

TARGETED ASSISTANCE COUNTRY

Country Operational Plan (COP) 2016

Strategic Direction Summary

Indonesia

May 1, 2016



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Goal Statement

In partnership with the Government of Indonesia (GoI), civil society organizations (CSOs), multilateral agencies and other donors, PEPFAR Indonesia will continue to focus support on the continuum of HIV prevention, treatment, and care for key (KP) and priority populations (PP) in select districts in Papua and Jakarta, and support a direct military to military program. Though the WHO's Test and Start Guidelines are not being implemented in Indonesia, the GoI launched in 2014 the "Strategic Use of ARVs" (SUFA) initiative which aims to provide immediate ARV treatment to HIV-positive KPs, pregnant women, sero-discordant couples, and TB and Hepatitis C patients in 75 districts, including all those supported by PEPFAR. PEPFAR Indonesia will support the implementation of SUFA through the capacity strengthening of KP-friendly public and private sectors clinics in Jakarta and Papua. PEPFAR Indonesia will also strengthen the reach of civil society organizations to improve prevention outreach and referrals for HIV testing and more targeted HIV case finding among key populations in Jakarta, and KP and PP in Papua.

In COP15, PEPFAR Indonesia set ambitious targets to significantly increase HIV diagnosis and ART coverage from FY14 APR results. In order to reach the FY16 treatment targets, PEPFAR expanded its technical support to increase ART coverage among key population beneficiaries in public facilities, alongside three private KP-friendly clinics PEPFAR supported in the past. As a result of this expansion, the HIV testing yield in FY16 Q1 was less than optimal and was lower than the projected FY16 target. The FY16 positivity yield target of 5,956 was set at 16% based on an FY14 private clinic APR of 22.4% yield. However, with the incorporation of public facilities where strategic and targeted key population testing is not yet in place, only 676 individuals (11.3% of annual target in the first 3 months) were identified with an average positivity yield of 8.0% in FY16 Q1. Based on this result, PEPFAR Indonesia will refocus efforts in COP16 on higher performing public facilities and expansion to additional private facilities. With this shift, PEPFAR Indonesia an increase of 99.6% for HIV testing among KP in Jakarta (with a 9% overall positivity testing yield) and increase the coverage in Papua from 17.2% in FY17 to 30% in FY18 for KP/PP.

As a TA/TC country, PEPFAR Indonesia's successful is intricately tied to that of the Ministry of Health (MoH) and Global Fund (GF) Principle Recipients. Indonesia's national AIDS program is 52% funded by the GoI, 25% by GF, 9% by PEPFAR and 8% other. With careful planning and collaboration, PEPFAR Indonesia resources leverage and complement those of the GF and GoI. For example, national government funding covers over 90% of first line ARVs and ~20% of second line ARVs, while the GF supports medicines for opportunistic infections and about 80% of second line ARVs. Prevention funding and HIV referrals for KP continue to be largely supported by international donors, primarily PEPFAR Indonesia and the GF.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Indonesia is a large and complex country with an estimated 255 million people and hundreds of different ethnic groups spread across nearly 17,000 islands. It has 34 provinces, and four special regions (Jakarta, Papua, Aceh, Jogjakarta), which are subdivided into 502 lower administrative districts (405 kabupaten [Districts] and 97 kota [Municipalities]). Local governments and municipalities became the key administrative units responsible for the provision and budgeting of public services when the Gol began decentralization in 2001. Around 60% of the population is concentrated on the island of Java (where two of the largest cities, Jakarta and Surabaya, are situated), and it has the highest concentration of HIV cases in the country.

Indonesia has had strong economic growth since 2010 and is one of only three countries (alongside China and India) in the G-20 posting consistent growth since the 2008 global financial crisis. It has a GNI per capita of USD \$3,580 and is classified as a lower-middle income country by the World Bank. However, the country continues to struggle with poverty, inadequate infrastructure, corruption, and more recently, with the complex rollout of the national single-payer universal healthcare scheme (JKN). Based on the 2012 WHO report, the total expenditure on health as a percentage of GDP in Indonesia is 3.0%.

The national HIV prevalence rate among adults aged 15-49 years is estimated at 0.4% (691,040 PLHIV).¹ With the exception of Papua and West Papua provinces, which have a low-level generalized epidemic (estimated HIV prevalence of 2.3%)², Indonesia continues to experience a concentrated HIV epidemic. While there are concerns about the overall quality of surveillance and size estimation data, available data from the latest preliminary results from the 2015 IBBS demonstrate an estimated prevalence rate among direct female sex workers (FSW) of 8.0%; 3.0% among indirect FSW (IDFSW)³; 24.8% among waria (transgender populations); 25.8% among men who have sex with men (MSM); and 28.8% among people who inject drugs (PWID).⁴

The 2015 AIDS Epidemic Model (AEM) indicates that the number of new infections will continue to grow, especially among MSM. It is estimated that the majority of new HIV infections will occur through unsafe sex, of which 29% will occur among MSM/waria and 32% among FSW.⁵

Table 1.1a: Estimated New Infections by Modes of Transmission (2015 AEM, National AIDS Commission (NAC) Investment Case Analysis (ICA))

Mode of Transmission	2012	2013	2014	2015	2016	2017	2018
FSW	21,524	21,030	20,606	20,576	20,559	20,562	20,588
Discordant couples	21,971	21,885	21,702	21,527	21,427	21,428	21,520

¹ 2014 Global AIDS Response Progress Report (GARPR)

² 2013 Tanah Papua IBBS for general population (MoH)

³ Direct FSW refers to venue-based SWs and indirect refers to street-based SWs.

⁴ 2015 iBBS Presentation, MoH, February 2016.

⁵ 2015 AEM estimates (MoH)

Casual sex	3,048	2,913	2,754	2,831	2,893	2,947	2,994
MSM	15,800	17,155	18,595	20,173	21,819	23,532	25,308
Needle sharing	2,777	2,459	2,101	2,109	2,160	2,208	2,252

Table 1.1b: Trends in HIV Prevalence and Size Estimates among Key Populations (2007-2015)

Key Population Group	HIV Prevalence 2007	HIV Prevalence 2011	HIV Prevalence 2013	HIV Prevalence 2015	Est. Population Size 2011	Est. Population Size 2015
PWID	52%	42%	41.2%	28.8%	105,784	77,286
Direct FSW	10%	9%	7.0%	8.0%	106,011	129,973
Indirect FSW	4%	3%	1.6%	2.2%	108,043	109,036
MSM	5%	12%	8.5%	25.8%	695,026	1,139,606
Waria	24%	23%	21.9%	24.8%	32,065	39,512

PWID currently still have the highest HIV prevalence amongst key populations in Indonesia at 28.8%, down from 41.2% in 2013. HIV disease burden among PWID has been on the decline nationally, despite the high prevalence rate, with an estimated 2,101 new infections (3% of total new infections) in 2014 compared to 12,981 in 2004.⁶ Based on estimates from the 2014 AEM, DKI Jakarta has the 3rd highest estimated number of PWID (7,534) in the country (behind West Java (13,925) and East Java (12,427), respectively). Furthermore, HIV prevalence among PWID in Jakarta continues to be significantly higher (43.6%) than the national average of 28.8%.⁷

High HIV prevalence among female sex workers is one of the major factors in the spread of HIV in Indonesia and the Asia Pacific region. The estimated number of FSW nationally in 2015 was 239,009, consisting of 129,973 direct (DFSW) and 109,036 indirect (IDFSW) sex workers. There were significant variations in HIV prevalence among cities and districts sampled in the 2011 IBBS (as district-level HIV prevalences for FSW in the 2015 IBBS are not yet available). While the overall prevalence rate among DFSW was 9%, the HIV prevalence in Jayawijaya City (Papua) was at 25% and 16% in Jayapura city (Papua). While Jakarta's estimated DFSW HIV prevalence was found to be 10.5%, it has the second-

⁶ 2015 GFATM Concept Note

⁷ 2015 IBBS Presentation, MoH, February 2016.

highest estimated number of DFSW (16,008) in the country (behind West Java's 18,827 estimated DFSW) according to the 2014 AEM estimates.

Although IFSW in general are harder to reach compared to DFSW, available data demonstrated that they had lower HIV prevalence rates compared to DFSW (Table 1.1.b). On average, HIV prevalence among IDFSW declined considerably from 3.3% (IBBS 2009), to 1.5% (IBBS 2013). However, Jakarta had an estimated prevalence of 5.2% (2013 IBBS) and has the highest estimated number of IFSW (24,318) in the country, according to 2014 AEM estimates.

Nationally, the 2015 IBBS among MSM demonstrated a significant increase in HIV prevalence, from 8.5% in 2011 to 25.8% in 2015. The average HIV prevalence among MSM in the larger cities (Jakarta, Bandung, Surabaya, and Malang) increased from 9.9% in 2011 to 17.3% in 2013 (IBBS 2011 & Sero Surveillance 2013). The latest 2015 IBBS data show that the prevalence of HIV among MSM in Jakarta is at 32.0% from 17.2% in 2013. The 2014 Mode of Transmission (MoT) mathematical model projects that the number of annual new HIV infections will rise most rapidly among MSM, soon surpassing the number of new infections among FSW (see Table 1.1.a). In addition, despite a national increase in prevention and testing coverage among MSM from 2009 to 2013, prevalence rates of syphilis (8% to 11%), gonorrhea (17% to 21%) and chlamydia (17% to 23%) continue to increase in this population.⁸

HIV prevalence among the estimated 39,512 waria remained high in 2015.⁹ However, Jakarta was reported to have a HIV prevalence of 30.8% (and syphilis prevalence of 31.2%) among waria in the 2011 IBBS.

IBBS 2012 data indicated that HIV prevalence within the Indonesian military (TNI) is 0.4%, with prevalence in Jakarta of 0.6% and in the Riau Islands of 1.0%. Due to high-risk behaviors, incidence in the military population may increase. Self-reported condom use rates were approximately 34% and STI rates approximately 9%.

In regards to the overall response, HIV/AIDS continues to be an important national concern in Indonesia. In November 2011, former President Susilo Bambang Yudhoyono, together with other ASEAN leaders, announced Indonesia's commitment to "Getting to Zero," a multipronged UNAIDS-supported strategy to halt and reverse the spread of HIV/AIDS. The GoI has also undertaken the "test and start" roll out of the "Strategic Use of ARVs—SUFA" among key populations and TB patients in PEPFAR-supported districts in 2014. Furthermore, with PEPFAR's technical support, the former Minister of Health embarked on the development and promotion of a national condom social marketing strategy at the end of 2013.

Available data and program review results suggest that while progress has been made, national HIV program efforts lack the coverage and intervention effectiveness needed to have a major impact on the course of HIV in the country.¹⁰ Two main targets of the Indonesian response to HIV and AIDS¹¹ were to "achieve coverage of 80% of key affected populations with effective programmes, with 60% of them

⁸ 2015 GFATM Concept Note

⁹ 2015 iBBS Presentation, MoH, February 2016.

¹⁰ 2015 GFATM Concept Note

¹¹ National AIDS Strategy and Action Plans, 2010-2014 (NAC)

engaging in safe behavior, and for 70% of funding for the targeted response coming from domestic sources.”

However, the quality and comprehensiveness of the national prevention package of services for key populations remain suboptimal. According to the 2013 UNAIDS Global AIDS Response Progress Reporting (GARPR) report and NAC data, only 18.5% of FSW and 23.4% of the estimated MSM in country had been reached. In addition, quality of the national program data is unclear and “reached” is defined as only one contact per person per year (regardless of which component(s) of the prevention package was received) under the national program.

