

STRATEGIC TECHNICAL ALIGNMENT FOR RESULTS (STAR) PROCESS

Indonesia

Country Operational Plan (COP) 2017

Strategic Direction Summary

February 16, 2017

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1.0 Goal Statement

In partnership with the Government of Indonesia (GoI), civil society organizations (CSOs), multilateral agencies and other donors, PEPFAR Indonesia's focus in COP 17/18 will be to expand support for improved access to and quality of services across the cascade for targeted populations in PEPFAR priority areas of Jakarta and Papua. This includes support to improve data collection, quality, and use to demonstrate achievement of 90-90-90 among targeted populations, in addition to efforts to reduce stigma and discrimination (S&D) and violence against vulnerable populations [REDACTED]. As a result of these efforts, PEPFAR Indonesia anticipates achieving results contributing to epidemic control in Jakarta and Jayawijaya over the next two years.

Improving access to the continuum of prevention, treatment, and care is critical to achieving control of the epidemic, as fewer than 200,000 people in Indonesia are aware of their HIV status, with only 63,000 people on ART.¹ Data indicates there is a major challenge in identifying people who are HIV positive, enrolling them into care, and retaining them on treatment. The number of patients on ART who achieve long-term successful outcomes, as measured by viral load suppression, is limited.

PEPFAR Indonesia's accelerated efforts to reach targeted populations have made a substantial contribution to the national HIV response, resulting in 53,244 key and targeted populations being tested for HIV and 5,132 PLHIV diagnosed. While these efforts will continue, there will also be a shift to ensure that those reached and diagnosed are enrolled in treatment and retained on ART. This requires moving from a focus on availability of and access to services to an increased emphasis on the quality and uptake of those services.

In FY18, PEPFAR Indonesia will accomplish a set of specific objectives designed to contribute to overall achievement of program goals. In particular, PEPFAR Indonesia will have assisted the Ministry of Health (MoH) and CSOs in establishing a tracked referral system to link prevention and outreach efforts to testing systems, thereby ensuring testing rates and yields meet targets for the Provincial Health Office (PHO) in Jakarta. In Papua, PEPFAR Indonesia will focus on improving data quality, reporting, analysis and utilization to support the national and local governments' need for high quality data for programming and monitoring. Overall, the MoH and CSOs will have improved quality data collection and will have used the data to make informed program and advocacy decisions that increase the number of PLHIV who know their status and are entered and retained in HIV treatment and care. Last, a plan to reduce stigma, discrimination, and violence against vulnerable populations [REDACTED] will be in place, with baseline measures documented and alliances established with vulnerable populations [REDACTED] networks and CSOs, and human rights and advocacy organizations CSOs.

PEPFAR Indonesia routinely assesses and manages partner performance through data reviews, partner meetings, and SIMS visits. Given modest resources, PEPFAR Indonesia implements high-performing

¹ WHO, MOH, HIV Epidemiologic Review, Indonesia, 2016

activities that complement and supplement Global Fund (GF) and GoI resources to maximize efficiencies in supporting the national HIV program.

PEPFAR Indonesia has a long history of partnering with civil society to achieve program results. In particular, PEPFAR Indonesia leverages CSOs' ability to reach key populations (KP) and provide support and care to PLHIV. In FY18, CSOs and health facilities will be better linked, working collaboratively, to reach and retain targeted populations in the continuum of prevention, treatment, and care.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country 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, and Yogyakarta), which are subdivided into 502 lower administrative districts (416 regencies and 98 municipalities). Local governments and municipalities became the key administrative units responsible for the provision and budgeting of public services when the GoI began decentralization in 2001. Around 60% of the population is concentrated on the island of Java and it has the highest concentration of HIV cases in the country.

Indonesia has a GNI per capita of USD 3,440 (2015), is classified as a lower-middle income country by the World Bank, has an economic growth of over 5%, and has increased its investment in health from 3.7% to 5% of the national budget. However, the country continues to struggle with fragile institutions, inadequate infrastructure, endemic corruption, terrorism, rising religious and ethnic intolerance, and the complex rollout of a national single-payer universal healthcare scheme (JKN). Indonesia is also faced with rising income inequality as 20% of the richest Indonesians hold 80% of the wealth and two-thirds of the population lives on less than USD 3 per day.

The national HIV prevalence rate among adults aged 15 years and above is estimated at 0.33% (613,435 PLHIV).² With the exception of Papua and West Papua provinces, which have a low-level generalized epidemic (estimated HIV prevalence of 2.3%)³, Indonesia continues to experience a concentrated HIV epidemic. Comprehensive HIV knowledge among young people ages 15-24 years is alarmingly low at only 10% for young males and 11% for young females.⁴ Available data from the 2015 IBBS demonstrate an estimated prevalence rate among direct female sex workers (DFSW) of 8.0%; 2.2% among indirect FSW (IDFSW)⁵; 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).⁶

² HIV Epidemiologic Review, Indonesia 2016, Drafted: January 15, 2017

³ 2013 Tanah Papua IBBS for general population (MoH)

⁴ Evidence to Action: HIV and AIDS Data Hub for Asia-Pacific, September 2016, www.aidsdatahub.org

⁵ Direct FSW refers to venue-based SWs and indirect refers to street-based SWs.

