double burden of receiving reduced earnings while simultaneously facing increased expenses. In line with this, 87.5% of respondents with at least one household member running a business said that the pandemic had impacted their business, and the proportion of women-owned businesses that were forced to close (7%) was twice as high as those owned by men.

In 2020, JIP, with support from UNFPA, conducted a rapid assessment of the COVID-19 situation in Indonesia entitled "The Impact of COVID-19 Pandemic on WLHIV and People Living with HIV-Positive Partners." Its purpose was to assess the implementation of a Community-based Partner Notification programme — a programme that aims to persuade the partners and children of PLHIV get tested for HIV — and its interlinkages with sexual reproductive health (SRH) and gender-based violence (GBV). It aimed to measure the impact of COVID-19 on the socio-economic situation, the prevalence of GBV, and the quality of sexual and reproductive health among WLHIV and women who are partners of PLHIV.

The assessment participants faced challenges accessing SRH and GBV information and services given closures and limited operating hours of those services during the pandemic. With regards to GBV, assessment participants reported being hit, slapped, kicked, and/or physically hurt by someone. According to the assessment data, the majority of those perpetrating the physical violence came from close family circles, most notably husbands (21.7%), followed by partners (19.6%) and ex-husbands (17.4%). Out of all respondents, 5.7% reported experiencing violence very often during the pandemic, while 8% reported experiencing it often and 18.4% not often.

The assessment also investigated the socio-economic situation of respondents. The assessment found that these women were worried about the economic consequences of COVID-19 and had limited access to social protection schemes from government and non-governmental organizations. The assessment found that 29% of participating HIV-positive women could not meet their basic needs, and the economic impact of COVID-19 was also felt by women who were partners of PLHIV. 28% of respondents had not received any assistance from government social protection schemes during the COVID-19 pandemic at the time of the assessment. One of the first reasons mentioned was that they had not received adequate information about existing national social protection and cash transfers that were implemented by the government within these. Furthermore, there have been significant difficulties related to registration for government social protection and CVA for these groups during the pandemic. When attempting to register for the government protection schemes, potential recipients often experienced difficulty meeting all of the administrative requirements such as having a personal ID card, a family ID card, and a reference letter from the civil office, among other requirements.

To address the challenges highlighted in JIP's 2020 rapid assessment, In 2021 UNFPA Indonesia and JIP joined forces to provide CVA for WLHIV, young PLHIV, and people with disabilities living with HIV during the COVID-19 pandemic. UNFPA Indonesia and JIP jointly designed the modality, carried out the implementation process, and documented the results of programme implementation. Following this, they were able to successfully expand the programme. While the project was initially conducted with the goal of mitigating the socio-economic vulnerability of key population groups during the COVID-19 pandemic, it has now expanded to also address the socio-economic situation of eventual recipients (source of income, system of support, etc) in order to determine their eligibility to receive cash assistance.



Programme overview and expansion

2020

Pilot for 155 female sex workers living with HIV
CVA given in 15 provinces

2021

1st phase of scaled-up programme
CVA given in 9 provinces

2022

2nd phase of scaled-up programme
CVA given in 16 provinces

Needs and coverage

Immediately following the initial pilot targeting 155 female sex workers living with HIV, the first phase of the scaled-up CVA programme covered nine provinces across western, central, and eastern Indonesia and targeted WLHIV, WLHIV and vulnerable to GBV, pregnant WLHIV, WLHIV and infected with COVID-19, adolescents living with HIV, as well as persons with disabilities living with HIV.

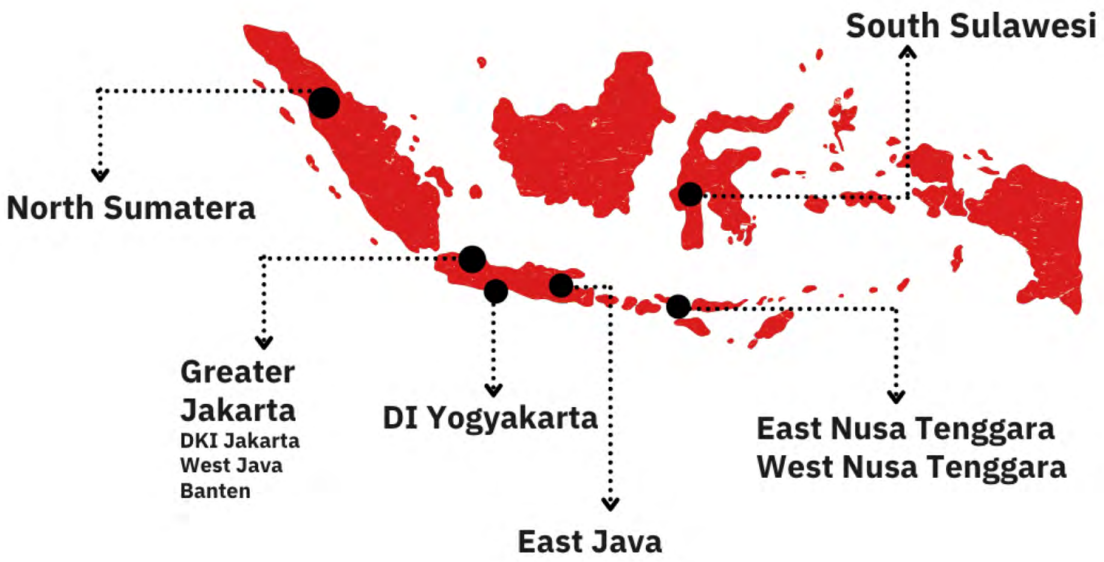


Figure 1. Phase 1 of the HIV CVA area interventions.

In the second phase of the scale-up, the expansion phase, several additional considerations were integrated into the CVA programming in order to cover other vulnerable key populations during the COVID-19 pandemic. These key populations were identified through ongoing assessments of the number of confirmed cases of COVID-19, the latest findings of HIV cases, the percentage of people living in poverty, and the unemployment rate of each province. These factors guided decisions on the groups and provinces eligible for the second phase of the programme by highlighting the areas of the first phase of the intervention that were most affected by COVID-19. These factors were then formulated and converted into a scoring matrix that used the Gini coefficient. Seven provinces were found to be eligible to be added to the CVA's area coverage in the second phase. And a number of additional groups were found eligible for cash assistance, including PLHIV with a tuberculosis comorbidity, transgender WLHIV, older persons living with HIV, and PLHIV and stopping treatment.

Scoring methods
Score = Position in the most recent HIV case discovery + Position in the most recent number of COVID-19 cases + Position in the most recent data on poverty + Position in the most recent open unemployment rate

Province	Active HIV Case Finding	Number of COVID-19 Cases	People in Poverty (%)	The Open Unemployment Rate (%)	Score	#
West Java	1115	900,862	7.97	9.82	25	1
Central Java*	1125	529,912	11.25	5.95	30	2
East Java	941	477,126	10.59	5.74	38	3
DKI Jakarta	964	1,112,077	4.67	8.5	40	
Banten	194	235,766	6.5	8.98	43	
North Sumatera	479	120,082	8.49	6.33	43	
East Kalimantan*	205	168,823	6.27	6.83	50	
South Sulawesi	223	120,642	8.53	5.72	50	
South Sumatera*	149	68,605	12.79	4.98	54	
Riau Islands*	153	58,050	5.75	9.91	57	
DI Yogyakarta	82	169,758	11.91	4.56	60	
Papua**	393	42,377	27.38	3.33	60	
West Papua**	72	27,007	21.82	5.84	62	13
Bali*	371	146,543	4.72	5.37	62	14
North Sulawesi*	113	40,849	7.36	7.06	63	15
East Nusa Tenggara	84	67,122	20.44	3.77	64	16
West Sumatera*	94	94,093	6.04	6.52	64	17

Table 1. The expansion of the second phase of the CVA trial area's coverage, where (*) denotes provinces not included in the first phase CVA trial area and (**) denotes provinces with a worsening security situation in West Sumatera*. Other Indonesian provinces were not included due to funding limitations.

