Socius: Jurnal Penelitian Ilmu-Ilmu Sosial
Volume 3, Issue 8, March 2026, P. 449-457
E-ISSN: 3025-6704
DOI: https://doi.org/10.5281/zenodo.19467072

Implementation of Minimum Service Standards Human Immunodeficiency Virus in Bandar Lampung City

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INFO ARTIKEL
Riwayat artikel:
Received 15 March 2026
Revised 25 March 2026
Accepted 27 March 2026
Available online 31 March 2026

Keywords: Manajemen Kepala Sekolah, Sistem Poin, Kedisiplinan, Motivasi Belajar, Strategi Pendidikan

Keywords: *Minimum Service Standards (SPM), HIV, policy implementation, public health governance, civil society organizations, Bandar Lampung.*

ABSTRACT
HIV prevention and treatment remain major public health challenges in Indonesia, particularly in achieving the global 95-95-95 targets and the "Three Zero" vision. In Bandar Lampung City, performance indicators still show a significant gap between targets and actual outcomes. This study aims to evaluate the implementation of Minimum Service Standards (SPM) for HIV services and identify factors influencing policy implementation using Jan Merse's framework (information, policy content, community support, and potential distribution). This research employed a descriptive qualitative approach grounded in post-positivism. Data were collected through in-depth interviews, observation, and documentation involving stakeholders from provincial and city health offices, community health centers (Puskesmas), and civil society organizations (CSOs). Data analysis followed the interactive model of Miles, Huberman, and Saldana, including data condensation, data display, and conclusion drawing. Data validity was ensured through triangulation, transferability, dependability, and confirmability. The findings reveal that HIV SPM implementation in Bandar Lampung is constrained by several factors. First, information dissemination is uneven, with CSOs often lacking understanding of policy substance due to informal communication channels and limited socialization. Second, policy content is insufficiently operationalized at the local level, with unclear technical guidelines and heavy reliance on donor funding. Third, community support is strong in outreach and case detection; however, CSOs remain marginal in formal planning and budgeting processes. Fourth, the distribution of resources and roles is structurally defined but uneven, with limited laboratory capacity, insufficient counselors, and weak institutionalization of coordination mechanisms. These challenges contribute to inconsistencies in service delivery and suboptimal achievement of HIV targets. The study confirms that gaps in communication, resource allocation, policy clarity, and coordination significantly affect policy implementation effectiveness. Strengthening institutional coordination, improving dissemination of policy substance, ensuring sustainable budget allocation, and integrating CSOs into formal governance structures are essential to enhance HIV service delivery.

INTRODUCTION

Human Immunodeficiency Virus (HIV) is a chronic infectious disease that progressively weakens the immune system and, if untreated, may develop into Acquired Immunodeficiency Syndrome (AIDS). Despite significant advances in prevention and treatment, HIV remains a persistent global public health challenge, particularly in developing countries where health system capacity and access to services vary widely. The persistence of HIV transmission is closely associated with structural inequalities, limited awareness, stigma, and gaps in health service delivery. These challenges highlight the importance of strengthening health policy implementation, particularly in ensuring equitable access to essential services for people living with HIV (PLHIV) (World Health Organization, 2022; UNAIDS, 2024).

At the global level, HIV control efforts have been guided by the 95-95-95 strategy, which aims to ensure that 95% of PLHIV know their status, 95% of those diagnosed receive antiretroviral therapy (ART), and 95% of those on treatment achieve viral suppression. This

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strategy is a cornerstone of the broader goal to end the AIDS epidemic by 2030. However, recent global reports indicate that progress remains uneven, with many countries still struggling to meet these targets due to systemic barriers such as limited resources, weak health systems, and social stigma (UNAIDS, 2024). These global disparities underscore the need for contextualized policy implementation at national and subnational levels.

In Indonesia, the government has adopted various regulatory frameworks and strategic plans to address HIV, including the National Action Plan for HIV/AIDS Control 2020–2024. Nevertheless, national achievements remain below the expected targets, reflecting ongoing challenges in early detection, treatment initiation, and long-term adherence to therapy (Afriana et al., 2023a). At the provincial and local levels, these challenges are often more pronounced, as disparities in infrastructure, human resources, and governance capacity affect service delivery outcomes. Lampung Province, including Bandar Lampung City, illustrates these challenges, with HIV service coverage indicators still lagging behind national and global targets.