⁶ HIV Epidemiologic Review, Indonesia 2016

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.⁷

HIV disease burden among PWID has been on the decline nationally, while there has been a significant increase of HIV among MSM in recent years.

Nationally, the 2015 IBBS among MSM demonstrated a significant increase in HIV prevalence, from 8.5% in 2011 to 25.8% in 2015. 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

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
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

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

High HIV prevalence among FSW is one of the major factors in the spread of HIV in Indonesia. There are significant variations in HIV prevalence among cities and districts, with prevalence of HIV among DFSW ranging from 2.5 to 17.5%. IBBS data demonstrates that HIV prevalence among DFSW in Jayawijaya (Papuan highlands) is as high as 25%, while Jakarta's estimated DFSW HIV prevalence was found to be 10.5%. 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 1.1b).

⁷ 2015 AEM estimates (MoH)

⁸ 2015 GFATM Concept Note

⁹ 2015 iBBS Presentation, MoH, February 2016.

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	Est. Population Size 2016 (revision)**
PWID	52%	41.2%	39.5%	28.8%	105,784	77,286	33,492
DFSW	10%	10.4%	7.2%	8.0%	106,011	129,973	226,791
IFSW	5%	2.9%	1.6%	2.2%	108,043	109,036	
MSM	5.2%	8.5%	12.8%	25.8%	695,026	1,139,606	754,310
Waria	24%	21.9%	7.4%	24.8%	32,065	39,512	38,928

*2013 iBBS data were sampled in different sites from 2007, 2011, and 2015 iBBS

**Revised 2016 PSE based on multivariate regression model extrapolation of 2015 PSE

IBBS 2012 data indicated that HIV prevalence within the Indonesian National Armed Forces (TNI) is 0.4%, with prevalence in Jakarta of 0.6% and in the Riau Islands of 1.0%. Self-reported condom use rates were approximately 34%; HIV knowledge is 8.8% and STI rates were approximately 9%. As such, the military continues to expand its testing and counseling activities throughout its large medical system distributed across the country [REDACTED].

Since 2014, the GoI has implemented “test and start” through its “Strategic Use of ARVs” (SUFA) initiative which provides immediate treatment for key populations, TB patients, and pregnant women in over 100 districts, including PEPFAR-supported districts, but the implementation and uptake of this policy has been slower than anticipated. PEPFAR Indonesia will work closely with the GoI to revise and align SUFA with WHO’s 2015 recommendation that anyone infected with HIV should begin ARV treatment immediately after diagnosis. WHO’s “treat-all” recommendation removes all limitations on eligibility for ART among people living with HIV; all populations and age groups are now eligible for treatment, regardless of CD4 count.

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 programs, with 60% of them engaging in safe behavior, and for 70% of funding for the targeted response coming from domestic sources.”

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

¹⁰ 2015 GFATM Concept Note

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

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, third highest in the region.¹³ In addition, the TB rate of infection in Indonesia is the 2nd highest in the world with 660/ 100,000 population. Additionally, eleven percent of tuberculosis cases are HIV positive.

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 and GoI's pledge for Jakarta to be included in the UNAIDS Fast Track response.¹⁴ The number of PLHIV currently on ART increased dramatically from 2,381 in 2005, to 24,410 in 2011, to 73,073 at the end of 2016¹⁵. However, despite the government's continued effort, the overall ART coverage rate in Indonesia remains low and viral load testing is still currently not widely available in country.

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

¹³ 2014 UNAIDS GAP Report

¹⁴ 2015 UNAIDS Fast Track Cities Update

http://www.unaids.org/sites/default/files/media_asset/JC2815_2015_Dec_update_Fast-track_cities_en.pdf