Kementerian Kesehatan Republik Indonesia Direktorat Jenderal Pencegahan dan Pengendalian Penyakit. (2021). Laporan Perkembangan HIV AIDS & Penyakit Infeksi Menular Seksual (PIMS) Triwulan I Tahun 2021 (p. 5).
Satuan Tugas Penanganan COVID-19. (2022). Peta Sebaran. covid19.go.id. Retrieved 20 February 2022, from https://covid19.go.id/peta-sebaran/
Persentase Penduduk Miskin (P0) Menurut Provinsi dan Daerah 2020-2021. Bps.go.id. (2022). Retrieved 20 February 2022, from https://www.bps.go.id/indicator/23/192/1/persentase-penduduk-miskin-menurut-provinsi.html.
Tingkat Pengangguran Terbuka Menurut Provinsi (Persen), 2020-2021. Bps.go.id. (2022). Retrieved 20 February 2022, from https://www.bps.go.id/indicator/6/543/1/tingkat-pengangguran-terbuka-menurut-provinsi.html.

The table on the previous page shows the top 17 provinces with a score above the average. There are eight provinces out of nine provinces that have previously been included in the first phase of the CVA trial area. Seven new provinces appear on the list, including Central Java, East Kalimantan, South Sumatra, Riau Islands, Bali, and North Sulawesi, West Sumatera. Two provinces, which were not covered in phase 1, were excluded from the potential expansion of the second phase of the CVA, namely the Provinces of Papua and West Papua. The conflict in these two provinces has continued to heat up since the attacks in Nduga at the end of 2018 and the demonstration in Papua in 2019 making the security situation there unfortunately too volatile to allow for the inclusion of these provinces in the programming. Until now, the government has continued to take a security-based approach in those two provinces by increasing the presence of security forces against separatist criminal groups. Along with this security approach, the number of victims in these two provinces continues to increase due to the security forces, KKSB, and civilians. Hence, it is only natural that these provinces are temporarily excluded from the list.