Available data prior to the launch of the national condom promotion strategy demonstrated that condom use was low among key populations. According to data collected in the 2011 IBBS among high risk groups, the rate of condom use during the last commercial sex encounter among FSW was 61% and only 47% of reported consistent use of condoms. Condom use at last commercial sex encounter for MSM was 61%, a decline from the 69% level measured in 2007, and 56% for PWID in 2011.

The latest preliminary data from the 2015 IBBS since the launch of the national condom promotion initiative demonstrate that condom use at last sex has increased among DFSW, MSM, and waria. However, there was a significant decrease in condom use among PWID (18% at last sex and 2.5% always use) and IFSW (from 67% to 52% at last sex) in 2015.

Despite the GoI’s commitment to control the HIV epidemic, UNAIDS listed Indonesia as one of the nine countries in the Asia Pacific region where HIV infections continued to rise, with new cases increasing by more than 25% between 2001 and 2011.¹² The situation in Indonesia is cause for concern, where new HIV infections increased by 48% from 2005 to 2013, and the country’s share of new HIV infections in the Asian Pacific region reached 23% in 2013, second only to India.¹³

ART scale-up has been a priority for the GoI since 2005 and its commitment to increase ART coverage was demonstrated with the launch of SUFA in 2014. The number of PLHIV currently on ART had increased dramatically from 2,381 in 2005, to 24,410 in 2011, to 63,066 at the end of 2015.¹⁴ However, despite the government’s continued effort, Indonesia, together with Afghanistan and Bangladesh, is one of three countries in the Asia and Pacific region with an ART coverage rate of less than 20% (8% national ART coverage in Indonesia).¹⁵ In addition, viral load testing is still currently not widely available in country and CD4 testing is not always conducted regularly among those currently on ART.

¹² HIV in Asia and the Pacific, UNAIDS Report, 2013

¹³ 2014 UNAIDS GAP Report

¹⁴ 2015 MoH Quarter 4 HIV Program Report

¹⁵ 2014 UNAIDS GAP Report

paternal, double)											
TB cases (Yr)	331,441		N/A	MoH Program data							
TB/HIV Co-infection	49,348	7.5%	N/A	GAPRS 2014 Report							
Males Circumcised	N/A	N/A			N/A	N/A			N/A	N/A	
Key Populations											
Total MSM*	1,139,606										Source: MoH 2015 AEM
MSM HIV Prevalence		25.8%									2015 IBBS
Total DFSW	129,973										Source: MoH 2015 AEM
DFSW HIV Prevalence		8.0%									2015 IBBS
Total IFSW	109,036										Source: MoH 2015 AEM
IFSW HIV Prevalence		2.2%									2015 IBBS
Total PWID	77,286										Source: MoH 2015 AEM
PWID HIV Prevalence		28.8%									2015 IBBS
Total TG (waria)	39,512										Source: MoH 2015 AEM
TG (waria) HIV Prevalence		24.8%									2015 IBBS
HIV prevalence of military personnel	434,410	0.40%									2012 IBBS among Indonesia military

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months) for National Program in 2015*

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate**	HIV Prevalence	Total PLHIV	In Care	Currently On ART	Retained on ART 12 Months	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	(#)	12 Months	(#)	(#)	(#)
Total population	255,461,700	0.28%	691,040	200,618	63,066	-	-	1,263,871	30,935	12,666***
Population less than 15 years	66,930,965	0.03%	22,542	8,160	4,866	-	-	-	-	2,850***
Pregnant Women	5,290,235	0.38%	20,103	3,169	806	-	-	293,825	17,807	1,825
Total MSM	1,139,606	8.48%	101,303	-	-	-	-	-	-	-
DFSW	129,973	7.00%	13,432	-	-	-	-	-	-	-
IFSW	109,036	1.60%	6,284	-	-	-	-	-	-	-
PWID	77,286	41.20%	34,711	-	-	-	-	-	-	-
Waria (TG)	39,512	21.90%	11,621	-	-	-	-	-	-	-
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

* 2015 MoH Quarterly Report on HIV/AIDS (December 2015)

** Estimated KP PLHIV based on 2015 AIDS Epidemic Model(AEM)

***Approximation of 2015 on ART minus 2014 on ART, not accounting for attrition of the 2014 ART cohort

Note: National number for "Ever initiated on ART" is 120,677 as of December 2015

Table 1.1.2.b Cascade of HIV diagnosis, care and treatment (12 months) for National Program by PEPFAR-supported districts in 2015 (12 month period)*

PEPFAR Municipality/District	Total Population	Total PLHIV	Est. MSM PLHIV**	Est. TG PLHIV**	Est. DFSW PLHIV**	Est. IFSW PLHIV**	Est. PWID PLHIV**	Est. Priority Population PLHIV***	Tested for HIV**	Diagnosed HIV Positive**	Testing Yield [†]	Currently on ART ^{††}

Papua													
Jayapura City	137,744	2,932	220	54	61	15	1	7,126	13,637	877	6.4%	1,103	
Jayawijaya District	223,949	4,817	21	14	29	5	-	2,310	3,651	233	6.3%	1,047	
Mimika District	241,280	13,701	46	20	36	11	-	3,397	48,178	397	0.8%	718	
	602,973	21,450	287	88	126	31	1	12,833	67,258	1,507	2.2%	2,868	
DKI Jakarta													
Central Jakarta	2,841,728	26,618	2,034	74	498	825	1,712		32,601	1,512	4.6%	6,171	
East Jakarta	2,407,170	27,102	1,026	199	467	419	926		30,821	974	3.1%	1,730	
North Jakarta	952,525	19,813	997	254	6	4	698		20,028	517	2.5%	2,397	
South Jakarta	1,735,968	18,764	2,239	236	715	331	1,125		19,398	810	4.1%	1,270	
West Jakarta	2,175,400	3,333	1,924	204	306	543	1,197		31,211	882	2.8%	3,069	
	10,112,791	95,630	8,220	967	2022	2122	7,769		134,059	4,695	3.5%	14,637	
Total 8 PEPFAR-supported districts													
	10,715,764	117,080	8,507	1,055	2,118	2,153	5,659		12,833	201,317	6,202	3.0%	17,505

*2015 MoH HIV report, Quarter 4

**2015 AEM estimates

*** Priority population defined as all client of sex workers and at risk women

† Not all sites reported on HTC results reported on positivity. Denominator to calculate % Yield only included sites that reported on positivity.

†† Based on MoH HIV Data from Quarter 3, 2015. Newly initiated on ART at district level not available

Table 1.1.2.b Cascade of HIV diagnosis, care and treatment (12 months) for PEPFAR Program by SNU in 2015 (12 month period)

PEPFAR Municipality/District	Total Population	Total PLHIV	Est. MSM PLHIV*	Est. TG PLHIV*	Est. DFSW PLHIV*	Est. IFSW PLHIV*	Est. PWID PLHIV*	Tested for HIV	Diagnosed HIV Positive (Yield)**	Newly Initiated on ART	Current on ART†
Papua											
Jayapura City	137,744	2,932	220	54	61	15	1	1,949	28 (3%)	54	429
Jayawijaya	223,949	4,817	21	14	29	5	-	3,319	494 (31%)	150	885

District											
Mimika District	241,280	13,701	46	20	36	11	-	6,376	1,049 (16%)	29	519
	602,973	21,450	287	88	126	31	1	11,644	1,571	233	1,833
DKI Jakarta											
Central Jakarta	2,841,728	26,618	2,034	74	498	825	1,712	4,228	769 (20%)	511	971
East Jakarta	2,407,170	27,102	1,026	199	467	419	3,037	1,648	194 (15%)	11	14
North Jakarta	952,525	19,813	997	254	6	4	698	1,046	83 (9.6%)	4	12
South Jakarta	1,735,968	18,764	2,239	236	715	331	1,125	1,589	96 (6.5%)	55	148
West Jakarta	2,175,400	3,333	1,924	204	306	543	1,197	864	33 (4.9%)	9	19
	10,112,791	95,630	8,220	967	2022	2122	7,769	9,375	1,175	590	1,164
Total 8 districts											
	10,715,764	117,080	8,507	1,055	2,118	2,153	5,659	21,019	2,746	823	2,997

* Not all sites reported on HTC results reported on positivity. Denominator to calculate % Yield only included sites that reported on positivity.

** Based on MoH HIV Data from Quarter 3, 2015. Newly initiated on ART at district level not available.

1.2 Investment Profile

Funding for HIV programs in Indonesia comes from domestic (52%) and external (43%) sources, totaling \$107m in 2014 (NASA, 2014). The national response is predominantly financed by the central government budget, through the MoH, and by local government budgets. The total national funding commitment for HIV has increased over recent years; however, the weaker than expected economic growth and depreciation of the Rupiah are working to diminish those gains. The district budgets cover the costs of health infrastructure, human resources and operational costs. Central government funding is presently used to procure HIV test kits and reagents, as well as first-line ART drugs. STI screening and treatment, and treatment for HIV-related opportunistic infections (OIs) are provided free of charge for persons covered by the social health insurance scheme, JKN. The GoI thus finances a substantial share of HIV-related treatment costs, although GoI funding for prevention, other than ART, is minimal.

International donors, most significantly the GF, PEPFAR, and DFAT contributed greatly to the national response (GFATM Counterpart Financing Table) in 2014. The new GF grant awarded in late 2015 has a total of \$78 million for 2016 and 2017 implementation years. Despite the \$78 million envelope, Indonesia's PRs have historically been unable to spend close to their total annual envelope. In COP 16, PEPFAR will work with the MoH and GF CCM and PRs to strengthen and optimize program resources and spending.

The majority of international resources focus heavily on strengthening prevention activities and the quality of care across the cascade, specifically for KP and PP. In 2013, 86% of prevention activities for KP were funded by international sources (NASA, 2013 data). More than 35% of the total budget under the new GF HIV grant is allocated for prevention programs targeting KP.

DFAT's departure in June 2016 will create a significant gap in KP and PP prevention of roughly \$2.2m, particularly for PWID, and in clinical care and treatment of \$3.4m (NASA, 2014). The HIV response in Papua has historically been heavily supported by DFAT. As these resources dry up, the HIV program in Papua may see a loss in the gains made over the last few years.

In COP 16, PEPFAR funding will continue to reach and strengthen services for KP in Jakarta and Papua, as well as strengthen GF PR, central government and district-level investments. PEPFAR TA will work to strengthen JKN to improve the quality and ease of receiving HIV services through the national social health insurance mechanism. PEPFAR will also leverage roughly \$2.4m of USAID TB funds to strengthen TB/HIV services for KP/PP.

Table 1.2.1 Investment Profile by Program Area

Program Area	Total Expenditure (in USD)	\$PEPFAR ^a COP13	\$ Global Fund ^b	\$ Host Country ^c	\$ Other ^c
Clinical care, treatment and support	\$37,605,594	\$241,062	\$3,053,472	\$30,746,032	\$3,565,028
Community-based care, treatment, and support	\$2,059,261	\$491,210	\$1,568,051	\$0	\$0
PMTCT	\$492,111	\$334,150	\$0	\$39,241	\$118,720
HTS (incl. VCT and PITC)	\$908,001	\$438,870	\$235,947	\$233,184	\$0
VMMC	\$0	\$0	\$0	\$0	\$0
Priority population prevention (incl. PLHIV, vulnerable and accessible pop, youth)	\$12,831,660	\$669,400	\$7,477,618	\$3,615,251	\$1,069,391
Key population prevention (SW, MSM, TG, PWID)	\$5,752,870	\$2,065,334	\$2,015,296	\$491,639	\$1,180,601
OVC	\$12,642	\$0	\$0	\$12,642	\$0
Laboratory	\$3,034,105	\$250,549	\$0	\$2,783,556	\$0
SI, Surveys and Surveillance	\$4,823,031	\$2,532,670	\$777,674	\$647,305	\$865,382
HSS ^d	\$6,420,333	\$327,366	\$6,092,967	\$0	\$0
Other	\$7,711,245		\$7,711,245		\$0
Totals^e	\$81,650,853	\$7,350,611	\$21,221,025	\$42,184,101	\$6,799,122
		9%	26%	52%	8%

Note: "Program Area" labels are those used by PEPFAR. But data are disaggregated and compiled differently by PEPFAR, the Government of Indonesia and Global Fund. Further, data from NASA do not fully capture expenditure by external donors. The "Other" Program Area category is used to capture GF program management expenditure (which may account for 20% or more of GF expenditure, depending on the PR). All figures in the table above are thus rough estimates for calendar year 2013 expenditure, and should be considered illustrative only.