¹⁵ 2016 MoH Quarter 4 HIV Program Report

Table 2.1.1 Host Country Government Results

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	255,461,700	100	32,829,213	49.4%	34,101,752	50.6%	95,002,352	50.4%	93,528,383	49.6%	Indonesia Bureau of statistics, 2010 census (2015 projection)
		0.33%		N/A		N/A		N/A		N/A	MoH Epi review 2016, for aged 15 and above
AIDS Deaths	36,936										MoH EPI review, Estimates & Projections of HIV/AIDS 2015-2020
# PLHIV	613,435										MoH EPI review, Estimates & Projections of HIV/AIDS 2015-2020
Incidence Rate (Yr)		0.03%									MoH EPI review, Estimates & Projections of HIV/AIDS 2015-2020
New Infections (Yr)	49,199										MoH EPI review, Estimates & Projections of HIV/AIDS 2015-2020
% of Pregnant Women with at least one ANC visit	5,110,367	96.6%	N/A	N/A				96.6%			DHS 2012
Pregnant women needing ARVs	17,987										MoH Program Data
Notified TB cases (Yr)	330,729		N/A		N/A		N/A			N/A	MOH EPI review/ Global WHO TB Report 2016
% of TB cases that are HIV infected		11%									MOH EPI review/ Global WHO TB Report 2016
Estimated Population Size of MSM*	754,310										MoH Epi review, Size estimation of KAP, MOH 2016
MSM HIV Prevalence		25.8%									MoH Epi review, estimates and projection of HIV/AIDS 2015 -2020
Estimated Population Size of FSW	226,791										MoH Epi review, Size estimation of KAP, MOH 2016
FSW HIV Prevalence (high risk)		8.0%					N/A	N/A			MoH Epi review, estimates and projection of HIV/AIDS 2015 -2020
FSW HIV Prevalence (lower risk)		2.2%					N/A	N/A			MoH Epi review, estimates and projection

											of HIV/AIDS 2015 -2020
Estimated Population Size of Transgender	38,928						N/A	N/A			MoH Epi review, Size estimation of KAP, MOH 2016
Transgender HIV Prevalence		24.8%					N/A	N/A			MoH Epi review, estimates and projection of HIV/AIDS 2015 -2020
Estimated Population Size of PWID	33,492										MoH Epi review, Size estimation of KAP, MOH 2016
PWID HIV Prevalence		28.8%									MoH Epi review, estimates and projection of HIV/AIDS 2015 -2020
Estimated Size of Targeted Populations (military)	434,410	0.40%									2012 IBBS among Indonesia military
<i>*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.</i>											

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*

Epidemiologic Data					HIV Treatment and Viral Suppression (2016 Q1- Q3)			HIV Testing and Linkage to ART (2016 Q1- Q3)		
	Total Population Size Estimate (#)	HIV Prevalence (%)*	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART** (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV** (#)	Diagnosed HIV Positive** (#)	Initiated on ART + (#)
Total population	255,461,700	0,33%	613,435		73,037	12%	N/A	1,894,104	52,956	9,971
Population less than 15 years	66,930,965	0.06%			5,559				1,698	
15-24 year olds									10,713	
25+ year olds									40,545	
15 and above	188,530,735									
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source:

* MoH EPI review 2016, KAP PSE and Projection of HIV/AIDS 2015 - 2020

** MoH 2016, Quarter 1, Quarter 2, and Quarter 3

+ Calculated based on 2016/Q3 TX_CURR minus 2015/Q4 TX_CURR)

[REDACTED]

2.2 Investment Profile

Indonesia's most recent NASA shows expenditures from domestic (57%) and external (43%) sources, totaling USD 107 million in 2014. However, the national budget for ARVs has grown from around USD 18 million in 2014 covering 49,606 PLHIV, to USD 63 million in 2016 for a targeted 90,000 patients, and to USD 91 million in 2017 for a targeted 138,000 patients.¹⁶ These recent governmental budget increases have greatly increased the share of domestic expenditures for the national HIV response.

International donors, most significantly the Global Fund (GF), PEPFAR, and Australia's Department of Foreign Affairs and Trade (DFAT), contributed greatly to the national response in 2014. However, DFAT's departure from HIV programming in mid-2016 has had the greatest impact on the HIV response in Papua, which was heavily supported by DFAT in the past. PEPFAR support to Papua is focused on ensuring that gains made under DFAT funding will continue through a more sustainable approach.

In late 2015 the GF approved an HIV grant of USD 97 million for 2016 and 2017 implementation years. Despite this envelope, Indonesia's PRs have historically been unable to spend close to their total annual budget. In COP 17, PEPFAR will work with the MoH, GF CCM, and PRs to both strengthen and optimize existing program resources and spending. In addition, PEPFAR is working with key partners to inform development of the new USD 92 million HIV and the related USD 102.4 million TB, three-year GF grants and their implementation starting in January 2018.

The majority of international resources focus heavily on strengthening prevention activities and the quality of care across the cascade, specifically for KP and other priority populations. In 2013, 86% of prevention activities for KP were funded by international sources.¹⁷ More than 35% of the total budget under the current GF HIV grant is allocated for prevention programs targeting KP.