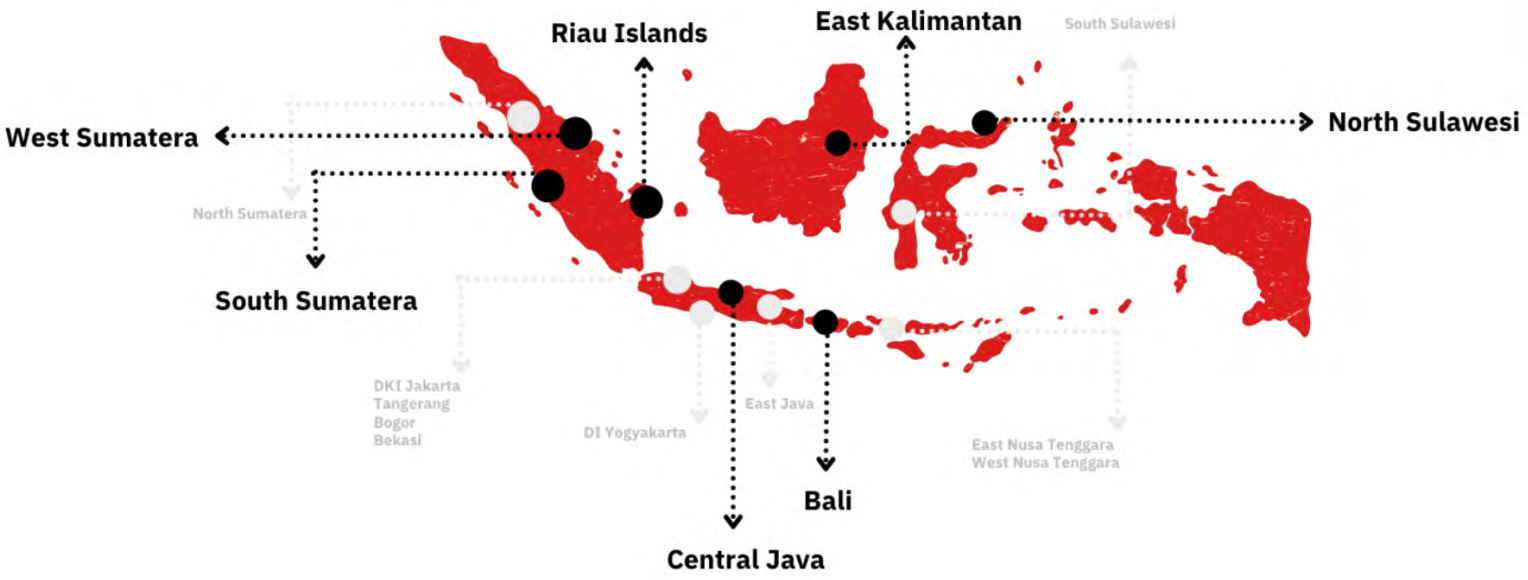


Figure 2. Intervention areas in phase 2 of the CVA for PLHIV scale-up

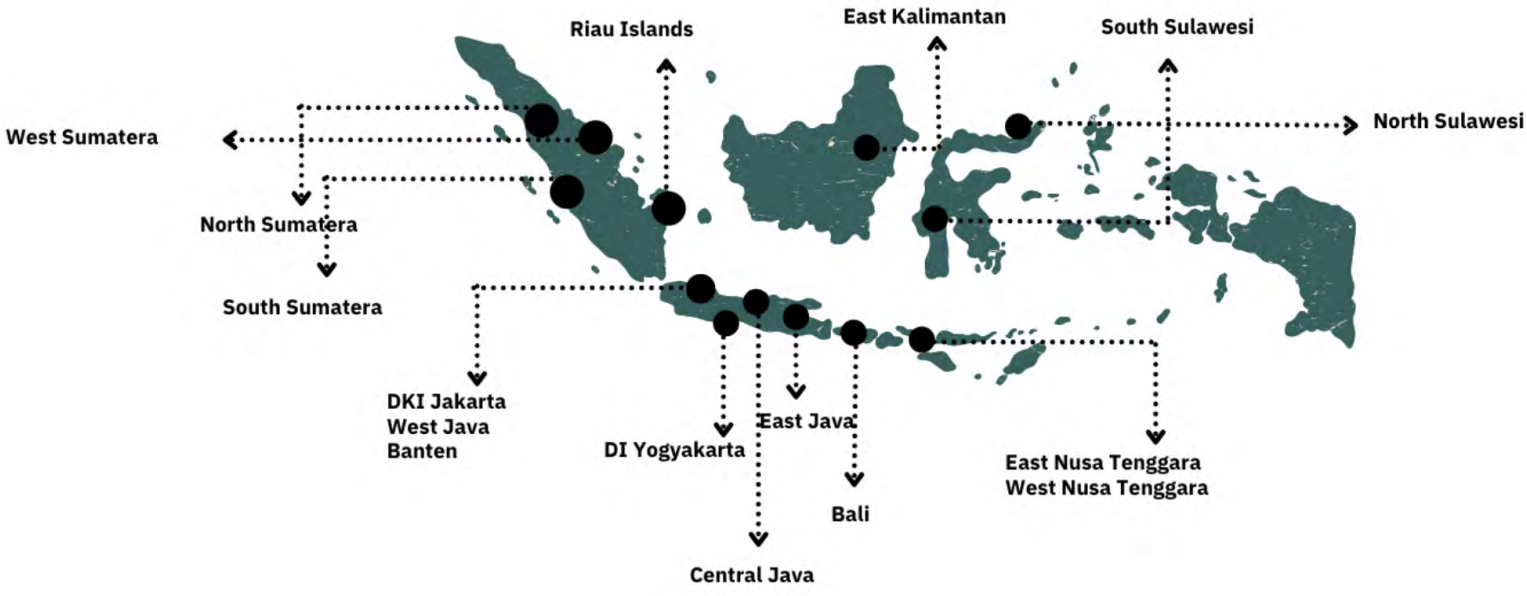


Figure 3. Provinces included included in phase 2 of the scale-up

Specific target groups and objective of the cash assistance

The following table presents an overview of the selection criteria for CVA recipients across both phases of the programme expansion. The inclusion criteria for eligible groups in the first phase of the scale-up were based on the results of the JIP survey and community consultations. In each phase of the project, the eligible groups received cash to reimburse transportation fees to ARV treatment services. The cash that pregnant WLHIV received was additionally intended to cover antenatal and postnatal care services.

Project phase	Category	Key Information
Pilot	Female sex workers (FSWs) living with HIV	This pilot responded to the sharp decrease in earnings and increased marginalization and vulnerability of FSWs during the COVID-19 pandemic.
Phase 1 & 2	•Women living with HIV •Women living with HIV and vulnerable to GBV •PLHIV and infected with COVID-19 •Pregnant women living with HIV •Persons with disabilities living with HIV	The CVA programming was designed to address the vulnerabilities of these groups, each of which were found to be in need of access to ARV treatment and complementary SRH and GBV services.
Phase 1 & 2	Young PLHIV	According to the Ministry of Health's report on HIV and Sexually Transmitted Diseases (Quarter I of 2021), youth accounted for 19% of all HIV cases from January to March 2021.
Phase 1 & 2	Transgender women living with HIV	During COVID-19, policies from the central government and local governments directly impacted the LGBTQ community, especially transgender women. Policy-related barriers to access the distribution of national COVID-19 assistance programs such as Non-Cash Food Assistance (BPNT), Direct Cash Assistance (BLT), and other programs remain fairly high in the LGBTQ community, meaning that they are often excluded from access to COVID-19 social protection schemes.
Phase 1 & 2	Aging PLHIV	Worldwide data showed that the elderly were among the most severely affected by COVID-19, facing higher mortality rates and greater severity of symptoms. In addition, the impact of COVID-19 on the elderly relates to their economic conditions and social connectedness. With this, the number of PLHIV who are elderly in Indonesia has increased in recent years: in 2016, elderly individuals living with HIV only accounted for 6.5% of the total PLHIV population, while in 2021, that percentage increased to 7.9%. Finally, in a study by JIP, 81 of 95 elderly respondents have more than one comorbidity (multimorbidity).

Phase 2	PLHIV who have stopped treatment (Loss to follow-up)	Loss to follow-up (LTFU) is defined as a situation in which a patient does not return to the health service one month after the last visit for medication or is recorded as “skipped” by the health service representative. The LTFU phenomenon is still common among PLHIV in Indonesia, with 26% (65,779 people) of those who started ARV treatment (262,693 people) ultimately being counted as LTFU. Even so, several people who were recorded as LTFU from national health services were found to have applied to receive the CVA for PLHIV programming.
Phase 2	PLHIV with tuberculosis (TB) comorbidity at the time of treatment for HIV	PLHIV are vulnerable to co-infection because of the immune system suppression caused by HIV. One of the most prevalent co-infections with HIV is TB. In 2016, it was found that HIV prevalence among TB patients reached 2.4%. Moreover, 25% of mortality among PLHIV is caused by TB.

Table 2. Types of recipients covered in both phases of the programme and key information on those populations.

Design Phase

Programmatic approach, inclusion, and gender

According to JIP's studies, PLHIV faced numerous challenges during the COVID-19 pandemic. The CVA for PLHIV programme is a complementary initiative that goes hand in hand with other JIP programmes such as the "Tanya Marolo" program for HIV counseling needs, "the Saya Berani" programme for HIV education, programmes for the distribution of dignity kits for PLHIV who are affected by natural disasters, and many other programmes responding to the needs of PLHIV. This highlights the fact that CVA should not be a standalone activity, but should rather be one component of a holistic approach to address the needs of PLHIV comprehensively. As such, it is vital that it serves as a complement to other existing programs and assistance activities.

The CVA programme component was designed in several stages: preparation, assessment and analysis, recruitment, distribution, implementation, evaluation, and feedback. In the preparation phase, JIP and UNFPA prepared the concept note and conducted capacity building among the key implementers. This process was then followed by an assessment to analyze the beneficiaries' demographics and needs. Recruitment, distribution, and implementation phases followed as the core processes of the programme. Finally, monitoring and evaluation were conducted and the implementation process was analyzed. The final stage was to monitor, evaluate, and analyze the implementation process with the goal of then replicating and expanding it.

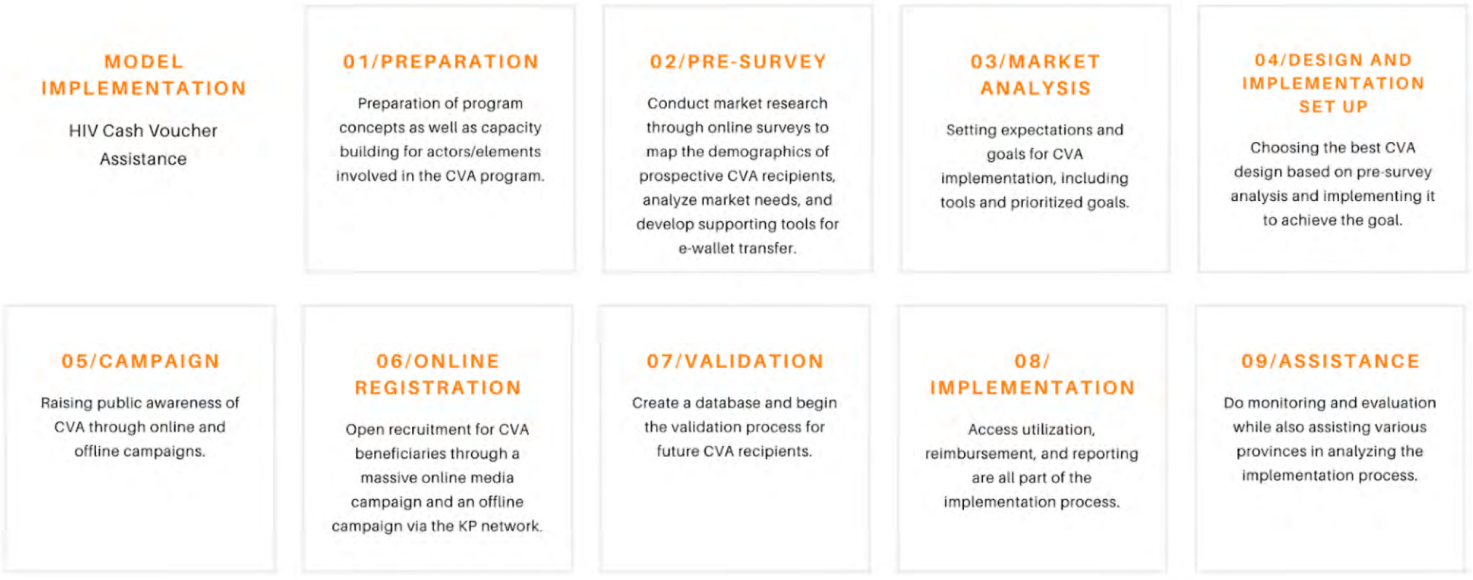


Figure 4. The CVA for PLHIV design and implementation model

This CVA programming was designed to help some of the most vulnerable groups of PLHIV. Although Phase 2 of the scale-up already expanded eligibility to additional groups (see Table 2), after three months of programme implementation the monitoring data showed a need to broaden the CVA recipient criteria even more to include transgender WLHIV, the aging living with HIV, PLHIV and LTFU, and PLHIV with TB comorbidity at treatment.