Additional notes

a - PEPFAR expenditures are derived from EA 2014.

b - Global Fund expenditures provided by the GF Indonesia Country Team, and include expenditures for 4 PRs: MoH, NAC, IPPA and NU. Expenditure time periods vary across PRs -- e.g., data for MoH and IPPA is for Jul 2012-Jun 2013; data for NAC and NU are from Jul 2013-Jun 2014.

c - Host Country and Other figures come from NASA 2014 (CY 2013).

d - Actual HSS value for PEPFAR = \$3,053,557. HSS is distributed across Program Areas.

e - Totals are not equal to total program spending.

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure (in USD)	% PEPFAR	% GF	% Host Country	% Other
ARVs ^a (ART) ^b	\$21,396,762	\$0	\$684,696	\$20,712,066	\$0
Rapid test kits	\$0	\$0	\$0	\$0	\$0
Other drugs (OI treatment)	\$7,031,133	\$0	\$0	\$7,031,133	\$0
Lab reagents	\$0	\$0	\$0	\$0	\$0
Condoms	\$1,878,168	\$0	\$1,759,296	\$105,663	\$13,208
Viral Load commodities	n/a				
VMMC kits	\$0	\$0	\$0	\$0	\$0
MAT	\$0	\$0	\$0	\$0	\$0
Other commodities	\$0	\$0	\$0	\$0	\$0
Total	\$30,306,063	\$0	\$2,443,993	\$27,848,862	\$13,208

a - Figures taken from the NASA 2014

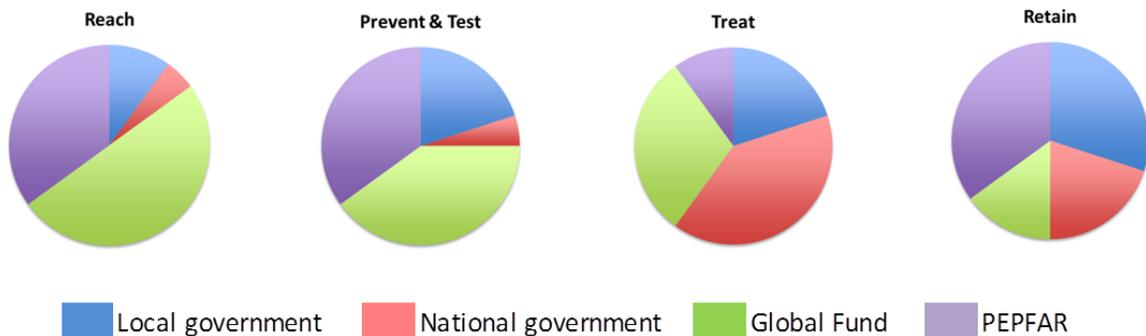
b - In NASA 2014, there is only a value for ART; there is no specific value for the cost of ARVs.

Table 1.2.3 Internal USG Program Integration and Leveraging

	Total Investment	Leveraged Funds	PEPFAR In-country Contribution	# of IMs	Notes
USAID MCH	\$20,000,000	-	\$151,800	2	
USAID Family Planning & Reproductive Health	-	-	-		
USAID TB	\$13,500,000	\$2,400,000	\$1,991,818	7	
CDC – Global Health Security	-	-	-	-	
NIH	-	-	-	-	
FDA	-	-	-	-	
Private Sector PPP Contributions	-	-	-	-	
PEPFAR Central Initiatives	-	-	-	-	
Total FY 15	\$13, 500,000	\$5,184,000	\$1,100,000	5	

Cross-leveraging in PEPFAR districts

In each of the eight districts where PEPFAR resources will be deployed, those resources will leverage funding provided by district governments, national government, and the Global Fund (GF). With careful planning and collaboration, PEPFAR resources will complement and supplement resources from GF and the Government of Indonesia. The figure below depicts how resources from each entity will link with and leverage resources from each other at each step in the cascade.



For example, to support **reach** activities, district governments pay for local health facilities, human resources, and operational costs. The national government contributes policy inputs and IT systems (e.g. *Sistem Informasi HIV-AIDS* (SIHA)). The GF pays for condoms, IEC activities, and support for outreach workers. PEPFAR will also support the critical outreach function, including training, IEC activities, and the development of innovative outreach IT solutions specifically focused on KP.

For **prevent and test**, PEPFAR's support of CSOs will strengthen advocacy and improve testing performance. District government funding is used to pay for some test kits, as well as support for collateral services (e.g. VCT and STI clinics). GF resources are also used to purchase test kits and to cover some VCT and STI treatment costs.

At the **treat** stage, national government funding covers nearly 100% of first line ARVs and ~20% of second line ARVs, while GF supports medicines for opportunistic infections (OIs) and about 80% of second line ARVs.

Finally, at the **retain** stage, PEPFAR plans to support the introduction of viral load testing. In the local context, this will require the district government to support the infrastructure, human resources, and operational costs. Resources from the national government will be needed to develop VL-testing policy and protocols, and possibly training. Global Fund will be requested to procure viral load testing cartridges for GeneXpert machines, and PEPFAR will support capacity building for CSOs, TA at public and private clinics, and for strategy development, IEC and mobile IT solutions to help outreach workers keep people on treatment.

1.3 National Sustainability Profile

To complete the Sustainability Index and Dashboard (SID), in January-February 2016, PEPFAR convened a series of meetings to gather input from a range of stakeholders. This included national and sub-national partners, such as the Ministry of Health, NAC, the Provincial AIDS Commission in Jakarta, and other multilateral organizations, such as UNAIDS and WHO. PEPFAR sought engagement from CSOs in Jakarta, meeting with thirteen representatives from national and sub-national CSOs in Jakarta and Bandung. This included CSOs that focus on advocacy for PLHIV, PWID, and MSM.

The following SID elements were identified as sustainability strengths:

- **Planning and Coordination:** Indonesia scored high on planning and coordination, but it is important to understand that there is a decentralized system in place. Thus, while the national government is responsible for the development and dissemination of guidelines, it has little to no authority over implementation, which is the responsibility of the sub-national (i.e., district) government. While planning and coordination with relevant stakeholders is high at the national level, it is still fragmented at the lower levels. This is an important consideration for implementation of the PEPFAR program, as the USG must consult and communicate with the local government on a regular basis to ensure effectiveness of program implementation.
- **Human Resources for Health:** HRH scored high due to a system and procedures being in place to maintain HRH, including pre-service and in-service training managed by the government, in addition to providing the majority of funding for health workers. While systems and procedures are in place, they do not always function optimally, as staff distribution and allocation are not based on program needs. For example, many public health facilities in Papua and other provinces in Eastern Indonesia have no medical doctors, nurses, or laboratory staff as there are inadequate incentives to encourage trained medical personnel to relocate to those provinces.
- **Performance Data:** Performance data also had a high score, as the government has set up a data collection system and collects HIV service delivery data, including for KP. However, data collection is largely for reporting and not for programming purpose; [REDACTED].

The following SID elements were identified as sustainability vulnerabilities:

- **Commodity Security and Supply Chain (SCMS):** This area received a low score largely due to a lack of information around the amount of financing for the supply chain plan provided by domestic sources and the lack of a comprehensive SCMS National Supply Chain Assessment. In addition, the decentralization of most administrative and procurement functions to the district level presents an enormous challenge for all health programs.

- **Service Delivery:** This area scored low in part due to sub-national health authorities’ capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control. In addition, while public facilities are able to tailor their services to KP’ needs, it is not consistent. Some health facilities offer same-day service for KP, but many still have to return for test results, which has a negative impact on the number of KP who know their HIV status.
- **Epidemiological and Health Data:** This area scored low due to a few factors. The government provides minimal financing for surveys and surveillance, and when they are undertaken, the results are not disseminated or used at the sub-national level. While the NAC conducts data quality assessments, accuracy of data is not assessed, but data is checked for timeliness and completeness. In addition, viral load data is not collected/reported.
- **Private Sector Engagement:** Historically, the private sector has not participated in the national HIV response in a significant manner. This is evident by the score reflected in the SID for private sector engagement. Most significantly, the percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector.

PEPFAR plans on addressing all of the domains that were identified as sustainability vulnerabilities in the SID. PEPFAR plans on scaling-up support to private clinics, as they have shown high yields of KP PLHIV. At the national level, PEPFAR will support government efforts to use and share high-quality data to monitor and report on program performance to ensure effective implementation and accountability. PEPFAR will also provide technical assistance to national and local government levels to strengthen the management of the supply chain, along with support for improved health facility reporting to the logistics management information system. Please see Section 6 for more detail.

1.4 Alignment of PEPFAR investments geographically to disease burden

In COP14, PEPFAR invested in 8 provinces and 28 districts. In COP15 the team pivoted to only 8 districts in 2 provinces; Papua and Jakarta. Papua has the highest HIV prevalence in the country at 2.4%, while Jakarta has the highest total number of PLHIV (105,182). In COP 16, PEPFAR resources will continue to strengthen the HIV response in Jakarta and Papua across the same 8 districts.

1.4.1: Table: Percent of PLHIV by SNU and PEPFAR 2015 Expenditure per PLHIV

SNU	Percent PLHIV by SNU	Total PLHIV by SNU	Expenditures per SNU	Spend per PLHIV
National	100%	128,774		
Papua	18.32%	23,592	\$1,304,920	\$55
Jakarta	81.68%	105,182	\$1,152,421	\$11

*Normally this graph is pulled from the EA-Epi tool; however, since the SNUs on the data pack and EA-Epi tool don't align, the expenditures could not be aligned directly. The datapack reports at the correct SNU level, so the PLHIV numbers and coverage numbers were aggregated manually to fit into Jakarta and Papua at large.

Table 1.4.1 compares FY 15 PEPFAR expenditures to the burden of disease in Jakarta and Papua. FY 15 Expenditures per PLHIV in Papua (\$55) are much higher than Jakarta (\$11), which is reasonable given the high costs of working in Papua. The high cost of doing business in Papua per PLHIV reflects the distance from the center (air travel), lack of infrastructure in the province, limited human resource capacity, etc.

Figure 1.4.1 - There are several considerations to keep in mind when reviewing this table (1) the number of PLHIV includes **ALL** PLHIV; however, expenditures only include PEPFAR resources. Hence, there is not a one-to-one relationship between resources and beneficiaries. (2) expenditure per PLHIV is not the same as the unit expenditure, since unit expenditure is specific to EA (e.g. PEPFAR resources over PEPFAR achievements) (3) Low volume typically drives expenditure per PLHIV up while high volume drives it down (i.e. Jakarta has low expenditure per PLHIV while Papua has high expenditure per PLHIV).

For COP16, a deeper comparison of UEs between Jakarta and Papua was conducted to parse out the expenditures by SNU to develop more accurate UEs for PEPFAR’s targeted-based budget approach. The PEPFAR team also looked at KP PLHIV when determining resource allocation.

Figure 1.4.2 compares ART coverage in Papua and Jakarta. Coverage as a percentage is comparable, with 14% in Jakarta and 12% in Papua.

