CONSULTATION REPORT

Young Key Population and Young PLHIV Priority Interventions

in Indonesia's Global Fund GC8 Funding Request

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Executive Summary

This report presents 13 priority interventions identified by young key populations, namely: young MSM, FSW, transgender individuals, and PWID aged 15–24 — for inclusion in Indonesia's Global Fund Grant Cycle 8 (GC8) funding request. The priorities are grounded in IBBS 2023 epidemiological data, a rapid review of GC7 program performance, and direct community voices from focused group discussions conducted as part of the Young People Engagement project.

The central finding is consistent across all activities: Indonesia's GC7 HIV program was structurally comprehensive but not youth-responsive. It was designed for key populations broadly but not for the vulnerable young people aged 15–24, and especially not for those under 18 who face additional legal and administrative barriers to accessing HIV services.

A critical and underaddressed gap runs across all three modulars: the absence of explicit programming for young key populations under 18 years old. Indonesia's MoH regulation Number 23/2022 already provides the legal basis for under-18 individuals to access HIV services with a companion — but this regulation is not consistently enforced. GC8 must translate this legal right into operational practice.

Prevention (4)	Test & Treatment (6)	RSSH (2)
• Sexual education in high schools + referral to young outreach workers • Youth outreach for <18 with legal protection (guardian mandate) + condom/PrEP distribution	• Mobile comprehensive testing (HIV+PrEP+ART+counseling) with extended hours • Enforce MoH Regulation number 23/2022: accept under-18 clients with outreach companion • Linkage-to-care with peer navigators + treatment for under-18 without parental consent • KDS Muda/Youth peer support group — mandatory referral for PLHIV <18 • Youth-specific ART adherence + peer	• Age-disaggregated SIHA data for <18 and <24 • Young peer educator capacity building & recognition

	counseling & mental health	

Section 1: Introduction

1.1 Purpose of This Report

This document presents the priority interventions identified by young key populations for Indonesia's GC8 funding request. Its primary purpose is to serve as the substantive input for the GC8 funding request proposal .

1.2 Methodology

This report integrates evidence from four activities:

#	Activity	Contribution to This Report
1	**Desk Review**	GC8 mechanism and HIV National Action Plan 2026–2030 draft
2	**Rapid Review (GC7)**	Gap analysis: GC7 program strategy and IBBS 2023 age specific analysis
3	**Community Training**	Built community capacity to engage with GC8 process; informed quality of consultation discussions
4	**Community Consultations**	FGDs with young MSM, FSW, TG, PWID

1.3 Overarching Finding

Across all four activities, one finding emerges consistently: Indonesia's GC7 HIV program was structurally comprehensive but not youth-responsive. It was built for key populations broadly without age-specific targeting, age-adapted service delivery, or age-disaggregated monitoring. The IBBS 2023 data documents the consequence: young key populations consistently underperform older age groups at every stage of the HIV response.

A sharper version of this gap centers on young people under 18 years old. This age group faces compounded barriers that GC7 entirely failed to address: service hours that clash with school schedules, parental consent requirements that prevent treatment access, legal uncertainty around commodity distribution to minors, and the absence of youth-specific peer support structures. These are not gaps that can be addressed by scaling up existing programs — they require new, specifically designed interventions.

Section 2: Situational Context

The following key data points from IBBS 2023 establish the epidemiological urgency behind the priority interventions in Sections 3–5.

#	Indicator	Young MSM	Young TG	Young FSW	Young PWID
1	**Sexual debut age 15–19**	**71%**	**70.7%**	**79.9%**	**34.1%**
2	**Consistent condom use (steady partner)**	**37%**	**17%**	**40.2%**	**10% (casual)**
3	**Never tested for HIV**	**38%**	**28.5%**	**50.4%**	**43.6%**

4	**Aware of HIV+ status (1st 95)**	**56%**	**39.7%**	**28.9%**	**36%**
5	**On ART (2nd 95)**	**43%**	**19%**	**7.9%**	**8%**
6	**Virally suppressed (3rd 95)**	**36%**	**14.3%**	**2.6%**	**8%**
7	**Avoid healthcare due to stigma**	**18%**	**31.5%**	**19%**	**—**

Source: IBBS 2023 (STBP 2023). All figures for young key populations aged 15–24.