Additionally, gender and social considerations were taken into account when developing the CVA component of the HIV programme. For example, a specific category for HIV-positive women who are vulnerable to GBV was created. Women in this category had the right to claim transportation to services related to GBV, such as complaint services, counseling services, and health services for ARV treatment. They were also eligible to receive more rounds of recurring cash assistance than other groups (i.e. five cash transfers, as opposed to the maximum of three for the other CVA recipients) so as to be able to access these additional services related to their specific situation.

Community participation and outreach

One of the guiding principles of UNFPA is that its programming should be community-centered whenever possible and safe. As such, when designing the CVA component, UNFPA and JIP strived to ensure that the CVA programme was implemented in line with the community's vision and needs. JIP and UNFPA hosted the first community consultation meeting in Bandung in 2021. During the meeting, participants discussed the design of the CVA criteria, the type of support, the modalities of collaboration with local organizations, awareness-raising strategies, the delivery mechanism, financial accountability, and monitoring and evaluating processes. The first community consultation meeting resulted in a draft CVA for PLHIV Standard Operating Procedure (SOP) document. The process continued with a second consultative meeting in Surabaya in 2021, where JIP presented the CVA and SOP designs to representatives from the Ministry of Health, the Provincial Health Office, and the PLHIV Initiator Groups. The PLHIV Initiator Groups are community-led organizations in each province dedicated to providing psychosocial support, access to ARV treatment, and other related services for PLHIV. Together with a support network, they are the "go-to" organizations for PLHIV and represent anchors of support for the HIV-positive community.

In order to facilitate communication between all the implementers (JIP, UNFPA, the Initiator groups, health officials), WhatsApp groups were created in each province to facilitate communication and monitor programme implementation, A suggestion box through email was also made available for the recipients to ask questions or register complaints directly to the JIP CVA team, which was in charge of the cash disbursements.

An awareness-raising strategy to promote CVA to a large number of potential CVA recipients was also put in place. Digital posters with information on CVA were widely distributed through JIP's official social media, and the Initiator Groups also distributed e-posters in each province via existing client WhatsApp groups. For example, in South Sulawesi printed posters were distributed to health services and displayed in the Wahidin Sudirohusodo Central General Hospital. Such awareness-raising strategies are particularly important given that obtaining a referral from an HIV service is one of the requirements to be eligible for CVA. This requirement is expected to have a positive domino effect by increasing the awareness of HIV services among the most vulnerable members of the HIV population.

JIP also disseminated information through the hosting of a national CVA webinar which involved UNFPA Indonesia, Ministry of Health representatives and CVA recipients. The webinar covered UNFPA and JIP's CVA approach. Broadcast from Bahasa, 128 people ultimately participated. In addition, a live Q&A on CVA was held on JIP's official Instagram to answer questions about the implementation of CVA.

Figure 5. A poster advertising the national CVA webinar (left) and a poster announcing the opening of the registration for CVA for PLHIV at the methadone poly counter at Wahidin Sudirohusodo Central General Hospital, Makassar (right).

Process, transfer modality, delivery mechanism, and coordination

The CVA was provided in the form of cash assistance through mobile e-wallet transfers. It was provided conditionally against verified attendance to the ARV treatment visits and pick-up of medication as well as to other SRH and GBV services. Other services obtained included TB treatment, reproductive health checks, pregnancy check-ups, COVID-19 infection testing, and mental health counseling. The CVA aimed to pay transport costs or/and a small part of eventual indirect costs of the services.

SOPs for the implementation of CVA for PLHIV were developed, including implementation mechanisms, work plans, distribution channels, types and frequency of CVA, monitoring, evaluation, reporting, complaint services, and risk mitigation management. The SOPs for the implementation of CVA for PLHIV exist as a "living document" that is updated as needed based on implementation results. The regular monitoring that is conducted allows for timely adjustment and constant improvement of the programme.

Figure 6. SOP Flow for the HIV CVA Program

A. Coverage and amount

Once the needs of the target populations were clear, the intended purpose of the cash assistance and the amount to be disbursed to each recipient were decided. This was discussed during consultation meetings with various organizations. Options included providing nutritional support for pregnant women and PLHIV infected with COVID-19 and providing CVA for access to check-ups for older people with HIV. It was ultimately determined that the most viable option was to use cash transfers to reimburse transportation costs incurred when accessing ARC services. Cash transfers were calculated based on the estimated costs of transportation to access health services. Implementing partner JIP determined that the transfer value for the transportation of beneficiaries to the health facilities at provincial capital level would be Rp150,000 (USD 10.46) in line with the general guidelines for implementing the Government of Indonesia-UNFPA cooperation program cycle. The number of times a recipient can receive this support is tailored to their needs.

B. Frequency

The number of CVA claims that each recipient can make varies based on the different categories of CVA recipients and their unique situations (outlined in Table 3 below). The maximum numbers of claims were based on analysis of the level of vulnerability of each specific category of CVA recipients and their specific needs related to these vulnerabilities. It was determined that for most categories of recipients, three rounds of transfers would already have a critical impact on the ability of targeted PLHIV to seek treatment during a period of major economic stress. The rounds are not necessarily monthly rounds but are based on the individual calendars, as defined with the health facility.

CVA recipient category	Maximum number of cash claims (conditional transfer rounds)
Women living with HIV	3
Women living with HIV and vulnerable to GBV	5
Pregnant women living with HIV	8
Women living with HIV and infected with COVID-19	5
Adolescents living with HIV	8
Persons with disabilities living with HIV	3
Transgender women (waria) living with HIV	3
Aging living with HIV (over 50 years old)	3
PLHIV and who had stopped treatment (LTFU)	3
PLHIV with TB comorbidity on treatment	3

Table 3. Maximum number of disbursements for each CVA recipient

C. Roles and responsibilities

The roles and responsibilities of the implementers were outlined in detail in the CVA for PLHIV SOPs. The section regarding implementation arrangement describes the stakeholders involved at each stage, ranging from the national to the local level.

In general, JIP was tasked with developing the model and system for the CVA for PLHIV programme, in addition to conducting campaigns and disseminating information, conducting screening based on administrative data, implementing the cash transfer process, and providing monitoring, evaluation, and assistance to the Initiator Groups. At the local level, the Initiator Group in each province participated in local outreach campaigns, validation through their peer support mechanism (as peer supporters are the ones working most closely with the affected population), contacting and confirming prospective CVA recipients, and producing monthly reports related to the CVA process and the claim process. Meanwhile, health services were expected to refer relevant PLHIV to the CVA programme. The communication between the CVA for PLHIV implementers was generally carried out online through various channels, but certain activities such as monitoring were conducted offline to allow for more time for in-depth discussions.