1.4.2: Table with percent PLHIV by SNU, total PLHIV by SNU, coverage of total PLHIV with ART

SNU	Total PLHIV by SNU	Percent PLHIV by SNU	Coverage of PLHIV with ART
National	128,774	100%	17,505
Papua	23,592	18.32%	2,868
Jakarta	105,182	81.68%	14,637

1.5 Stakeholder Engagement

In working towards reaching the goal of controlling the HIV epidemic, it is critical that PEPFAR provides support to national and local governments and local institutions with an approach focused on building a sustainable national response. Shared partnerships—financial and programmatic—are essential in establishing and sustaining epidemic control and responding to new challenges in the future. The PEPFAR team sought to engage all relevant stakeholders in addressing the HIV epidemic in this COP development process.

1. Host country government

The PEPFAR team worked closely with the Ministry of Defense (MoD), MoH, NAC, local civil society, and other donors and development partners in the development of the COP16. Over the course of many years, the PEPFAR team has established consistent communication and collaboration with counterparts in the Gol in the process of developing annual operational plans and implementing and monitoring them.

This year, the USG consulted with [REDACTED] head of the National AIDS Program (NAP) at the MoH, [REDACTED], secretary of the NAC, [REDACTED] from the Indonesian military's Surgeon General's Office (SG), [REDACTED] from the MoD, and their teams regarding proposed activities that the USG would undertake to support the National Strategic Plan, including geographic prioritization, populations of focus, and the types of activities that would be undertaken. The discussion also centered on how USG activities would coordinate with proposed activities under the GF Concept Note since the MoH and NAC are two of the Principal Recipients. In addition to that, the team also consulted with Spiritia, a national CSO that is a Principal Recipient of the GF. The consultations also addressed specifics regarding TA provided to each of these entities (i.e. challenges in supply chain management, required TA for establishing viral load testing, and improved collaboration for HIV/AIDS program in Jakarta and Papua with the GF and Fast Track Initiatives). The USG team obtained MoH, NAC, SG and MoD concurrence on the activities proposed, and will share the final draft of the plan with them as soon as it is finished.

In Papua, the PEPFAR team also participated in a coordination meeting for seven highland districts in Jayapura. The meeting was led by the Provincial Health Office to improve coordination among the districts, and ensure provision of continuum of care services. The meeting was attended by MoH, NAC, UNAIDS, UNICEF and representatives of District AIDS Commissions, District Health Offices, local community leaders, local community and faith based organizations, and KP-friendly clinics from the seven districts.

2. Global Fund and other external donors

With Australian support to Indonesia's health sector ending in June 2016, there are essentially now two external donors to the national HIV/AIDS response in Indonesia, namely the GF and PEPFAR.

According to GF's counterpart financing calculations, GF now contributes 41% of the funding needed to implement the HIV National Strategic Plan. Because the counterpart calculations do not include funding from other donors (i.e., only GF and GoI contributions are "counted"), when PEPFAR funding is included in the mix, GF's relative contribution is reduced to 25%; nevertheless, GF's contribution is considerable. Indonesia's GF grant portfolio is the second largest in Asia, after India. As such, the GF is a critical partner to PEPFAR in Indonesia.

In the first quarter of 2016, new grant implementation periods began, or will begin, for the three HIV Principal Recipients (PRs). Spiritia Foundation signed its Grant Confirmation with the GF in late 2015 and received its first disbursement at the start of January 2016. The MoH's Grant Confirmation for the HIV Sub-directorate was signed in late February, and the MoH quickly received its first disbursement for the new implementation period. As of this writing, the Grant Confirmation for the NAC has not been signed.

In the Indonesian context, GF Concept Notes for HIV are explicitly based on the HIV National Strategic Plan (NSP). The PEPFAR COP16 program is also based on the NSP, and indeed is specifically designed to directly leverage both GoI and GF resources in focus districts. In this sense, there is seamless alignment between PEPFAR and GF programming.

Under the new GF HIV grants, support for KPs is shared by Spiritia and the NAC. PEPFAR has held consultations with both Spiritia and NAC regarding the two PRs' plans within the PEPFAR focus

districts, and the PEPFAR team will maintain a close collaborative relationship with Spiritia and the NAC as their workplans are developed and implemented. A key objective of PEPFAR's collaboration with Spiritia and the NAC is to ensure that activities focused on KP are synergistic. An additional objective is to ensure that PEPFAR will be in a position to influence the "reprogramming" that will take place under the GF grants as the grant implementation periods progress. In this way, lessons learned through PEPFAR-funded activities will help to inform the more or less continual process of PR workplan revision and refinement that is a common feature of GF grant implementation.

USG also enjoys a close collaborative relationship with the GF itself, a relationship that is facilitated and sustained by the resident Global Fund Liaison. USG maintains its seat on the CCM, and is represented on the CCM's Oversight Committee, and, perhaps most importantly, USG representatives also participate as members of the CCM's Technical Working Groups (TWGs, one for each GF disease area and HSS). The TWGs are "where the action is" – TWGs take the lead in Concept Note development and conduct primary grant oversight. They review PR Management Letters from the GF/Geneva and develop responses for submission to the CCM. TWGs have emerged as important forums for discussion, debate and information-exchange across stakeholder groups. TWG HIV, for example, is the one forum where all stakeholders routinely gather: MoH, civil society, representatives of KP, the multi- and bilateral HIV/AIDS donor community, and the HIV PRs. TWG HIV members have a voice in the broader conversation about HIV in Indonesia. If that voice is clear and persuasive, then TWG participation can influence the content and direction of the conversation. USG participation on TWG HIV is thus important to the success of the PEPFAR program as well as the GF grants.

PEPFAR's collaboration with GF is also demonstrated through support from Grant Management Solutions (GMS), which is assisting Indonesia in improving funding flows and program management at the subnational level. A long-standing constraint to program performance in Indonesia is related to the challenges of managing sub-recipients (SR) (typically at the province level) and sub sub-recipients (typically at the district level). Once GF resources have been disbursed to the province level, for example, the central level's ability to direct and manage those resources diminishes considerably. A recent OIG report identified a wide range of risks and management issues confronting government PRs at the SR level. As a result, a new grant requirement was included in the Grant Confirmations for all government PRs: by April 30, 2016 the PRs must have a (draft) risk-differentiated plan in place for improving the management of their SRs. CCM Indonesia submitted a technical support request to GMS for assistance, which has been approved by OGAC's TSAP, and a GMS team will begin work on the SR management improvement plans on April 4, 2016.

3. Civil Society

Civil society is, and has been, a vital part of the broader HIV response in Indonesia. PEPFAR has historically had a good relationship with CSOs, and a limited group of academia, community-based organizations (CBOs) and network partners. In this year's COP development process, the team held one consultation meeting in addition to attending regular meetings with local CSOs led by implementing partners, and CSO meetings led by the NAC. Seven CSOs representing KP were represented at the consultation meeting, along with a PLHIV group and a national coalition for AIDS; some of these receive PEPFAR funding, and some do not. [REDACTED]. The meeting included information on progress of COP15 and future plans and directions for PEPFAR programming in

Indonesia as planned in the draft COP16. This included discussion of investments in CSO management and technical capacity building to ensure KP has access to services.

Highlights from the discussion include the following:

- Although Indonesia has a history of discrimination and violence against LGBT, recent events suggest that the situation is getting worse. The absence of a clear government response addressing discrimination and violence against LGBT is perceived as neglect of Indonesia's commitment to uphold international and domestic human rights law. Some CSOs have been contacted by National State Intelligence and directed to not accept international funding for implementing LGBT programs. One national KP association has concealed information on their to prevent fundamentalist organizations from targeting their office.
- CSOs agreed that the activities of the CSOs forum initiated as a result of the COP15 consultation need to intensify. The regular meeting they have is mostly to provide updates on the progress of their programs and to discuss potential short-term strategies in dealing with challenges. The forum may need to orient itself to be more of a strategic discussion around such issues as advocacy for inclusion of viral load testing in the national health insurance scheme.
- Participants felt that ICT platforms could be better used to ensure CSOs in Indonesia have equal opportunity to participate in discussions and processes. This could include using existing ICT maps and ICT platforms such as Whatsapp; Facebook; Google Plus+; live streaming mobile stations; webinar software; smartphone mobile applications; and websites.
- Community monitoring and evidence-informed advocacy need to be prioritized; these areas have been less funded in the past. These two areas have a strong connection with quality improvement of service delivery and increasing domestic spending to fund the HIV/AIDS response.

The PEPFAR team has utilized this feedback in its planning process, and will share the final plan with partners. The team will meet after the COP submission to determine how best to address CSO concerns.

4. Private Sector

Historically, the private sector has not participated in the National HIV Response in Indonesia in a major way. [REDACTED]. This year, PEPFAR/Indonesia will engage more with private clinics, specifically select high-performing KP friendly private clinics that show the potential to produce a high yield of KP PLHIV. PEPFAR will continue to explore opportunities for increased private sector engagement in addressing the HIV epidemic in Indonesia, but this remains a challenge given the populations most affected by HIV.

2.0 Core, Near-Core and Non-Core Activities

For COP16, a key priority is to support countries to rapidly adopt the new WHO guidelines that recommend ART for all PLHIV irrespective of CD4 cell count and change service delivery so high-quality HIV testing and ART can be delivered in a less expensive, maximally efficient manner for both health programs and the community. In Indonesia, the government initiated a test and treat strategy in 2014, rolling out the "Strategic Use of ARVs" (SUFA) among KP, pregnant women, sero-discordant couples, and TB and Hepatitis C patients in 75 districts, including all those supported by PEPFAR.

USG activities in COP16 largely support capacity building and technical assistance to the national and local governments; higher-performing public facilities, and KP friendly clinics. Indonesia also provides direct services for KP. With limited PEPFAR funds, the determination of core, near-core and non-core activities reflects the priorities in the SID. The resulting activities include very limited direct service delivery; these efforts focus on innovations, demonstrating best practices, and assisting the country in ensuring their response is strategic, data-driven, and state-of-the-art for KP and ethnic Papuans in priority areas in achieving sustainable epidemic control. The activities also reflect support for national and sub-national above site work, which remain aimed at strengthening critical health systems, supporting the development or implementation of health financing schemes, and creation of an enabling environment, including the development and implementation of an MoD policy for HIV-testing of Indonesian soldiers pre- and post-deployment as UN peacekeepers.

The PEPFAR team designed their approach in a way that takes into account the national context and builds on and leverages national processes and information to help the GoI achieve epidemic control, which is the primary goal of PEPFAR programs. The team has taken into account the sustainability of the activities in partnership with civil society and the GoI. The team has also worked closely with UNAIDS and GF PRs to ensure that resources are strategically focused on the right things, in the right places, and at the right time. See Appendix A for a full list of core, near-core, and non-core activities.

3.0 Geographic and Population Prioritization

The MoH has estimated HIV prevalence among people aged 15-40 years at 0.4% based on the AIDS Epidemic Model (AEM). With the exception of the provinces of Papua and West Papua (which have a low-level HIV epidemic of 2.3% prevalence), Indonesia's HIV epidemic is concentrated among KP. Based on Indonesia's epidemiologic data, PEPFAR is focusing its efforts in the top 2 provinces (Jakarta and Papua) which represent 28% of the PLHIV burden nationally. Jakarta, with an estimated 104,595 PLHIV, represents 16% of the national of PLHIV, and 11.3% of the national KP PLHIV burden according to AEM estimates (See Table 3.1). As for Papua, it has an estimated PLHIV of 80,035 and represents 12% of the national HIV burden.