Bandar Lampung City presents a particularly critical case, where the gap between policy targets and actual achievements remains substantial. A significant proportion of PLHIV are either unaware of their status, have not initiated ART, or have not achieved viral suppression. These gaps indicate systemic issues in access to testing, continuity of care, and effectiveness of outreach strategies (Marlina et al., 2023). Previous studies have emphasized that the success of HIV programs is highly dependent on service accessibility, community engagement, and effective coordination among stakeholders (Asyulia & Hastono, 2023) Therefore, understanding local implementation dynamics becomes essential for improving program outcomes.

The implementation of HIV services in Bandar Lampung involves a complex network of actors, including public health centers (Puskesmas), hospitals, and civil society organizations (CSOs). Puskesmas play a central role in early detection and primary care services, while hospitals provide advanced diagnostic services such as viral load testing. Meanwhile, CSOs contribute significantly to outreach activities, particularly in reaching key populations and providing peer support. Evidence suggests that community-based interventions are effective in increasing HIV testing uptake and improving treatment adherence, especially among marginalized groups (Sabin et al., 2019). However, the sustainability of these efforts is often constrained by reliance on external funding and limited integration into formal health systems.

Despite the existence of Minimum Service Standards (SPM) as a regulatory framework to ensure basic health service delivery, their implementation in the HIV sector faces multiple challenges. These include limited financial resources, inadequate infrastructure, shortages of trained personnel, and weak coordination mechanisms among stakeholders. Furthermore, inconsistencies in policy interpretation and operational guidelines at the local level often lead to variations in service quality and accessibility (Priyatna et al., 2024) From a public policy perspective, effective implementation requires not only clear policy content but also adequate communication, resource allocation, and institutional coordination (Cairney, 2012)

Given these challenges, this study aims to analyze the implementation of HIV Minimum Service Standards (SPM) in Bandar Lampung City using a qualitative approach. By examining key factors such as information dissemination, policy content, community support, and distribution of resources, this research seeks to provide a comprehensive understanding of the barriers and opportunities in HIV service delivery. Ultimately, the findings are expected to contribute to evidence-based policy recommendations that can enhance the effectiveness of HIV programs and accelerate progress toward achieving the 95-95-95 targets at the local level.

METHOD

This study employed a descriptive qualitative approach grounded in a post-positivist paradigm to explore the implementation of HIV Minimum Service Standards (SPM) in Bandar Lampung City. Research participants were purposively selected based on their authority and involvement in HIV program implementation, including representatives from the Lampung Provincial Health Office, Bandar Lampung City Health Office, selected primary healthcare facilities (Kemiling and Gedong Air Community Health Centers), and civil society organizations (CSOs) such as PKBI Sumbar, PKBI Riau, and YKSS Jambi. The study was conducted in Bandar Lampung City as the primary locus of analysis (Cahya Pratama et al., 2025). Data were collected through multiple techniques, including direct field observation, in-depth semi-structured interviews using open-ended questions, and review of relevant program documents to ensure data richness and triangulation.

Data analysis followed the interactive model of Miles, Huberman, and Saldana, encompassing data condensation, data display, and conclusion drawing in an iterative process. To ensure the rigor and trustworthiness of the findings, data validity was assessed using established qualitative criteria, including credibility through triangulation of sources and methods, transferability through detailed contextual description, dependability through audit trails, and confirmability to minimize researcher bias (Fiantika et al., 2022).

RESULT

1. **Operational Overview**

   The implementation of Minimum Service Standards (SPM) for HIV services in Bandar Lampung City reflects a multi-level governance structure involving both governmental institutions and civil society organizations (CSOs). The institutional mapping conducted in this study reveals a relatively well-defined bureaucratic arrangement, encompassing the provincial and municipal health offices, primary healthcare facilities (Puskesmas), referral hospitals, and non-governmental actors. This structure is intended to ensure a clear division of authority, functional coordination, and allocation of human resources across different administrative levels.

   At the provincial level, HIV program management is situated within the disease prevention and control division, specifically under the infectious disease control unit. The provincial HIV team consists of a coordinator (civil servant) supported by four non-civil servant personnel funded through the Global Fund, covering surveillance, data management, finance, and administrative functions. A similar structure is replicated at the municipal level in Bandar Lampung City, indicating institutional alignment between provincial and city governance systems. At the Puskesmas level, HIV services are integrated into Cluster 4, focusing on disease prevention and public health protection through early detection and rapid response. Each Puskesmas HIV team typically comprises a coordinator, laboratory personnel, data recording staff, counselors, and nurses.

   Beyond formal government structures, CSOs play a critical operational role in outreach and patient support. Organizations such as PKBI and YKSS demonstrate substantial engagement in field-level interventions, including peer education, outreach to key populations, and long-term treatment adherence support. Their organizational capacity varies, with some deploying extensive outreach networks and peer support systems, highlighting their strategic importance in bridging service delivery gaps, particularly among hard-to-reach populations.