Stakeholder	Function
UNFPA	• Determine the feasibility and response analysis for the use of the CVA. • Determine the objective, targeting, and overall design of the programme. • Select and contract of implementing partners. • Use country and global CVA tools and guidance throughout the programme process. • Provide programme oversight and coordination.
Jaringan Indonesia Positif (JIP)	• Design the CVA for PLHIV CVA model in collaboration with UNFPA. • Provide technical assistance and coaching to Initiator Groups and health services about the CVA for PLHIV program. Both the Initiator Groups and health services received information related to CVA criterias and on how recipients can access this programme. • Implement and monitor pre-survey studies, as well as conduct data analysis. • Develop posters, articles, and webinars to raise public awareness of the CVA program in collaboration with UNFPA. • Screen prospective CVA recipients and create a database to record related matters. • Make the CVA transfers after attendance has been verified (upon confirmation of the health facilities and the Initiator Groups) . • Monitor and evaluate the CVA component's implementation, as well as provide assistance/coaching.

Table 4. Stakeholders' roles in the CVA for PLHIV programme

The Initiator Group	• Participate in the CVA campaign programme, both offline and online. • Validate data to ensure that the targeting of recipients is accurate. • Secure consent of CVA recipients who pass the screening in their respective provinces. • Carry out field implementation by keeping track of the recipients' registration cards that are used to verify identity and registration at the moment of attendance at the health facility and subsequent cash transfer. • Transfer cash to recipients using the predetermined payment method (i.e. cash transfer through mobile e-wallet with an alternative option of physical cash in case the recipient does ott have a phone). • Produce reports on relevant data from the CVA for PLHIV programme in their respective provinces.
Provincial Health Office/District Health Office and Health Services	• Give endorsement for the CVA programme implementation and communicate directly with health services. • Validate beneficiaries' data when they access health services.
CVA recipients	• Enroll into the CVA. • Access ARV treatment and other SRH services. • Obtain their cash transfers. • Know how to give feedback in case of any issues, including related to the CVA.

Table 4. Stakeholders' roles in the CVA for PLHIV programme

D. Data protection and risks

Data protection, safety and security are vital elements of any CVA programming. In the CVA for PLHIV programme, several steps were taken to ensure data security for CVA recipients. These steps included limiting the data access of the different parties involved (including the mobile operator), making it so that they could only access the personal data of recipients that was strictly necessary to the transfer. Aggregate data was additionally limited in order to reduce risk. Through this process, the provincial Initiator Groups could only access data from their own province, and were prevented from accessing the raw data from other provinces. Recipients' information – such as their names and contact numbers – were also hidden when conducting data analysis with third parties.

Various measures were put in place to ensure the safe transfer of cash to each CVA recipient. At the national level, JIP ensured a safe screening mechanism. In parallel, the Initiator Groups worked as local implementors to support screening and data verification in coordination with peer support staff in their respective provinces.

Implementation

Capacity-building is imperative to effective CVA implementation. To this end, two trainings were conducted with community focal points in November 2021 and February 2022. Each time, these activities involved around 15-20 representatives from the CVA target area, including staff from implementing partners, from the Initiator Group, from peer support, and health officials. The CVA SOPs were introduced to the participants, including information on reimbursement mechanisms, data verification, and data validation. As a follow-up to the trainings, the JIP national secretariat established a platform for two-way communication as part of its virtual coaching strategy. A WhatsApp Group was established to ensure regular coordination with local implementers and coaching, social media, and emails were used to collect feedback. This communication mechanism for all parties involved in the programme implementation was also expected to broaden the sharing of CVA programme's information and its visibility.

Figure 7. Photo from CVA training, on March 7, 2022 in Bali covering the activities taking place in seven provinces involving program representatives and administrative data personnel.

Monitoring

Working with technical assistance from UNFPA Indonesia, JIP developed monitoring and evaluation tools to regularly measure the programme's effectiveness. Field monitoring was conducted to ensure programme accountability. The field monitoring team consisted of JIP and UNFPA staff who worked to arrange in-depth interviews with the CVA recipients. The CVA for PLHIV program monitoring tool was designed to collect information on recipients at the individual level. It was based on the Post-Distribution Monitoring (PDM) tools developed by UNFPA's Humanitarian Response Division CVA team and was also inspired by other existing tools. In addition to the regular monitoring process, the programme also established a communication system through which CVA recipients were able to raise questions and concerns through emails, quarterly national webinars for recipients, and Q&As on Instagram. As part of its troubleshooting strategy, JIP also held regular online meetings with the Initiator Groups to ensure that any issues were adequately addressed and resolved immediately.

The monitoring process also included interviews with representatives of the provincial Initiator Groups and visits to health facilities. Furthermore, holding public events such as live Q&As on Instagram via JIP's official social media aimed to provide the opportunity for direct feedback and accountability. The results of the monitoring visits were used to expand the targeting criteria for CVA recipients and inform programme adjustments and the revision of the SOPs as needed (including on the duration of data verification and validation).

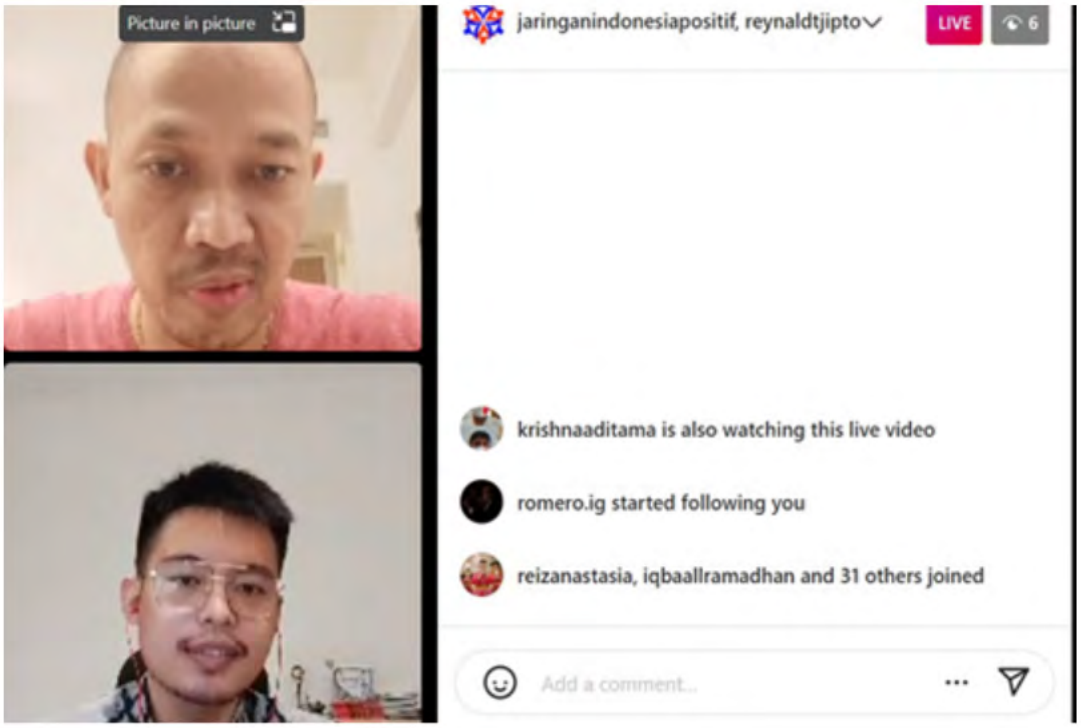


Figure 8. Live Q&A with JIP staff (both images) on Instagram

The security of feedback data is an essential concern of CVA recipients when providing input and expressing issues. JIP established a data security and safety mechanism that ensures that any feedback sent is anonymized during both the review process and during any presentation to stakeholders. The individual data can only be accessed by the data officers in the JIP secretariat and in the local Initiator Group. In an effort to continue to approve the programme, JIP is working on a website with a data security system to protect the data of beneficiaries and any feedback that they send.