The HIV epidemic in Indonesia continues to be driven by and concentrated among FSW, MSM, TG, and PWID. According to estimates from the 2014 AEM, KP will constitute approximately 64% of all new HIV infections in 2016 (28% FSW, 35% MSM, and 3% PWID). As new preliminary data emerge from the 2015 KPs' IBBS demonstrating the significant increase in HIV prevalence among MSM, the proportion of new infections among KP may continue to increase in the coming years.

Table 3. 1: Comparison of KP PLHIV in DKI Jakarta vs. National KP PLHIV estimates by Key Populations

	2015 IBBS National Prevalence*	2015 IBBS Jakarta City Prevalence*	2015 National PSE	2015 National KP PLHIV estimates**	2015 Jakarta KP PLHIV estimates**	% KP PLHIV in Jakarta vs. National total KP PLHIV
PWID	28.8%	43.6%	77,286	34,711	5,658	16.3%
Direct FSW	8.0%	--	129,973	13,432	1,992	14.8%
Indirect FSW	2.2%	--	109,036	6,298	2,122	33.7%
MSM	25.8%	32.0%	1,139,606	101,303	8,220	8.1%
Waria (TG)	24.8%	--	39,512	11,621	967	8.3%
Total KP			1,495,413	167,365	18,959	11.30%

*Preliminary data from 2015 IBBS presentation (MoH, 2016)

**Data based on 2014 AIDS Epidemic Model's 2015 projections

A situation analysis conducted by the MoH in May 2013 demonstrated that the number of new reported cases is highest in Jakarta and HIV prevalence among KP in Jakarta are generally higher compared to the national prevalence rates. For COP16, PEPFAR will work in 5 of the 6 districts where 91% of PLHIV in Jakarta are located. These districts are North Jakarta, Central Jakarta, South Jakarta, East Jakarta and West Jakarta. Key populations, including FSW, MSM, TG, and PWID are the target populations for PEPFAR's program.

Jakarta

PEPFAR Indonesia will saturate Jakarta by intensifying its current program focus on HIV case finding and implementing "Test and Start" among KP. CSOs located in priority districts will strengthen linkages and referrals to health facilities for HIV testing, care, and treatment, building on current successes. In FY17, PEPFAR Indonesia will continue this approach and projects an increase of 99.6% for HIV testing among KP in Jakarta (with a 9% overall positivity testing yield).

The proposed total currently on treatment (TX_CURR) target for FY17 is 7,381, with the goal of improving ART coverage among KP in Jakarta from the estimated 47% (December 2015) to 64% by the end of FY17, and reaching ART saturation (second "90" of 81%) among KP by FY18¹⁶.

After the successful introduction and support of KP-friendly private clinics to provide comprehensive clinical services (including the initiation of ART) in Jakarta, PEPFAR Indonesia will continue to strengthen linkages with CSOs and these clinics to accelerate the scale up of ART among KP. One of the two private clinics, [REDACTED] in Jakarta has seen an exponential increase of ART initiation among MSM/TG over the past year (71 in FY14 APR to 960 in FY15 APR) as nearly all recently diagnosed PLHIV are placed on ART shortly after receiving a positive diagnosis. Fourteen higher performing public facilities (with

¹⁶ Proportion of KP currently on ART among all ART patients is not available. This calculation assumes that 50% of all ART patients in Jakarta are key populations (with a 75% retention rate and 6% annual incidence among KP).

friendlier services/receptivity to KP, high positivity yield and substantial ART patient load, and/or high TB burden) have been selected to intensify ART scale up in FY17.

The focus in 2019 and 2020 will be on ensuring national program partners are able to sustain the rapid scale up achieved during the previous two years and continue to build on their success. In order to ensure sustainability of gains made in 2017 and 2018, PEPFAR Indonesia will collaborate closely with Global Fund PRs/SRs, including the GoI and CSOs, to build capacity and advocate for increased local investment in HIV/AIDS. This is particularly critical as it is currently anticipated that Indonesia will no longer be eligible for Global Fund support after 2020.

Papua

In Papua, PEPFAR will concentrate in 3 districts (Jayawijaya, Jayapura City and Mimika) among KPs and priority populations (clients of sex workers and at-risk women). Within Papua, these three districts account for approximately 36% of the total number of PLHIV. In the three districts where PEPFAR will be working in Papua, the general population HIV prevalence rate is 3.6%, greater than the overall prevalence in Papua of 2.3%.

The geographic choices are also based on one of the highest priorities in the SRAN 2015-2019 (Indonesia's National HIV/AIDS Strategy and Action Plan), which is strengthening the existing continuum of care service delivery (LKB) for HIV/STI promotion, prevention, and treatment in primary health care facilities and hospitals. The current HIV program is focused on the 142 high burden districts (including 75 SUFA districts); PEPFAR districts are all high-burden SUFA focus districts where TA provision will play a vital role in success in reaching KP and getting them into the cascade.

ART coverage in these provinces (based upon the assumption that all PLHIV need to initiate ART and upon the SUFA initiative) ranges from 5.2% in Papua (4,572 of 88,041 estimated PLHIV) to 14.0% in Jakarta (14,666 of 105,182 estimated PLHIV), reflecting the continued high unmet need.¹⁷ Geographic distribution of ART patients shows Jakarta and Papua provinces at approximately 23 percent (14,666/63,066) and 7.2 percent (4,572/63,066), respectively, of the total number of patients currently on ART as of December 2015.

As a result of this analysis and the country context, PEPFAR has prioritized an appropriate mix of core activities within these provinces in hopes of saturating ART coverage (81%) among all KP PLHIV in Jakarta by 2018 and aggressively scaling up ART and improving retention of existing ART patients in the three PEPFAR-supported districts of Papua.

Military

In alignment with Indonesia national strategy, the DOD program will focus on direct military to military engagement at the above-site level. Activities will include HIV policy strengthening; comprehensive HIV education and capacity strengthening; and collaboration with the Indonesian military to conduct an HIV seroprevalence study (SABERS) to further focus prevention efforts where they are most needed.

¹⁷ 2015 Quarter 4 MoH Program Data Report and 2015 AEM PLHIV estimates

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

Although the numbers of PLHIV currently on ART have dramatically increased in recent years, treatment coverage in Indonesia remains low. By the end of 2015, only 63,066 (approximately 9%) of the population in need of ART were enrolled in treatment, according to 2015 Q4 MoH data for the national HIV program. Treatment targets in the national 2015-2019 strategy called for 50% of PLHIV to be on ART. Meeting the ambitious national ART targets will require in-depth strategic planning to achieve the most impact with the proposed activities. The roll out of SUFA in 2014 stipulated the “Test and Start” policy for KP, alongside TB/HIV patients, pregnant women, and sero-discordant couples. However, time lapse from diagnosis to ART initiation among KP for the national program is unclear. Anecdotally, a number of public facilities where PEPFAR began support in 2015 stated that the time from diagnosis to ART initiation for KP is approximately 2 weeks in light of SUFA. Furthermore, even though the national HIV reporting system, SIHA, has the option of reporting the disaggregation of KP on ART, it is often incomplete and cannot be used to accurately estimate the proportion of KP currently on ART. There is also no program data for retention and lost to follow-up (LTFU) in these populations.

One major challenge has been the low number of KP with knowledge of their HIV status. Based on 2011 IBBS data, only 57% of DFSW, 36% of IFSW and 39% of MSM have ever had a HIV test, although preliminary data from the 2015 IBBS demonstrate that the percentages of KP ever receiving a HIV test have increased. The percent of TG and PWID ever being tested for HIV were higher (72% and 63% respectively). However, no data is available on the percentage of those tested in the last 12 months and how many of those tested ever received their results from the 2007, 2011, and 2013 IBBS surveys. No national data is available on the coverage rate for HIV testing among KP reached.

Since COP15, PEPFAR has placed a greater emphasis on intensifying HIV case-finding and implementing “Test and Start” among KP in Jakarta and Papua. CSOs located in priority districts significantly improved the linkages and referrals to health facilities for HIV testing in the past 12 months. In FY15 APR, more than 70% of all KP and PP reached were tested for HIV (with an overall 16% positivity yield) in the eight priority SNUs compared to 37% of all KP reached by PEPFAR prevention services (with a 9.4% sero-positivity yield) in FY14. In FY17, PEPFAR will continue this approach and projects a 80% coverage rate for HIV testing among those reached by PEPFAR program, with a 11% overall positivity testing yield.

Ambitious targets were set in COP15 (for FY16) to significantly increase HIV diagnosis and ART coverage from FY14 APR results of 1,254 HIV positive diagnosis (HTC_TST, positive) and 71 on ART (TX_CURR) to FY16 targets (in COP15) of 2,746 HIV positive diagnosis and 6,764 individuals currently on ART by the end of FY16. In order to reach the FY16 treatment targets, PEPFAR expanded its technical support to increase ART coverage among KP beneficiaries in public facilities, alongside the three private KP-friendly clinics PEPFAR had supported in the past. As a result of this expansion, the HIV testing yield in FY16 Q1 was less than optimal and was lower than the projected FY16 target. The FY16 positivity yield target of

5,956 was set at 16% yield (based on FY14 private clinic APR of 22.4% yield). However, with the incorporation of public facilities where strategic and targeted KP testing is not yet in place, only 676 individuals (11.3% of annual target in the first 3 months) were identified with an average positivity yield of 8.0% in FY16 Q1.

As such, FY17 targets for HTC and yield have been lowered to 3,612 newly diagnosed as positive, with an overall 12% yield. The 12% yield is based on a weighted average of 22% positivity yield among private KP and PP friendly clinics and a 6% yield among public facilities. However, PEPFAR will continue to scale up “Test and Start” among KP in Jakarta and KP/PP in the three districts in Papua in FY17. Because it seems unlikely that the ambitious ART target set for FY16 will be achieved based on Q1 results, the total target for PLHIV currently on treatment (TX_CURR) for FY17 will be set at 6,709 (compared to 6,764 in FY16), with the goal of improving the retention of KP/PP PLHIV already on ART and initiation of newly diagnosed KP/PP PLHIV (See Table 4.1.1.a and 4.1.1.b).

After the successful introduction and support of KP-friendly private clinics to provide comprehensive clinical services (including ART initiation) in Jakarta, PEPFAR will continue to strengthen the linkages of CSOs and these clinics will continue to support “Test and Start” among KP. One of the two private clinics [REDACTED] in Jakarta has seen an exponential increase of ART initiation among MSM/TG over the past year (71 in FY2014 APR to 960 in FY15 APR), as nearly all recently diagnosed PLHIV are placed on ART shortly after. Furthermore, technical support will be provided to one faith-based clinic in Papua for clinical care and ART services in FY16 for FSW and priority populations. Nineteen higher performing public facilities (with friendlier services/receptivity to KP, higher positivity yield and substantial ART patient load, and/or high TB burden) have been selected to intensify ART scale up in FY17. [REDACTED].