2. **Service Capacity**

The HIV service delivery network in Bandar Lampung consists of 31 Puskesmas and multiple referral hospitals and clinics, totaling 62 service points. While Puskesmas function as primary entry points for HIV screening and initial care, hospitals provide advanced diagnostic services, including viral load (VL) and early infant diagnosis (EID) testing. Despite the formal establishment of HIV service teams and mandatory training programs, service capacity remains constrained by a shortage of specialized personnel, particularly counselors and laboratory technicians.

Furthermore, access to VL and EID testing is still limited and concentrated in a small number of referral hospitals, which restricts routine monitoring and delays clinical decision-making. This uneven distribution of technical capacity creates bottlenecks in the continuum of care, ultimately affecting treatment outcomes and the achievement of viral suppression targets.

3. **Data Systems, Validation, and Reporting**

The HIV/AIDS Information System (SIHA) serves as the primary platform for data collection and reporting in Bandar Lampung City. While the system provides a centralized database for program monitoring, its implementation is not yet fully optimized. Data validation is conducted periodically typically on a quarterly or semiannual basis although some facilities and CSOs perform more frequent cross-checks through locally established agreements.

However, several challenges persist, including reliance on manual reporting processes, underreporting, and inconsistencies between government and CSO data. These limitations reduce the timeliness and accuracy of information, hindering early detection of service gaps and weakening program responsiveness. Additionally, concerns related to data protection and confidentiality highlight the need for stronger regulatory and technical safeguards in line with national health information system standards.

4. **Analysis Based on Jan Maarse's Policy Implementation Framework**

a. **Information**

The study finds that the effectiveness of HIV SPM implementation is strongly influenced by the quality of information dissemination, reporting mechanisms, and data validation processes. In practice, policy communication often relies on informal channels such as internal messaging groups, resulting in limited understanding among CSOs regarding the substantive aspects of the policy. Consequently, many actors focus primarily on operational targets without fully comprehending regulatory frameworks. This information asymmetry contributes to inconsistencies in data reporting and differing interpretations of program targets. Strengthening formal communication channels, increasing the frequency of data validation, and improving data governance systems are therefore essential.

b. **Policy Content**

Although HIV SPM policies are formally mandatory, their operationalization at the local level remains incomplete. Technical guidelines are either insufficiently detailed or unevenly disseminated, leading to challenges in translating national targets into actionable local programs. The top-down nature of policy targets—such as the 100% SPM coverage and 95-95-95 indicators—often lacks contextual adaptation for key populations. In addition, heavy reliance on donor funding further constrains implementation capacity. These findings indicate the need for locally tailored technical guidelines and better alignment between policy objectives and regional planning and budgeting mechanisms.

c. **Community Support**

CSOs emerge as critical actors in HIV service delivery, particularly in outreach to key populations and provision of peer support. However, their integration into formal planning processes and policy frameworks remains limited. In some cases, CSOs operate with targets that are not fully aligned with government benchmarks, and their dependence on external funding raises concerns about program sustainability. Strengthening formal partnerships, integrating CSOs into regional planning and budgeting processes, and diversifying funding sources are necessary to enhance long-term program effectiveness.

d. **Potential Distribution**

The distribution of roles among stakeholders is structurally defined but functionally uneven. While Puskesmas lead early detection and primary care, hospitals handle specialized diagnostic services, and provincial authorities focus on supervision and coordination. However, disparities in resource allocation particularly in laboratory capacity, human resources, and funding limit overall system performance. Moreover, the absence of formal institutionalization of HIV SPM teams at the municipal level results in fragmented and ad hoc coordination. Addressing these challenges requires formalizing institutional structures, redistributing technical resources, strengthening referral systems, and aligning budget allocations with operational needs.

Overall, these findings highlight that while the institutional framework for HIV SPM implementation in Bandar Lampung is structurally established, significant gaps remain in coordination, capacity, and policy translation, which collectively hinder the achievement of optimal service outcomes.

DISCUSSION

Structural Gaps in Policy Implementation: Communication, Coordination, and Resource Misalignment

The implementation gap of HIV Minimum Service Standards (SPM) in Bandar Lampung reflects persistent structural challenges in public policy execution, particularly in communication breakdowns, limited resource allocation, and fragmented inter-organizational coordination. Classical implementation theories emphasize that policy success is contingent upon clear communication, adequate resources, and coherent institutional arrangements (Cairney, 2012; Tachjan, 2015).