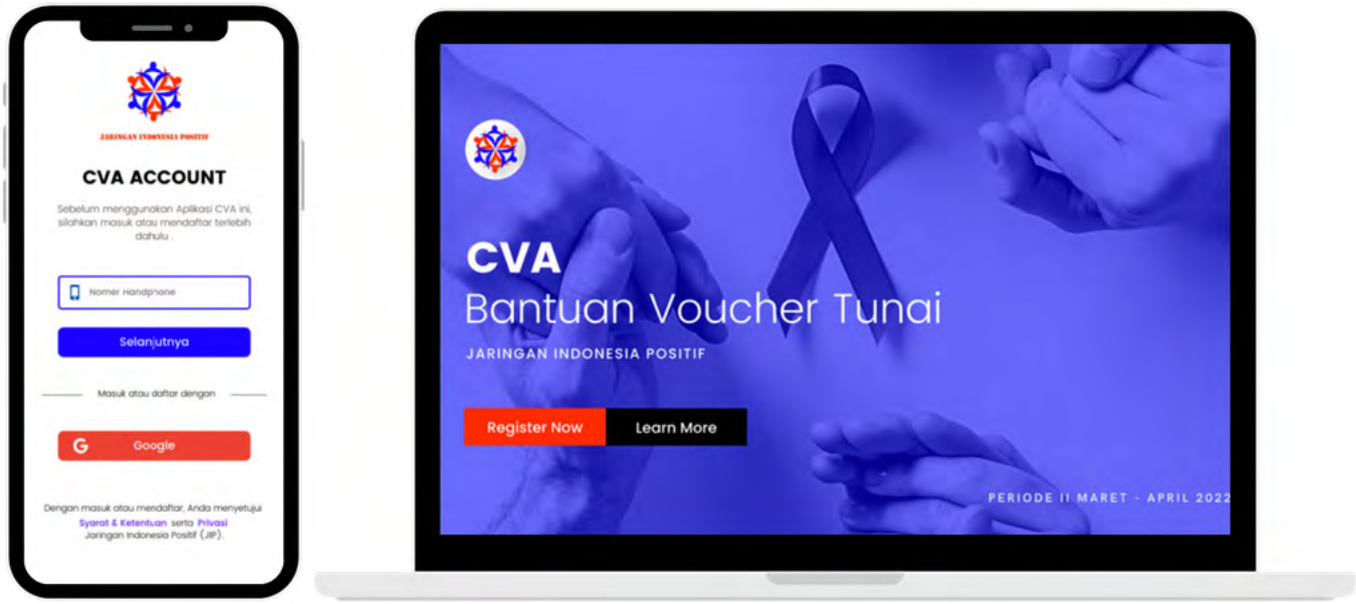


Figure 9. Mock-up of CVA for PLHIV website

Programme Results

At the moment when the monitoring was conducted, in September 2022, 716 people had received CVA in either phase 1 or phase 2 of this programme. The number of people who completed registration, passed the eligibility requirements, and ultimately claimed the CVA for PLHIV was well-monitored through programme indicators when distributing the CVA.

There was a significant improvement in participation in the second phase, with the number of registered people increasing by 20.53%, the number of people who passed the eligibility screening increasing by 184%, and claims recipients increasing by 59.42%. One of the major contributing factors to these improvements was the revision of the CVA registration form to make it easier for beneficiaries to fill out.

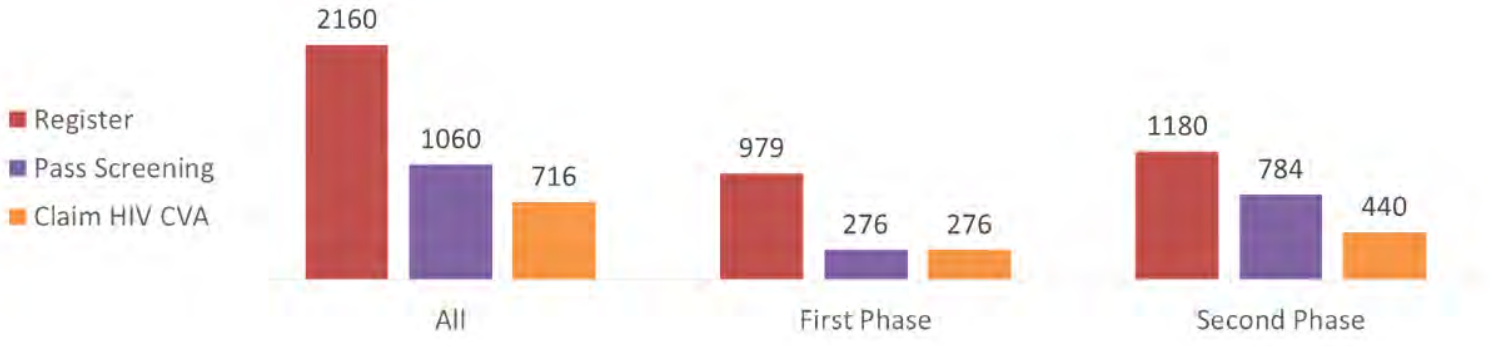


Figure 10. Total number of people who registered for the CVA for PLHIV programme, passed the eligibility requirements, and claimed the CVA

The claims of CVA varied by province, with Yogyakarta leading the way with 34.63% of the claims, followed by East Java (22.48%), East Nusa Tenggara (15.78%), West Nusa Tenggara (11.17%), Greater DKI (9.21%), North Sumatra (4.18%), and South Sulawesi (2.51%). The data also showed an increased number of claims in the second phase in four provinces, while three provinces registered a decreased number of claims in the same phase. This was due to an issue with the deadline imposed to ask for CVA after having registered for it. This was later adjusted.

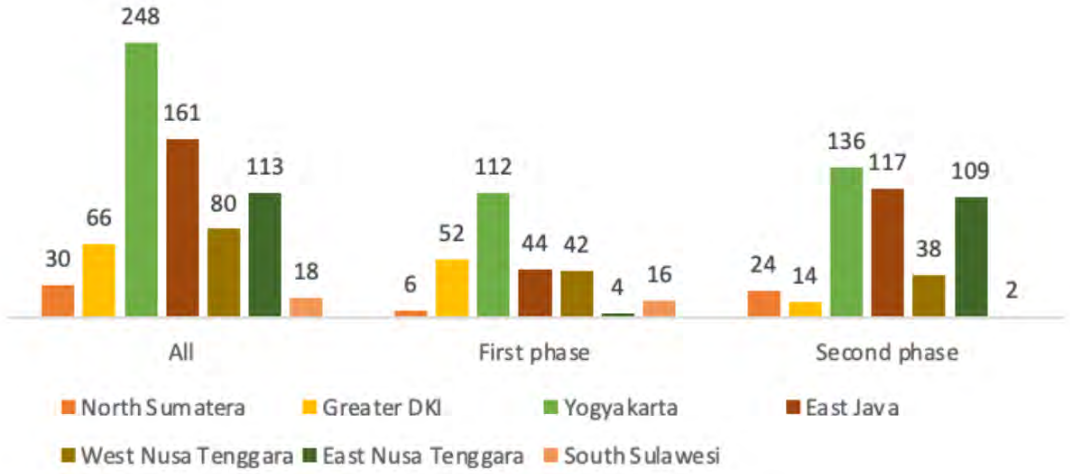


Figure 12. Coverage of the CVA programme by province.