Table 4.1.1.a ART Targets in Scale-up Sub-national Units for Epidemic Control among Key Populations for DKI Jakarta

SNU	Total KP PLHIV	Currently on ART by HCG (FY 15)*	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) TX_CURR	Newly initiated (APR FY 17) TX_NEW
Central Jakarta	5,143	4,937	2,009	0	1,888	1283
East Jakarta	3,037	1,384	327	1,046	385	417
North Jakarta	1,959	1,918	1,020	0	1,482	926
South Jakarta	4,646	1,016	1,123	2,701	1,029	815
West Jakarta	4,174	2,455	911	884	769	532
Total	18,959	11,710	5,390	4,631	5,553	3973

Table 4.1.1.b ART Targets in Scale-up Sub-national Units for Epidemic Control among KP and PP for Papua (Jayapura City, Jayawijaya, Mimika)

SNU	Total KP and PP PLHIV	Currently on ART by HCG (FY 15)*	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) TX_CURR	Newly initiated (APR FY 17) TX_NEW	ART Coverage including national program (APR 17)
Jayapura City	7,477	882	1,103	5,099	522	273	11.8%
Jayawijaya	2,379	838	1,047	1,066	379	170	35.2%
Mimika	3,510	574	718	2,234	255	125	16.4%
Total	13,366	2,294	2,868	8,399	1,156	568	17.2%

*MoH September national program data—discounting at 20% for KP and PP (assuming 80% of all ART patients are KP and PP since KP/PP disaggregates are not available for clinical data)

Table 4.1.2 Entry Streams for Adults Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)	Identified Positive (APR FY17)	Newly initiated (APR FY 17) TX_NEW
Adults	30,082	3,612	2,714
Clinical care patients not on ART			
HIV+ TB Patients not on ART			
HIV-positive Pregnant Women			
Other priority and key populations	30,082	3,612	2,714
Total	30,082	3,612	2,714

Table 4.1.4 MSM for Prevention Interventions to Facilitate Epidemic Control (KP_PREV)

SNU	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
Central Jakarta	27,706 (5 SNUs)	N/A	1,548
East Jakarta			1,077
North Jakarta			568
South Jakarta			1,662
West Jakarta			1,229
Total		22.0%	6.084

Table 4.1.4 TG for Prevention Interventions to Facilitate Epidemic Control (KP_PREV)

SNU	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
Central Jakarta	1,502 (5 SNUs)	N/A	155
East Jakarta			148
North Jakarta			177
South Jakarta			138
West Jakarta			178
Total		53.0%	796

Table 4.1.4 PWID for Prevention Interventions to Facilitate Epidemic Control (KP_PREV)

SNU	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
Central Jakarta	13,391(5 SNUs)	N/A	217
East Jakarta			266
North Jakarta			443
South Jakarta			220
West Jakarta			285
Total		10.7%	1,432

Table 4.1.4 FSW for Prevention Interventions to Facilitate Epidemic Control (KP_PREV)

SNU	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
Central Jakarta	28, 984	N/A	2,430
East Jakarta	(5 SNUs in Jakarta only)		1,458
North Jakarta			2,597
South Jakarta			1,080
West Jakarta			1,508
Jayapura City	Papua SNU not available		1,307
Jayawijaya			310
Mimika			314
Total			11,004

Table 4.1.4 Priority Populations for Prevention Interventions to Facilitate Epidemic Control (PP_PREV)

SNU	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
Jayapura City	Not available	N/A	3,928
Jayawijaya			6,042
Mimika			6,446
Total			16,416

Table 4.1.5 Military Population Targets

DoD Metrics	Target for FY17	Target for FY18	Target for FY19
Number of Indonesian soldiers tested for HIV pre- and post-deployment for UN peacekeeping missions	3,000	3,500	4,000
Number of trained military medical physician and nurses	110	110	110
Number of military personnel trained on HIV military education	240	300	300
Number of military personnel trained on monitoring and evaluation		20	20

4.2 Priority Populations Prevention

Based on priority and KP data, national- and district-level context, and the core, near-core and non-core analysis, PEPFAR proposes to focus its technical assistance and partnership with Gol on activities that will prevent HIV transmission among KP (and PP in Papua) and expand the reach of civil society organizations that target KP in scale-up districts to reach 90/90/90.

Because stigma and discrimination and gender-related discrimination remain important obstacles to providing quality services for HIV/AIDS and controlling the epidemic, the PEPFAR approach addresses barriers to access, including: flexible hours of operation with access to multiple integrated services; confidentiality and privacy; training for providers on the importance of relevant and respectful care to all clients, including women, girls, and marginalized groups; and provision of alternative service delivery options (e.g., home visits and mobile units) for clients unable to reach or unlikely to use facility-based services.

The PEPFAR program works to provide innovative and locally effective interventions to improve service delivery for KP/PP and better collaborate with community-based organizations and leaders to increase demand creation of testing services. While not all of the core services recommended for comprehensive KP services across the continuum of HIV prevention, treatment, and care are being implemented either through PEPFAR funds (i.e., needle and syringe programs and opioid substitution therapy) or in Indonesia, generally (e.g., PreP), the activities are in-line with both service delivery approaches and supportive interventions necessary to strengthen and build an enabling environment for KP to access services. PEPFAR is also investing in intensifying HIV case finding among KP/PP (with 80% reached with prevention services receiving HTC testing) and in assisting the Gol to better target KP for HIV testing in public facilities.

PEPFAR works to build capacity of local government and NGOs to deliver HIV/AIDS services on a sustainable basis including improving the use of data, strategic planning and implementation and health

systems strengthening. Through a grants programs and technical assistance, PEPFAR will support CSOs to advocate for and leverage resources with national and local government while sustaining the quality of their programs and expanding their reach to KP with priority HIV interventions.

In FY2017, PEPFAR will continue to accelerate the roll out of the National Condom Strategy, including condom promotion and use among high-risk groups. Targeted technical assistance for implementation of condom promotion activities remain a priority for PEPFAR in COP16 in priority PEPFAR districts.

4.3 Voluntary Male Medical Circumcision (VMMC)

Key findings from the 2013 IBBS survey indicate that 3% of ethnic Papuans are HIV infected, higher than the 0.4% prevalence found among non-Papuans in Papua. Male circumcision was significantly correlated with HIV infection, with 2.4% of non-circumcised men infected with HIV compared to only 0.1% among circumcised men. While Indonesia is not a focus country for PEPFAR VMMC support, USG activities in Papua where VMMC is being considered by provincial and district authorities need to be conducted in collaboration with possible VMMC activities funded by the GoI.

4.4 Preventing Mother-to-Child Transmission

Based upon current data and priorities for PEPFAR in Indonesia, PMTCT, while an important intervention, is a non-core activity, and therefore the PEPFAR program will not support any PMTCT programming.

4.5 HIV Testing and Counselling

While the MoH policy on SUFA in 75 priority districts presents an opportunity to increase the number of KP and other high-risk group members in high prevalence districts to initiate early ART, treatment coverage in Indonesia has not improved greatly. Fear of disclosure, mistrust in health care staff, and concerns regarding patient confidentiality are often concerns for KP, TB patients, and other at-risk groups. These factors continue to reduce demand for HIV testing and promote late initiation of ART.

The MoH also issued Regulation No. 5/2014, allowing primary health centers to provide HTC and ART for simple cases of HIV. Utilizing primary healthcare as a testing venue in the public and private sectors, supported by adequate finance, infrastructural and human resources, should increase the access for KP, high-risk groups, and PLHIV to healthcare. The scale-up of HIV testing and treatment is primarily related to improving access, as well as integrating HIV services and adherence programs at the primary healthcare level.

PEPFAR will provide support to the national and local governments to make necessary policy and program changes to improve HIV testing and treatment. PEPFAR will provide critical support to the GF CSO PR to pilot community-based screening among MSM in Jakarta using OraQuick. In addition, PEPFAR is investing its resources to intensify HIV case finding among KP/PP (with 80% reached with prevention services by CSOs receiving HTC), improve HIV testing among known TB patients, and assist the GoI in better targeting KP for HIV testing in public facilities.

PEPFAR provides technical support to national and local governments and health facilities to improve distribution systems to support differentiated service delivery models that includes less frequent ARV dispensing for stable patients and innovative drug distribution strategies, particularly for KP and PP that are highly mobile. PEPFAR works closely with higher performing public facilities and KP-friendly clinics to improve the quality of data through improved health facility reporting to the logistics management information system in order to identify stock-outs more quickly.

4.6 Facility and Community-based Care and Support

CSOs in Indonesia play a key role in establishing the networks necessary to link KP PLHIV to health facilities to access care, support, and treatment services upon diagnosis. In Papua, PEPFAR will aggressively increase identification of new PLHIV on ARV, and prioritize support for an effective continuum of response for PLHIV by intensifying collaboration with community and faith-based organizations. Anecdotal data from CSOs and public facility staff suggest that ART retention rates in the Papua Highlands are low as a result of limited road access and high transportation costs. While PEPFAR will continue to scale-up ART coverage in Papua, it will focus on developing a community-based adherence model where community workers will serve as ART dispensers for stable patients.

In Jakarta, PEPFAR will increase collaboration with the Principal Recipients of the GF and UNAIDS, who will lead the Fast Track Initiative. To improve care provided to KP, PEPFAR will support the continuum of care model to improve the linkages between community and clinical services for KP, including assuring access to clinical services, counseling and testing, adherence support for treatment and management of opportunistic infections, social support, and improving the enabling environment.

PEPFAR programs are continuing to develop, innovate, monitor, and expand replicable best-practice models and focus on building the capacity through technical training of CSOs and other implementing partners to assure high-quality service delivery.

4.7 TB/HIV

Indonesia is second among the global TB disease burden countries, while HIV prevalence in the general population remains relatively low, except in Papua. While TB/HIV collaborative activities began in Indonesia in 2007, only 2.9% of TB patients in 2014 had a known HIV status. Compared to most other countries this is extremely low – HIV testing is the gateway to HIV services for patients with TB.

Of those tested, 24% were co-infected (TB cases with HIV infection) and, of these, 43% received ART, and 49% received cotrimoxazole preventive therapy (CPT). Only 49% of the previous year's co-infected patients were successfully treated. In Papua, the proportion of TB patients registered in 2014 who had an HIV test result recorded in the TB register was 27.8% (2,496/8,967), and of those, 30% were HIV positive (749/2,496). Of those, only 31% received CPT and only 25.2% were given ART during TB treatment.

PEPFAR will provide technical assistance to higher-performing public facilities and KP-friendly clinics and CSOs to improve the referral of PLHIV for TB testing and provide support for TB treatment in priority districts.

4.8 Adult Treatment

In 2014, the MoH launched a new initiative, SUFA, designed to accelerate expansion of ARVs for treatment and prevention of HIV in Indonesia, and accelerate the number of people currently on treatment. The effort focuses on KP and high-risk groups, sero-discordant couples, TB/HIV co-infected individuals, and pregnant women, where ART is expected to begin at the time of diagnosis, regardless of CD4 count. Treatment for HIV/AIDS is fully supported by the Gol and the GF.

Support for the SUFA initiative is built into the proposed USG activities, particularly through grants to local CSOs, technical assistance for improved drug quality assurance, and technical assistance to build epidemiologic analytical capacity. PEPFAR will provide technical assistance in the eight districts to support the MoH's scale up, and develop successful and innovative models for strengthening the capacity of the range of district partners to implement a high-quality treatment cascade model, with a focus on SUFA and the continuum of care.

PEPFAR will support a key component of the PEPFAR Quality Strategy to increase acceptability and accessibility of clinical services that promote linkage and retention. Specific activities will be harmonized with those supported by the GF and be tailored to enable these activities to achieve improved outcomes.

4.9 Pediatric Treatment

Based upon current data and priorities for PEPFAR in Indonesia, Pediatric Treatment, while an important intervention, is a non-core activity, and therefore the PEPFAR program will not support any PMTCT programming.

4.10 Orphans and Vulnerable Children

Based upon current data and priorities for PEPFAR/Indonesia, OVC programming is not supported by PEPFAR in Indonesia.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

The availability of HIV-related services in Indonesia has increased significantly over the past several years. The number of public health facilities offering sexually transmitted infection (STI) diagnostic and

treatment services increased nearly eightfold from 92 in 2010 to 801 in 2014; HTC services from 385 to 1,391, methadone maintenance therapy (MMT) from 65 to 87; ART services from 195 to 455, and PMTCT services from 29 to 116 during the same timeframe. However the majority of these services are still provided as vertical interventions (vs. part of an integrated package of services), and providing a mandatory minimum standard of service everywhere has proven challenging.