Empirically, this study identifies significant information asymmetry between government agencies and civil society organizations (CSOs), where operational actors often lack sufficient understanding of regulatory frameworks such as Permendagri No. 59/2021 and national HIV targets. This condition leads to misalignment of program targets, duplication of efforts, and weakened coordination effectiveness. Moreover, the reliance on informal communication channels (e.g., WhatsApp groups) undermines institutional continuity and accountability, particularly in dynamic bureaucratic settings. These findings align with prior studies highlighting that weak coordination and limited policy clarity are key barriers in achieving SPM health targets at the local level (Priyatna et al., 2024). Therefore, strengthening formal coordination mechanisms and ensuring comprehensive policy dissemination are critical for improving implementation performance.

Data Governance, System Limitations, and Implications for Service Accuracy

Effective HIV program implementation is highly dependent on robust health information systems; however, this study reveals critical deficiencies in data governance, reporting accuracy,

and system integration. Despite regulatory mandates requiring secure, accurate, and accountable health data systems, such as those outlined in national health policies, the SIHA (HIV/AIDS Information System) remains suboptimal due to manual reporting practices, delayed validation cycles, and underreporting. These limitations contribute to discrepancies between CSO and government data, ultimately distorting the actual epidemiological profile of key populations. From a policy perspective, inadequate data systems not only hinder evidence-based decision-making but also pose risks to data confidentiality and public trust. This finding is consistent with global and national evidence emphasizing that strong data systems are essential for monitoring HIV interventions and achieving epidemic control targets (UNAIDS, 2024). Furthermore, previous research highlights that weaknesses in reporting systems and data utilization significantly affect the effectiveness of HIV service delivery (Afriana et al., 2023a). Consequently, improving data governance through system digitalization, real-time validation, and stricter access control mechanisms is imperative to enhance both program accountability and service outcomes.

Community Participation, CSO Dependence, and Sustainability Challenges

Community participation plays a central role in HIV service delivery, particularly in reaching key populations; however, the current model in Bandar Lampung demonstrates a paradox between strong operational involvement and weak structural integration. CSOs actively contribute to outreach, case finding, and referral processes, reflecting high levels of participation in implementation stages, consistent with participatory development frameworks (Noor et al., 2022).

Nevertheless, their involvement remains limited in formal decision-making and budgeting processes, indicating partial participation that has not yet reached collaborative governance maturity. In addition, heavy dependence on donor funding accounting for the majority of program financing poses significant risks to long-term sustainability (Marlina et al., 2024). Empirical evidence from other HIV programs also shows that reliance on external funding and lack of institutional integration can weaken program continuity and local ownership (Sabin et al., 2019; Buck et al., 2017). Therefore, integrating CSOs into formal regional planning mechanisms (e.g., RPJMD and APBD) and strengthening government financial commitment are essential strategies to ensure sustainable, inclusive, and resilient HIV service systems.

CONCLUSION

1. Excessive reliance on personal and informal communication channels, such as officers' personal WhatsApp messages, poses a significant risk to program sustainability (institutional memory), as personnel turnover can quickly disrupt strategic information and coordination networks. Furthermore, this one-way flow deprives strategic partners, such as CSOs, of access to the legal framework and policies that should underpin their collaborative work.
2. Massive inconsistencies in service standards exist, with double standards in fees and medical procedures across community health centers (Puskesmas). Without operational technical guidelines (Juknis) at the city level, policy implementation becomes highly subjective. This turns the public's right to minimal services into a lottery; the quality and cost of services patients receive depend entirely on which community health center they attend.
3. A paradox of dependency exists; the government relies heavily on CSOs to achieve its targets, as evidenced by their contribution to case referrals reaching over 50%, yet their capacity is systematically restricted. CSOs are denied access to regional budget (APBD) funding or formal space in planning forums like the Musrenbang (Regional Development Planning Forum). In

short, communities are asked to spearhead case finding without being provided with budgetary support or a seat at the decision-making table.

4. A disconnect between technical executors and budget planners. The P2PM (Communicable Disease Control) division is positioned solely as a field implementer, with no control over the allocation of funds, which is fully controlled by the planning team. This creates a structural barrier where emergency needs in the field cannot be responded to quickly through budgetary policies, as financial decision-makers are far removed from the technical realities of the HIV program.

SUGGESTION

1. The government needs to institutionalize communication by establishing integrated data centers and regulations to ensure strategic information remains secure and transparent for all parties.
2. Develop detailed operational guidelines for HIV SPM to standardize medical procedures and harmonize service rates across all health facilities without administrative barriers.
3. Provide formal legitimacy for CSOs in the regional planning cycle and initiate the allocation of grant funds to support the sustainability of outreach operations.
4. Substantially integrate technical areas into the budget planning process and strengthen the legal basis of cross-sector teams through explicit regional head regulations.

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