According to the criteria for the CVA for PLHIV recipients, WLHIV were the largest group of claimants, registering more than half of the total claims (61.17%), followed by young PLHIV (19.55%), aging individuals with HIV (4.6%), PLHIV and a TB comorbidity (3.49%), transgender WLHIV (2.93%), pregnant women living with HIV (2.93%), persons with disabilities living with HIV (2.51%), individuals LTFU (1.25%), WLHIV who are vulnerable to violence (1.25%), and women living with COVID-19 infection (0.27%).

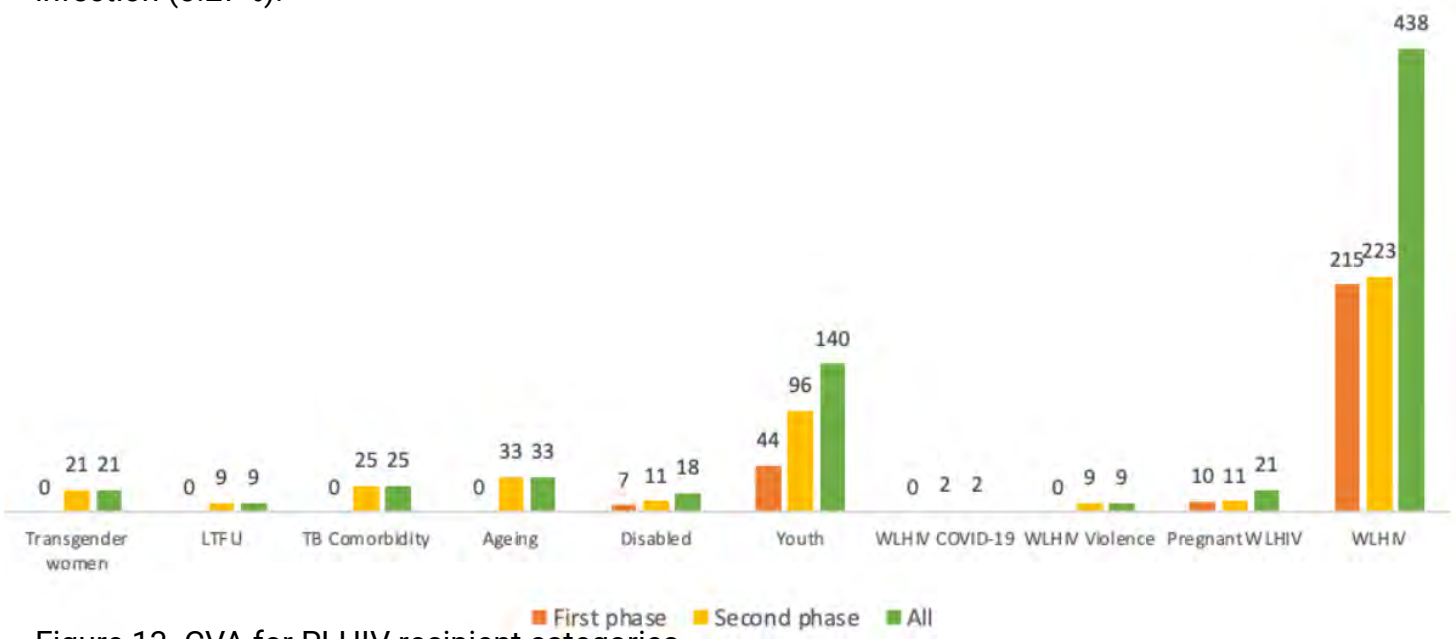


Figure 13. CVA for PLHIV recipient categories.

A total of 1,468 CVA transfer requests/claims were registered across the 716 recipients. The vast majority were CVA for PLHIV recipients (97.34%) who claimed transportation costs for ARV treatment, while only a few claimed transportation costs for other treatments and services (2.65%). According to the monitoring results, the highest priority for CVA recipients was to secure access to ARV treatments. Other services obtained included TB treatment, reproductive health checks, pregnancy check-ups, COVID-19 infection testing, and mental health counseling. The CVA aimed to pay transport costs or/and a small part of eventual indirect costs of the services.

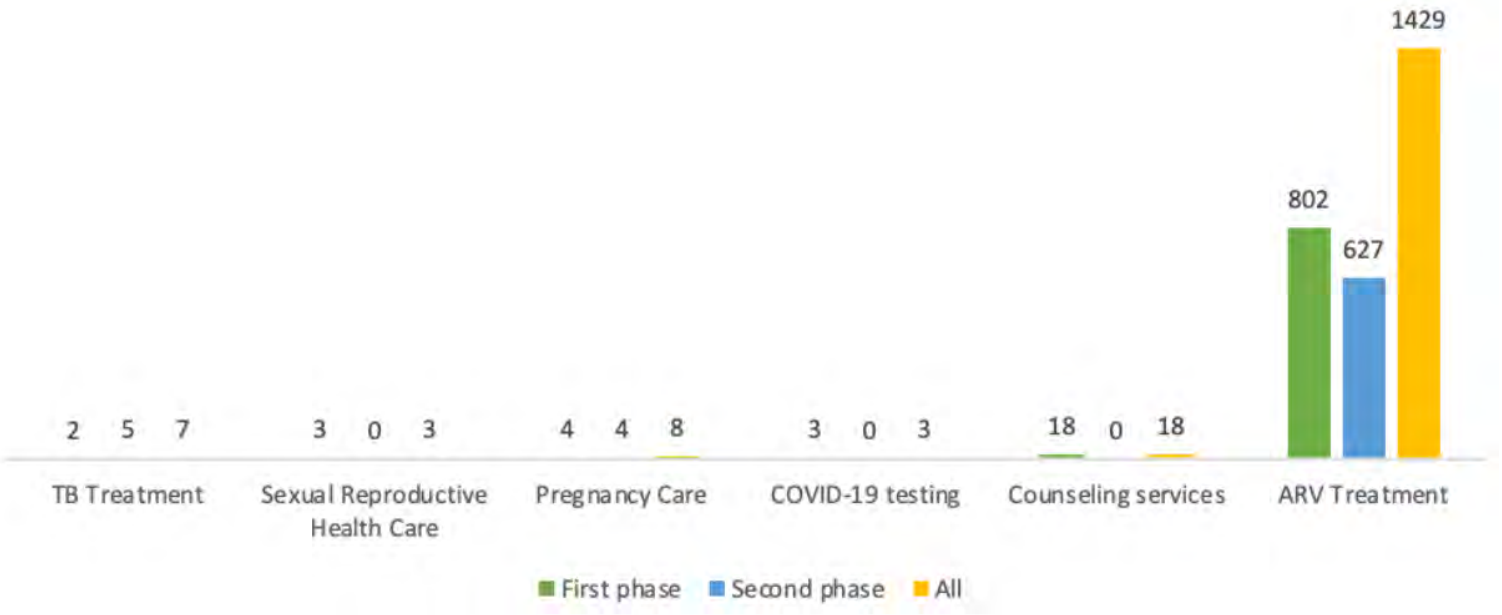


Figure 14. Services or treatments for which the CVA recipients claimed CVA.