Section 3: Priority Interventions — Prevention Modular

P1 | *Prevention Modular*

Sexual Education in High Schools with Referral Mechanism to Young Outreach Workers

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
IBBS 2023 shows that sexual debut between ages 15–19 is the norm across all young key population groups (71% MSM, 79.9% FSW, 70.7% TG). This is precisely the age when young people are in high school. No GC7 prevention program reaches this window of vulnerability — prevention programming begins only after someone has already been identified as a key population member.	Introduce sexual health education in senior high schools (SMA/SMK) delivered by trained young peer educators from the community. Develop a formal referral mechanism linking students who want to access HIV testing or counseling directly to community outreach workers. Engage school counselors (BK) as gatekeepers to the referral pathway. Design curriculum that covers: HIV risk, testing, condom use, consent, and how to access services — without stigmatizing language.

💬 Community Voices

"Outreach is essential, but the presentation isn't very appealing—it needs to be tailored to be more relevant to young people."

"Outreach efforts carried out by youth organizations are greatly needed."

"HIV awareness initiatives in higher education are also needed—this is an area that has been neglected so far."

Source: Community Consultation — FGD Prevention & Screening, 2026

P2 | *Prevention Modular*

Youth Outreach for Under-18 with Legal Protection: Guardian Mandate + Condom & PrEP Distribution

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
Under-18 key populations are effectively invisible in GC7 programming. Field workers	Establish a formal guardian/companion mandate for outreach workers serving key

lack legal protection when working with minors — creating fear of criminalization when distributing condoms or accompanying clients under 18 to services. MoH Regulation Number 23/2022 provides a legal basis for service access with a companion, but no equivalent mechanism exists to protect outreach workers in the community setting.	populations under 18 years old — formalized through an official assignment letter that designates the outreach worker as the legal companion/guardian for the purposes of service access. This letter provides legal protection for: (1) distributing condoms and lubricant to under-18 clients; (2) distributing PrEP information and referral; (3) accompanying under-18 clients to health facilities. Set explicit program targets for reaching key populations aged 15–17 across all four groups. Coordinate with the local government and Kemenkes to ensure the assignment letter is recognized by health facilities.

💬 Community Voices

"There is a fear of bringing supplies to the field due to the HIV regulation—staff need clear legal protection.

"For those under 18, they're asked to bring a parent—but that's exactly what they can't do."

"There are safety considerations regarding staff diversity—protection for both staff and clients is equally important."

Source: Community Consultation — FGD Prevention & Screening, 2026

Section 4: Priority Interventions — Test & Treatment Modular

T1 | *Test & Treatment Modular*

Mobile Comprehensive Testing with Extended Hours: HIV + PrEP + ART + Counseling in One Point

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
Service hours at health facilities (typically 08:00–12:00) systematically exclude young key populations who attend school or work during the day. Existing mobile testing is limited to HIV testing only — young people cannot access PrEP, ARV, or counseling through mobile services. This forces multiple visits to multiple locations, creating loss-to-follow-up at every step.	Establish mobile comprehensive service delivery units that provide in one visit: HIV testing (including rapid and OFT), PrEP initiation and refill, ARV dispensing (for existing PLHIV), pre- and post-test counseling, and STI screening and treatment referral. Operate these units during non-standard hours: after school (15:00–20:00 on weekdays) and on weekends. Implement appointment-based scheduling via WhatsApp/digital channels to minimize waiting time. Ensure units are specifically authorized to serve under-18 clients with an outreach companion.