While the availability of services is generally in place, demand has not been generated sufficiently among KP and PPs to utilize them. HIV testing among KP and PPs is still low. HIV testing coverage has increased from 33,577 in 2010 to 1,263,871 at end of 2015, but remains sub-optimal within an AIDS elimination context. There is no national data available on the proportion of key or priority populations reached who test for the virus, nor is there comprehensive data available on the proportion of KP tested within a 12-month period. PLHIV are not being successfully linked to care and treatment. While ART coverage has tripled since 2009, just 9% of those estimated to be living with the virus are retained in care and treatment services. The slow pace of HIV treatment service decentralization from large hospitals to primary health centers limits enrollment of PLHIV.

[REDACTED]. The absence of a clear government response addressing discrimination and violence against the LGBT community is perceived by CBOs as an indication of reduced commitment to uphold international and domestic human rights law. FSWs work in an uncertain environment in which HIV response guidelines may be contradicted by local regulations that, for example, allow possession of condoms as admissible evidence of a criminal act. Waria and MSM are often faced with social, moral and religious prosecution, while PWID may be subject to criminal arrest and legal action when they access HIV services.

PEPFAR will utilize existing program data to intensify its collaboration with higher-performing public facilities and identify additional KP-friendly clinics to increase rates of service uptake. PEPFAR will also work with the local government and CBOs to provide services with flexible hours for KP, in particular, one-stop-shops to ensure linkages from testing to initiation and retention in care and treatment. The team will advance the use of innovative technical tools and approaches that foster demand and promote uptake of HIV outreach, testing, and care and treatment services among KP. ICT reviews will be conducted to develop or expand solutions that capitalize on the use of mobile technologies, link applications to track CoPCT service uptake, and reach KP where they are. Particularly in Papua, the team will work with public and KP-friendly clinics to intensify mobile testing services in areas where risk screening has identified significant numbers of KP and PPs. HIV yield rates will be monitored closely to ensure that mobile testing services focus on highest impact areas only, and are quickly discontinued in places of low HIV positivity.

The team will support development of patient tracking and management systems, which will be closely monitored via existing GoI information systems. In the absence of robust LTFU tools and interventions, PEPFAR will develop a simplified and locally validated LTFU instrument. This instrument will include tools and key interventions that prevents LTFU by engaging facility- and community-based personnel as case managers for high-needs clients; provides data analytics support to detect possible LTFU individuals; and promotes community-based case finders for those individuals who are LTFU. These interventions, together with the decentralization of services, will work towards a goal of ensuring that 80% of current patients are retained in treatment and 60% of LTFU clients are rapidly returned to care.

At the national level, PEPFAR will work with international partners and the national government to address stigmatization and discrimination towards KP and PPs. The team will emphasize the importance of advocacy for addressing barriers to accessing services. The team will also work with the MoH to

strengthen the stigma and discrimination reduction elements of the SUFA capacity building strategy in an effort to ensure that stigma and discrimination reduction is a core component of all SUFA training sessions.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

Low coverage of key and priority populations with HIV testing services

A key gap to achieving sustained epidemic control in Indonesia is the low coverage of key and priority populations with HIV testing services. PEPFAR will focus on the following key barriers to this area: high levels of stigma and discrimination for KP; no community-based HIV testing by non-medical personnel; and an uncoordinated and inconsistent supply chain for HIV testing commodities.

Like many other countries, there are high levels of stigma and discrimination for KP in Indonesia. This is compounded by restrictive LGBT policies and laws. In addition, steps have been taken to close brothels, which has served decreased street-based SWs' access to STI and HIV testing services as they fear being reported by public providers to the police and penalized (i.e., fined or imprisoned). In Jakarta, sex workers have reported a preference for mobile clinics. In 2016, PEPFAR is working with UNAIDS on the Stigma and Discrimination Index in health care settings, which will help inform future PEPFAR-supported activities in this area.

Indonesia initiated test and start in 2014 in national HIV treatment guidelines through the SUFA Strategy in order to put all HIV-positives on treatment for those who come from KP, sero-discordant couples, pregnant women, ethnic Papuans, and TB/HIV and HIV/HBV co-infected patients. The initiative is aligned with WHO's Test and Start Guidance. Despite the existence of national guidelines and policies, common practice among physicians is to test, but delay starting PLHIV on treatment until the physician has assessed whether the patient will adhere to treatment. In COP16, PEPFAR will provide targeted mentoring at health facilities to strengthen consistent application of national test and start policies and guidelines.

PEPFAR began discussions with the MoH during COP15 to support community-based testing for key populations. This discussion continues, with an increased recognition that by reaching KP with HIV testing through CSOs, the national program will be able to have a greater impact on the epidemic. The MoH has allowed oral testing for MSM by CSOs, as included in the recently awarded GF grant, but is not endorsing it per se. Currently, the national policy does not allow for blood to be drawn by non-medical personnel. In many PEPFAR locations, there is a shortage of medical personnel to conduct whole blood tests. In COP16, PEPFAR will continue to support mobile clinics for KP to increase the level of KP tested at the community level and explore the possibility of rapid HIV-testing using fingerprick by non-medical personnel. PEPFAR will also provide TA to the GF CSO PR to roll out community-based oral testing (OraQuick) for MSM in GF sites.

The inconsistent supply chain for HIV testing commodities impacts the national program's ability to increase its testing numbers. [REDACTED].

Low coverage of key and priority populations with ART

Another key gap to achieving sustained epidemic control in Indonesia is the low coverage of key and priority populations with ART. In particular, key barriers in this area including the following: limited number of health facilities that initiate and refill ART and limited human resources to provide ART.

In Indonesia, only a limited number of health facilities are currently initiating ART as initiation of ART is still primarily provided at hospitals. KP have a difficult time accessing HIV services at these service delivery points due to stigma, discrimination, inflexible working hours, and long travel times. In Papua, ethnic Papuans living in the highlands and rural villages travel very long distances (often times by foot) to access health services. Similarly in Jakarta, traffic conditions can increase travel time to an additional 1-2 hours, forcing PLHIV to choose between regular work attendance and pharmacy refills. In COP16, PEPFAR will apply innovative cost-effective models in priority districts in Papua and Jakarta to reduce the number of visits for refills and bring ARV refills closer to patients. Models will include multi-month scripting and look to utilize religious, KP, commercial and/or PLHIV networks to bring ARVs closer to PLHIVs and reduce loss to follow-up over the next three years.

As a result of the Situation Analysis Report for Supply Chain Management conducted in 2014, the MoH pushed to decentralize the supply chain for ARVs from the central level to provinces and districts in order to further increase access to ART for KP/PP. Decentralization enables districts to easily resupply ARVs to lower-level service delivery points and will increase the total number of health facilities that can initiate and refill ARVs.

In COP15, PEPFAR supported the MoH to develop an ARV decentralization pilot, which prepares provinces, districts and health facilities for decentralized ARV drug management and delivery. The pilot has since been adopted and scaled up by the MoH to non-PEPFAR locations using GF resources. PEPFAR is currently supporting the MoH in the operationalization of multi-month scripting for KP in Jakarta and KP/PP in Papua. With COP16, PEPFAR will work to further strengthen supply chain management of ARVs and rapid diagnostic commodities at decentralized priority PEPFAR locations and build on the gains made during the pilot.

Limited viral suppression of key and priority populations

Another key gap to achieving sustained epidemic control in Indonesia is the limited viral suppression of key and priority populations. [REDACTED].

Currently, there are 16 viral load machines in Indonesia, limiting PLHIV access to VL testing. Most PLHIV do not live within a reasonable distance of the VL machines. The costs of the VL machines and tests are high. In addition, there is no national laboratory strategy for HIV.

The majority (50-80%) of ARVs procured by the National HIV Program are produced by local Indonesian manufacturers. These locally produced medicines are not WHO prequalified and only recently received Good Manufacturing Practices (GMP) re-certification, with PEPFAR support. [REDACTED]. PEPFAR will continue to strengthen the Post-Market Surveillance (PMS) program for ARVs and the National Drug Authority's ability to detect and recall poor quality medicines. PEPFAR will also strengthen the MoH and National Drug Authority's capacity to use data (price and drug quality) from PMS to improve decision making on procurement and product selection for ARVs.

Note: Section 6.1 Critical Systems Investments for Achieving Key Programmatic Gaps includes investments made in key policy areas, such as Test and Start and new and efficient service delivery models. As such, all activities are included in Section 6.1 and Section 6.2 was considered redundant.

Table 6.1.1 Key Programmatic Gap #1: Low coverage of key and priority populations with HIV testing services

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
High levels of stigma and discrimination for KP	1. Greater number of public and private health care providers providing KP-friendly services 2. Increased number of KP accessing HIV testing services	Activity 1: In collaboration with local governments, conduct needs assessment with higher performing public facilities and KP-friendly clinics to increase coverage for provision of continuum from prevention to care and treatment	HVOP	[REDACTED]	17600 (LINKAGES)	Service Delivery(6.30)
		Activity 2: Train health care providers on KP issues to ensure KP-friendly sites	HVOP HVCT	[REDACTED]	17600 (LINKAGES)	Human Resources for Health (7.58)
		Activity 3: Provide KP-friendly service hours to increase testing and treatment coverage for KP	HTXS	[REDACTED]	17600 (LINKAGES)	Service Delivery (6.30)
		Activity 4: Improved collaboration with community based organizations for testing referral of KP and PP	HVTC	[REDACTED]	17600 (LINKAGES)	CSO Engagement (7.00)
		Activity 5: Improve collaboration within the military for HIV policy anti-stigma and discrimination	18222 (DoD TBD)	[REDACTED]		
No community-based whole-blood testing	1. Lower unit cost of OraQuick 2. Increased support for CSOs/CBOs to conduct rapid HIV testing for KP 3. Improved collaboration with District Health Office for continued funding for mobile clinics to hard to reach sites.	Activity 1: TA to support mobile clinics to reach KP with increased HIV rapid testing services	HVTC HTXS	[REDACTED]	17600 (LINKAGES)	Service Delivery (6.3)
		Activity 2: TA to Principal Recipient to roll out OraQuick for MSM.	HVTC HTXS	[REDACTED]	17600 (LINKAGES)	Service Delivery (6.3)
		Activity 3: In collaboration with International Partners, continue providing advocacy to national governments on benefits of community testing.	HVOP HVCT	[REDACTED]	17600 (LINKAGES)	Service Delivery (6.3)
Uncoordinated and inconsistent supply chain for HIV testing commodities	1. Increased number of external quality assessments for rapid tests 2. Minimize stock-outs of reagents in priority locations	Activity 1: Develop national laboratory strategy for HIV, including testing and external quality assessments.	HLAB	[REDACTED]	(GHSCP)	Commodity Security and Supply Chain (4.1)
		Activity 2: Provide TA to local government to strengthen supply chain for testing commodities	OHSS	[REDACTED]	(GHSCP)	Commodity Security and Supply Chain (4.1)
TOTAL				[REDACTED]		