On average, in the first phase of the project recipients of the CVA for PLHIV received three cash transfers (3.014). This is in line with the fact that the majority of recipients in the first phase were HIV-positive women with the possibility to claim transfers for a maximum of three times.

In the second phase, recipients of the CVA for PLHIV claimed their cash assistance for access to services an average of only once or twice (1.445). This is not surprising given that recipients of the CVA for PLHIV in the second phase may have been less aware of the possibility of making multiple claims (up to the maximum of cash transfers they are eligible for in accordance with their targeting category) and due to the fact that at the time of the writing of this report the second phase of the programme was still in progress. In line with this, the data shows that there are 344 PLHIV who had passed the screening but had not yet made their claims for CVA at the time of writing, as illustrated in figure 15. Outreach and awareness raising will continue for the new category of recipients who are less familiar with the CVA component, helping to steadily increase access to treatments and services.

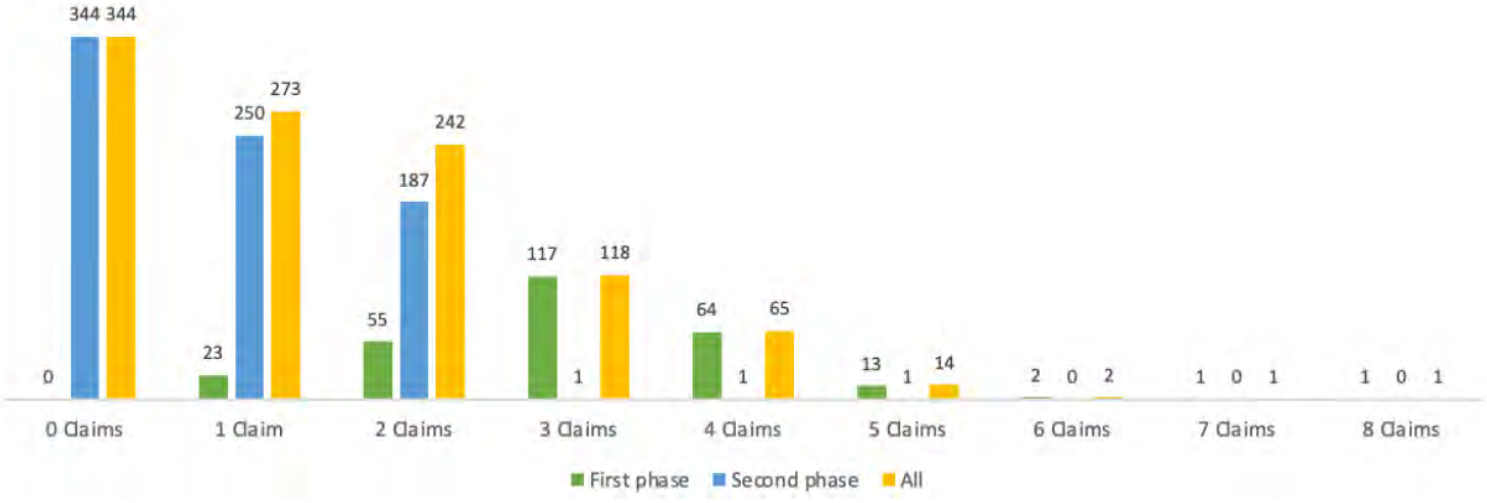


Figure 15. Number of cash transfer claims made.

Sustainability and exit strategy

Meaningfully impacting health-seeking behaviors in times of significant economic vulnerability requires medium to longer term programme durations, including for programming such as CVA. With this, to be truly effective CVA programming must exist as a complementary component within other comprehensive programmes that ensure the provision of education, availability of services, respectful and dedicated staff, and other important needs. At the same time, CVA must also be designed to address the recurring needs of its target groups, such as by providing a minimum of three rounds of cash transfers when appropriate.

While the CVA for PLHIV programme was initially started in response to the impact of the COVID-19 pandemic, the programme continues to this day in order to respond to the continued financial challenges of its vulnerable target groups. To do so, UNFPA Indonesia and its partners continue to work closely with the Government of Indonesia to cover a gap in the national HIV social assistance programme by reaching some of the PLHIV who are left the furthest behind, relying on peer support networks to do so. To show them how to replicate assistance modalities with high levels of engagement, UNFPA Indonesia continues to include health officials at district level in the programme at the initial design stages. The newfound experience of health officials and partners in the use of CVA for PLHIV – a notable area of interest for the Government – will hopefully pave the way for further replication on their part. Exploring partnerships with individuals and philanthropy organizations will also be strategic for the sustainability of the CVA for PLHIV programme. The CVA model and design could be presented to philanthropy networks, Islamic financing institutions, and other public-private partnership platforms as part of transitioning the programme away from UNFPA.

Conclusion

The report demonstrates how UNFPA Indonesia has used the scale-up of the CVA for PLHIV programme to continue to expand and diversify its CVA programming. New CVA projects are planned in new programme areas in 2023, illustrating the successful approach of initiating a pilot and then learning, improving, and scaling it up. At the UNFPA level, pre-conditions for a successful CVA programme were ideal given the strong support of the Senior Management for CVA and a very committed and innovation-driven team.

Information collected throughout monitoring shows that once outreach and awareness-raising were completed, there was good uptake of obtaining CVA in order to access ARV treatment, TB treatment, reproductive health checks, pregnancy check-ups, COVID-19 infection testing, and mental health counseling. More data will be shared in the future on the feedback of recipients, their satisfaction with the CVA, and their interest in continuing to practice positive health-seeking behaviors.

Based on its initial experience with the small pilot of CVA for female sex workers, UNFPA Indonesia strengthened and expanded its use of CVA for PLHIV in this scale-up. It focused on having a quality programme in place, with CVA as just one component within a comprehensive programme of support to PLHIV, thereby multiplying the CVA's impact. UNFPA Indonesia has aimed to provide tailored support to address the realities of PLHIV, for instance by tailoring the frequency of cash transfers that PLHIV are able to obtain based on their category of needs and vulnerabilities. In the future, UNFPA Indonesia might also look to tailor the CVA to personal needs even further by adjusting cash transfer amounts to fit the needs of each individual when relevant.

This is already being done in the CVA component of another project whereby a “menu” of different cash amounts are made available to correspond to the varied individual needs. This is a great illustration of the fact that UNFPA globally strongly advocates for cash assistance on the grounds that it is a flexible modality.

An important element for the success of the CVA for PLHIV implementation was the involvement of the Initiator Groups at the provincial level, building on and strengthening existing networks. This trusted network of support played a significant role in disseminating information on the CVA, conducting data screening and validation and conducting data and financial reporting.

This project directly stimulated the building of local knowledge and capacity on CVA. UNFPA Indonesia made sure to build the capacity of its key local partners on CVA through a dual approach of learning by doing and organizing capacity-building events with all partners. This approach was very successful in shifting power and knowledge: today, it is implementing partners like JIP who are the ones sharing their CVA knowledge and experience with partners working for PLHIV as well as for other programme areas.

This report demonstrates UNFPA Indonesia’s ongoing efforts to collaborate with local and community-based partners to continue to improve and expand its projects for PLHIV and beyond. Moving forward, this work will continue to be conducted in close collaboration with Government entities with the goal of possibly converting some of the experience with UNFPA Indonesia’s CVA for PLHIV programme into sustainable components of nationwide programming.

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