💬 Community Voices

“A fully equipped mobile clinic for testing and treatment—not just testing, but a comprehensive package from testing to immediate access to services.”
“HIV clinic hours from 8:00 a.m. to 12:00 p.m. aren’t suitable for young key populations who are in school or at work during the day.”
“The services needed are more flexible—they should offer appointment-based options and be accessible outside of regular business hours.”
Source: Community Consultation — FGD Testing & Treatment, 2026

T2 | *Test & Treatment Modular*

Enforce MoH Regulation Number 23/2022: All Facilities Must Accept Under-18 Clients Accompanied by Outreach Companion

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
MoH Regulation No. 23/2022 establishes that individuals under 18 may access HIV services when accompanied by a companion. However, community consultations confirm this regulation is not consistently enforced — facilities still refuse to serve under-18 clients without a parent or guardian, or are simply unaware of the regulation. This leaves young key populations under 18 without legal access to HIV services.	Include enforcement of MoH regulation No. 23/2022 as an explicit requirement in GC8 program implementation. Require all GC8-funded health facilities to: (1) display the regulation publicly; (2) train all HIV service staff on its provisions; (3) accept under-18 clients accompanied by a certified outreach companion; and (4) document under-18 client visits in a way that enables age-disaggregated reporting. Develop a standardized companion authorization form for outreach workers. Include facility compliance as a Community-Led Monitoring indicator.

💬 Community Voices
“‘For those under 18, they’re asked to bring a parent—but that’s exactly what they can’t do.”.
“Collaboration between the Ministry of Youth and Sports and the Ministry of Health is essential to ensure young people can access services without administrative barriers.”
“It is hoped that partners and caregivers can serve as consent providers—this needs to be clearly legalized.”
Source: Community Consultation — FGD Testing & Treatment, 2026

T3 | *Test & Treatment Modular*

Linkage-to-Care with Peer Navigators + Treatment for Under-18 Without Parental Notification

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
The treatment cascade collapses after diagnosis for all groups. Young FSW: 28.9% know status → 7.9% on ART. Young PWID: 36% → 8%. A critical sub-gap is that under-18 PLHIV face an additional barrier: parental consent requirements for treatment	Establish a dedicated linkage-to-care component with trained peer navigators for all young PLHIV. Mandate same-day ART initiation as standard practice. For under-18 PLHIV: develop a protocol that allows treatment initiation with outreach companion as consent party (without parental

initiation. Community consultations document cases where young PLHIV are lost to follow-up specifically because they cannot or will not involve their parents.	notification), aligned with Permenkes 23/2022 and developed in collaboration with Kemenkes and KemenPPA. Train outreach workers and peer navigators specifically on supporting under-18 PLHIV through treatment initiation. Create systematic follow-up protocols to prevent loss-to-follow-up after diagnosis.

💬 Community Voices

"Primary healthcare providers can provide same-day ARVs—this should be the standard, not the exception."

"Loss to follow-up occurs when ARVs are not provided on the same day—delays are the main obstacle to linkage to care."

"A personalized approach is crucial for adolescents under 18—they need a support person they trust."

Source: Community Consultation — FGD Testing & Treatment, 2026

T4 | *Test & Treatment Modular*

KDS Muda — Young Peer Support Groups as Mandatory Referral for PLHIV Under 18

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
There is no structured peer support system specifically for young PLHIV in GC7. Older PLHIV support groups (KDS) exist but are not appropriate for under-18 individuals who face different social, psychological, and legal challenges. Community consultations document that young PLHIV — especially those newly diagnosed — need peer support from people their own age in order to accept their status, remain on treatment, and navigate the social consequences of being HIV-positive as a young person.	Establish KDS Muda (Young Peer Support Groups) as a new intervention — specifically for PLHIV aged 15–24, with dedicated sub-groups for under-18 individuals. Mandate referral to KDS Muda as a standard step in the post-diagnosis care pathway for PLHIV under 18. Fund community organizations that currently provide informal peer support to formalize and expand this function. Train KDS Muda facilitators in: psychosocial support, treatment literacy, confidentiality, and the specific legal rights of young PLHIV. Integrate KDS Muda activities into the RSSH/CSS component as a community systems function.