Table 6.1.2 Key Programmatic Gap #2: Low coverage of key and priority populations with ART						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Limited number of health facilities that initiate and refill ART	1. Increased number of health facilities providing ART 2. All priority district warehouses and health facilities properly store ARVs and report ARV stock.	Activity 1: Strengthen ART decentralization pilot, including ART delivery through alternative networks	OHSS	[REDACTED]	(GHSCP)	Commodity Security and Supply Chain (4.1)
		Activity 2: Providing clinical mentoring to the health facilities for multi-month scripting	HTXS	[REDACTED]	17600 (LINKAGES)	Service Delivery (6.3)
PLHIV travel long distances to initiate and access ART	1. Reduction in loss to follow up 2. National policy approved for multi-month scripting. 3. Innovative model adopted and rolled out to other districts.	Activity 1: Assist in developing national policy for multi-month scripting.	OHSS	[REDACTED]	(GHSCP)	Service Delivery (6.3)
		Activity 2: Assist the national government for implementation of multi-month scripting for priority districts	OHSS	[REDACTED]	(GHSCP)	Service Delivery (6.3)
		Activity 3: Assist the local government to implement multi month scripting	OHSS	[REDACTED]	(GHSCP) (LINKAGES)	Service Delivery (6.3)
		Activity 4: Advocate the national government, based on the implementation of multi month scripting in select site, to widely implement policy of multi-month scripting	OHSS	[REDACTED]	(GHSCP)	Service Delivery (6.3)
		Activity 5: Implementation of multi month scripting for the military and to be written in the TNI policy	18222 (DoD TBD)	[REDACTED]		
Limited human resources and limited capacity to provide ART	1. Physicians follow standardized procedure for determining when PLHIV go on treatment.	Activity 1: Pilot implementation of multi-month scripting in select sites.	OHSS	[REDACTED]	(GHSCP)	Service Delivery (6.3)

	2. Adequate human resources for providing ART.	Activity 2: Introduce innovative models to deliver ARVs that utilize existing community or commercial networks	HBHC/HTXS	[REDACTED]	(GHSCP)	Service Delivery (6.3)
		Activity 3: Increasing collaboration with community based organizations and community leaders for community ARV distribution	HBHC	[REDACTED]	17600 (LINKAGES)	Service Delivery (6.3)
		Activity 4: Advocating local government of HRH and commodity security and supply Chain for and continued budget for HIV/AIDS program	OHSS	[REDACTED]	(GHSCP) 17600 (LINKAGES)	Service Delivery (6.3) and Commodity Security and Supply Chain (4.1)
TOTAL				[REDACTED]		

Table 6.1.3 Key Programmatic Gap #3: Limited viral suppression of key and priority populations						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Constrained environment for viral load testing	1. Established national laboratory strategy for HIV, including viral load. 2. Increased number of viral load tests undertaken for key and priority populations.	Activity 1: Develop national laboratory strategy for HIV that includes viral load.	HLAB	[REDACTED]	(GHSCP)	Laboratory (6.3)
		Activity 2: Leverage GeneXpert machines for viral load testing.	HLAB	[REDACTED]	(GHSCP)	Laboratory (6.3)
		Activity 3: Work with CSOs to advocate for inclusion of viral load testing into Universal Health Coverage	OHSS/HVOP	[REDACTED]	17600 (LINKAGES)	Civil Society Engagement (7.00)
Poor quality of locally produced ARV medicine	1. MOH uses post-market surveillance (PMS) data for decision-making 2. Reduced time from medicine test result to product recall	Activity 1: Strengthen Post-Market Surveillance system for ARVs	OHSS	[REDACTED]	(PQM)	Quality Management (6.48)
		Activity 2: Strengthen communication and data share between the MoH and National Drug Authority	OHSS	[REDACTED]	(PQM)	Quality Management (6.48)

	3. Increased share of best-value ARVs procured by MoH	Activity 3: Advocacy for strengthened quality procurement requirements, including use of data for decision-making	HVSI/O HSS	[REDACTED]	(PQM)	Quality Management (6.48)
TOTAL				[REDACTED]		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Finance							
Health financing	Support inclusion of HIV services in universal health care	This activity will address all of the 90s and sustained epidemic control.	Targeted elements of the HIV program will be covered by universal health care.	[REDACTED]	OHSS	17854 (HFG)	Domestic Resource Mobilization (7.78)
Governance							
Governance	Accessing funding from national and local governments for HIV/AIDS program managed by CSOs	This activity will address financial sustainability	CSOs will be able to access and managed funding from national and local government budget	[REDACTED]	OHSS	17600 (Linkages)	Policies and Governance (6.58)
Inst & Org Development							
CSO Development	Developing organizational, institutional, and advocacy capacity for CSOs especially in the area of strategic planning, evidence based programming	This activity will address the sustained epidemic control.	CSOs' capacities in maintaining partnership with national and local government, health facilities will be improved to access quality and friendly services.	[REDACTED]	OHSS/ HBHC	17600 (Linkages)	Civil Society Engagement (7)
CSO Development	Developing community engagement	This activity will address sustained epidemic control	Community based organizations will be able ensuring the quality and	[REDACTED]	HVOP HBHC	17600 (Linkages)	Civil Society Engagement (7)

			friendliness of services provided by public and KP friendly clinics.				
Strategic Information							
Monitoring and evaluation	Secondment of a senior M&E technical expert to the MoH to address clinical data quality issues and to streamline the national HIV data management system (SIHA).	Addresses the 1 st and 2 nd 90 in that accurate, complete, and timely clinical data, including the number of individuals newly diagnosed with HIV and individuals on and retained on ART, are needed to adequately assess national achievements/progress towards 90-90.	1) Improved HIV program data quality reported to MoH from facilities providing HTC services and ART. 2) Improved capacity of national MoH staff in identifying and addressing HIV program data quality issues at the national and sub-national levels. 3) Increased number of facilities with accurate and timely reporting of HIV data through the national reporting system (SIHA)	[REDACTED]	HVSI	BANTU	Performance Data (8.43)
Surveys and Surveillance	Secondment of a senior surveillance expert/epidemiologist to the MoH to improve the HIV surveillance system in country	Addresses the 1 st and 2 nd 90 and addresses 4) epidemic control, by gaining a better understanding of the total estimated prevalence and estimates of KP PLHIV through sentinel surveillance and integrated biobehavioral surveys for KP. This would in term help Indonesia to know the coverage gap for the 1 st , and 2 nd 90, and how the country is performing in terms of epidemic control	1) Improved accuracy in population size estimates and prevalence estimates for FSW, MSM/TG, and PWID. 2) Improved capacity of MoH staff in conducting IBBS (including survey design, implementation, and analysis). 3) Improved analysis of diagnosis and treatment gaps for KP PLHIV.	[REDACTED]	HVSI	BANTU	Epidemiological and Health Data (6.90)
	Assisting MoD in conducting military seroprevalence study	Addressing the 1 st 90 by gaining a better understanding of the total estimated	1) Improved accuracy in population size estimates and prevalence for the military	[REDACTED]			

		prevalence and PLHIV estimates through surveillance and integrated biobehavioral survey for the military. This would in turn help TNI know the coverage gap for the 1 st and 2 nd 90 and how the country is performing in terms of epidemic control.	2)Improved capacity of MoD staff in conducting IBBS (including survey design, implementation and analysis)				
Systems Development							
TOTAL				[REDACTED]			

7.0 Staffing Plan

[REDACTED]

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<p>Support public facilities and KP friendly clinics for learning sites for delivery of the Continuum of Prevention, Care and Treatment Interventions for key populations: HTC, Care and Treatment in sustained districts.</p> <p>Technical assistance mechanism driven through learning site clinics to strengthen the quality of clinical care and treatment across MoH/GF clinics in sustained districts</p> <p>Increasing treatment coverage and retention of key populations in saturated districts with community services; delivering innovative outreach referrals, multi months scripting, intensifying collaboration with community based organizations and community leaders to improve care and retention.</p> <p>Strengthen KP/PLHIV/CSO/Network capacity to advocate with local authorities and providers for budget allocations and friendly services, and quality service provision for key and priority populations</p> <p>Support CSOs to provide advocacy to local and national government on supply chain management of STI and HIV commodities</p>	Priority Populations (STI and TB patients, sero discordant couples and clients of sex workers)	
Local Government level	<p>Technical assistance at district health office to strengthen (1) supervision and monitoring of Prevention, Care and Treatment services and (2) reliable condom and HIV drug supply</p> <p>Introduce routine program monitoring system with individual tracking to manage service delivery in outreach and facilities with real time data at site levels.</p> <p>Technical assistance at district levels hospitals to provide clinical mentoring to higher performing public facilities and KP friendly clinics for providing reliable and friendly one shop center for HIV testing, care and treatment to key and priority populations.</p> <p>Organizational and management support to district government for evidence-based programming and allocating financial resources and human resources for sustainable epidemic control.</p> <p>Support to civil society groups to advocate for human rights and civil society engagement issues as part of the HIV response including addressing stigma and discrimination, improving local policies/regulations to improve quality service provision</p> <p>Strengthen systems for the decentralization of ARV services (Quality Management, HRH and Performance Data)</p>		
National level	Strategic Information including site level program data M&E, surveillance and size estimation, operations research (Epidemiological and Health Data; Performance Data)		

Conduct assessment of stigma and discrimination Jakarta and Papua to create recommendation for quality service of continuum of Prevention, Care and Treatment for key and priority populations. (Service Delivery, Commodity Security and Supply Chain, Laboratory , Quality Management)

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

	Core Activities	Near-core Activities	Non-core Activities
HTC	<ul style="list-style-type: none"> Support increase uptake of HTC and HTC yield amongst key populations in select higher performing public facilities and KP friendly clinics Train outreach workers on innovative outreach models. 	<ul style="list-style-type: none"> Support the national level government for size estimation for key populations. 	
Care and Treatment	<ul style="list-style-type: none"> Technical assistance to increase new ART patients already registered in care Support operationalization of ART retention indicator in select districts Pilot interventions to measure and increase yield of HIV prevention, diagnosis, care and treatment cascade amongst key populations 	<ul style="list-style-type: none"> Targeted laboratory quality improvement focused on priority districts and municipalities 	
Prevention	<ul style="list-style-type: none"> Support Ministry of Health to develop an M&E System to capture- reach-test-treat-retain cascade for KP 		
TB/HIV	<ul style="list-style-type: none"> Provide technical assistance and conduct pilot to test innovative strategies on intensified case finding in key population program and ART centers Provide technical assistance to increase co-located HIV/TB testing facilities in designated microscopy centers 		
Cross-cutting			
Laboratory	<ul style="list-style-type: none"> Provide technical assistance to MoH to develop national laboratory strategy 	<ul style="list-style-type: none"> Provide laboratory capacity to support clinical monitoring at each stage of the continuum 	
Strategic Information	<ul style="list-style-type: none"> KP surveillance and programmatic data collection, analysis and use Creation/re-operationalization of retention indicator and system for collection Creation of VL monitoring indicator and system for collection 		
Health System Strengthening	<ul style="list-style-type: none"> Provide technical assistance to the ARV drug supply chain system especially for forecasting for ARV to ensure the implementation of multi month scripting Provide technical assistance to the MoH on supply Chain Management for other commodities Strengthen the provision of HIV services to be included in Universal Health Coverage 		

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$ 590,353	\$9,409,647	\$10,000,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	\$1,902,421
IDUP	Injecting and Non-Injecting Drug Use	\$91,123
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	\$633,591
HBHC	Adult Care and Support	\$404,341
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	\$2,158,311
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	\$202,170
HLAB	Lab	\$200,000
HVSI	Strategic Information	\$1,760,000
OHSS	Health Systems Strengthening	\$1,304,119
HVMS	Management and Operations	\$1,343,924
TOTAL		\$10,000,000

B.2 Resource Projections

PEPFAR utilized a combination of target-based budgeting and lump sum budgeting to develop the COP 16 budget. The planning process evaluated UEs with targets, as well as program and country specific information to develop an optimized budget. Adjusted UEs derived from EA FY14 were used to build the target based portion of the HVOP, IDUP, HTXS, and HVCT budget codes as displayed in the PBAC. Lump sum budgeting was used for above-site activities based on methods used to develop IGCEs. M&O was developed in tandem with the USG Financial Management Office in Indonesia. The total budget allocation = target-based budgeting (Site-level) + lump sum (largely above-site) + M&O.

APPENDIX C

List of PEPFAR-Supported Clinical Facilities

[REDACTED]