T5 | *Test & Treatment Modular*

Youth-Specific ART Adherence Support + Peer Counseling & Mental Health Integration

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
ART coverage is stagnant or declining: young TG 21%→19%, young FSW 7.9%, young PWID 8%. Even among those on ART, viral suppression rates are critically low. Community	Increase number of peer support workers with dedicated caseloads for young PLHIV — maximum 30 active young clients per PS. Mandate an intensified first-3-months protocol

consultations reveal that peer support workers (PS) manage caseloads of hundreds of clients — making meaningful adherence support impossible. Counseling quality is also inconsistent, with religious framing and non-affirming approaches actively alienating young clients.	for young PLHIV: regular peer check-ins, mental health screening, and proactive LTFU prevention. Develop community-sensitive, non-judgmental counseling protocols — explicitly excluding religious framing and affirming of gender and sexual diversity. Integrate mental health screening as standard in post-test counseling and first-year treatment follow-up. Establish formal referral pathways from HIV counseling to mental health services.

💬 Community Voices

“One social worker handles nearly a hundred clients—it’s impossible to provide meaningful support with such a heavy caseload.”

“The first three months of support are crucial for young people living with HIV—they’re the ones who most often fall through the cracks.”

“Religious aspects in counseling are irrelevant—they actually discourage young clients from returning.”

Source: Community Consultation — FGD Testing & Treatment, 2026

Section 5: Priority Interventions — RSSH / Community Systems Modular

Three RSSH priorities are essential to making the Prevention and T&T interventions work — and to ensuring that GC8 program performance for young key populations can be measured, monitored, and improved over time.

R1 | *RSSH Modular*

Age-Disaggregated Data in SIHA: Mandatory Reporting for Under-18 and Under-24

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
This is the most fundamental structural gap in the entire GC8 program architecture. Indonesia's SIHA (Sistem Informasi HIV-AIDS) does not systematically disaggregate program data by age. Without age-disaggregated routine data, it is impossible to know whether GC8 interventions are reaching young key populations — or whether the under-18 gap is being closed. The IBBS 2023 survey is the only existing source of youth-specific data, but it is periodic and not sufficient for program management.	Require SIHA to collect and report data disaggregated by age group: under-18, 18–24, and 25+ for all key population program indicators. Mandate age-disaggregated targets in the GC8 Performance Framework for all three modulars. Provide technical support to sub-recipients to ensure age-disaggregated data collection is operationally feasible. Include age-disaggregated data quality as a CLM monitoring indicator.

R2 | *RSSH Modular*

Young Peer Educator Capacity Building and Formal Recognition

🔴 THE GAP	🟢 RECOMMENDED INTERVENTION
Peer educators and outreach workers (PL) are the primary HIV prevention and testing access point for young key populations — and the backbone of the P1 and P2 interventions proposed in this report. Yet community consultations consistently reveal that PL face: inadequate training beyond basic testing; no formal health system recognition; excessive caseloads; unsustainable compensation; and insufficient skills to serve the specific needs of under-18 clients.	Develop a dedicated Youth Peer Educator training curriculum covering: HIV+STI+TB prevention, PrEP, harm reduction, mental health first aid, human rights and legal literacy (including Permenkes 23/2022 and surat tugas mechanism), gender-affirming communication, and working with under-18 clients. Establish formal recognition of young peer educators within the health system. Set sustainable compensation standards. Develop PL capacity building specifically for PWID-focused outreach. Create inter-district peer educator networks for shared learning and mentorship.

💬 Community Voices
“Outreach workers (PL) are desperately needed—but it’s too focused on test scores rather than the deeper needs of young people.”
“We need more PL programs specifically for Penasun—this group has very different and specific needs.”
“The language and approach of PL need to be more approachable—especially to reach young people who are new to this.”
Source: Community Consultation — FGD Testing & Treatment, 2026

Section 6: Cross-Cutting Recommendations

6.1 Operationalizing MoH Regulation Number 23/2022 Across All Modulars

The single most cross-cutting recommendation in this report is the full operationalization of Moh Regulations Number 23/2022 — the regulation that already grants under-18 individuals the right to access HIV services with a companion. This right exists on paper. GC8 must make it real in practice across prevention (P2), testing and treatment (T2, T3), and community systems.

> GC8 should include a specific program component dedicated to Permenkes 23/2022 enforcement: facility training, standardized companion authorization forms, compliance monitoring, and a complaint mechanism for under-18 individuals whose rights are denied.

6.2 Youth-Responsiveness as a Design Standard

Every GC8 intervention must explicitly answer: does this reach young key populations aged 15–24, and does it specifically account for the additional barriers facing those under 18?
Youth-responsiveness cannot be achieved by adding a sentence about 'young people' to an existing program. It requires deliberate choices at every level — service hours, language, delivery channels, consent protocols, peer workforce, and monitoring indicators.

6.3 Stigma Reduction Embedded Across All Modulars

Stigma is the structural driver behind every gap in this report. 31.5% of young TG avoid healthcare due to stigma. 65% of young FSW hold discriminatory attitudes toward PLHIV. Anti-stigma programming in GC7 (Module 6) was generic and not designed for young key populations. GC8 must embed anti-stigma work specifically targeting young people — both in healthcare settings (provider training, complaint mechanisms) and at community level (peer-led campaigns, internal stigma reduction within key population communities themselves).

Section 7: Summary of Priority Interventions

The following table consolidates all 13 priority interventions for direct use as input to the Civil Society and Communities Annex of Indonesia's GC8 funding request.

#	Modular	Priority Intervention	Primary Target	Type
P1	Prevention	**Sexual education in SMA/SMK + referral to young outreach workers**	Young KP, students 15–18	New
P2	Prevention	**Youth outreach <18 with legal protection (surat tugas guardian) + condom/PrEP distribution**	Young KP <18	New
T1	Test & Treatment	**Mobile comprehensive testing (HIV+PrEP+ART+counseling) with extended hours**	All young KP, esp. <18	Strengthen
T2	Test & Treatment	**Enforce MoH Regulation Number 23/2022: accept <18 clients with outreach companion**	All facilities, young KP <18	New (enforcement)
T3	Test & Treatment	**Linkage-to-care with peer navigators + treatment for <18 without parental notification**	All young PLHIV, esp. <18	New
T4	Test & Treatment	**KDS Muda — mandatory referral for PLHIV <18 to young peer support groups**	Young PLHIV <18	New
T5	Test & Treatment	**Youth-specific ART adherence + peer counseling & mental health integration**	All young PLHIV	Strengthen
R1	RSSH	**Age-disaggregated SIHA data for <18 and <24 years**	All GC8 programs	New
R2	RSSH	**Young peer educator capacity building & formal recognition**	Young PL/peer educators	Strengthen

New = not present in GC7, must be introduced as a new intervention in GC8. New (enforcement) = legal basis already exists (Permenkes 23/2022) but is not implemented — GC8 must operationalize it. Strengthen = exists in GC7 but must be redesigned with explicit youth-specific targeting, age-adapted delivery, and age-disaggregated performance indicators.

This report was prepared through a participatory process engaging young key populations as active contributors — not as passive subjects. The 13 priority interventions documented here are grounded in both epidemiological evidence and lived experience. CCM Indonesia and the GC8 development team are urged to ensure these priorities are not only acknowledged but structurally embedded in the final funding

request — particularly the operationalization of Permenkes No. 23/2022 and the introduction of dedicated programming for young key populations under 18 years old.