In COP 17, PEPFAR funding will continue to reach and strengthen services for targeted populations in Jakarta and Papua, as well as strengthen GF PR, central government, and district-level investments. PEPFAR will provide technical assistance to strengthen universal healthcare coverage (JKN) and to improve the quality and ease of receiving HIV services through this national health insurance mechanism. TB/HIV services will be supported through USAID's bilateral TB program.

¹⁶ Progress 2011-2016, Subdit HIV Indonesia

¹⁷ NASA, 2013 data

Table 2.2.1 Investment Profile by Program Area¹⁸

Program Area	Total Expenditure (USD)	% PEPFAR (COP 13) (a)	% GF (b)	% GoI (c)	% Other (c)
Clinical care, treatment and support	\$37,605,594	1%	8%	82%	9%
Community-based care, treatment, and support	\$2,059,261	24%	76%	0%	0%
PMTCT	\$492,111	68%	0%	8%	24%
HTS	\$908,001	48%	26%	26%	0%
Targeted population prevention (incl. PLHIV, vulnerable and accessible pop, youth)	\$12,831,660	5%	58%	28%	8%
Key population prevention [REDACTED]	\$5,752,870	36%	35%	9%	21%
OVC	\$12,642	0%	0%	100%	0%
Laboratory	\$3,034,105	8%	0%	92%	0%
SI, Surveys, and Surveillance	\$4,823,031	53%	16%	13%	18%
HSS (d)	\$6,420,333	5%	95%	0%	0%
Other	\$32,854,989	6%	23%	67%	3%
Totals (e)	\$106,794,597	9%	27%	57%	7%

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.

¹⁸ "Program Area" labels are those used by PEPFAR. 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). This also illustratively captures PEPFAR and Host Country management expenditures. All figures in the table above are thus rough estimates for calendar year 2013 expenditure, and should be considered illustrative only.

Table 2.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure 2016(c)	% PEPFAR	% GF(a)	% GoI(b)	% Other
ARVs ART	\$66,047,194	0%	3%	97%	0%
Rapid test kits	\$9,369,318	0%	0%	100%	0%
Other drugs	\$7,031,133	0%	0%	100%	0%
Lab reagents	\$5,296,779	0%	0%	100%	0%
Condoms	\$1,795,477	0%	100%	0%	1%
Viral Load commodities	\$3,622,665	0%	0.5%	99.4%	0%
MAT	\$0	0%	0%	0%	0%
Other commodities	\$130,769	0%	0%	100%	0%
Total	\$93,263,336	0%	4%	96%	0%

a. GF figures take from procurement orders for 2016 for ARVs and VL syringes and other GF not included.

b. GoI figure taken from APBN, this does not include subnational level procurement.

c. Figures mix budget with procurement orders. This should only be considered a rough estimate.

Table 2.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$20,000,000	\$3,140,000	2	\$1,670,000	Expand availability of and access to quality health services covered by the national health insurance scheme (JKN).
USAID TB	\$11,000,000	\$3,350,000	4	\$3,420,000	Expand availability of and access to quality health services covered by the national health insurance scheme (JKN); Strengthen commodity supply chain, availability and utilization of quality assured HIV and TB drugs, and improve access to lab services (VL and GeneXpert); Strengthen integration of TB/HIV services to improve diagnostics and treatment for both diseases in HIV and TB health facilities.
Total	\$31,000,000	\$6,490,000	4	\$5,090,000	

Note: The USAID TB row includes two mechanisms that are also included in the USAID MCH row, as both receive multiple streams of funding. As such the PEPFAR contribution to those mechanisms is double counted in the PEPFAR COP Co-Funding Contribution column total.

2.3 National Sustainability Update

As PEPFAR Indonesia is not required to complete a Sustainable Index Dashboard for COP17/18, the team engaged closely with national and local government partners to gather input on the components below that are deemed important in the management of the HIV program.

- **Human Resources for Health:** HRH scored high in COP16, however the systems and procedures do not always function optimally, as staff distribution and allocation are not based on program needs. In COP17/18, PEPFAR Indonesia will provide technical assistance to the MoH to develop comprehensive mapping of human resource for health gaps and provide technical assistance to local governments to implement an HRH strategy to overcome barriers to delivery of HIV services for targeted populations.
- **Performance Data:** Performance data also had a high score in COP16. However, data collection is largely for reporting and not for programming purposes; aggregated data submitted to the national government is not being used consistently to improve service provision or quality. PEPFAR Indonesia will intensify work with national and local governments to improve the quality and use of programmatic data.
- **Commodity Security and Supply Chain:** This area received a low score largely due to a lack of a comprehensive National Supply Chain Strategy and human resources with sufficient technical capacity to ensure the system functions at a high level. Additionally, the high price of ARVs (\$740 per patient) and other essential HIV commodities places a high cost on the national program. In addition, the decentralization of most administrative, planning and management functions in the supply chain presents an enormous challenge in ensuring adherence to national guidelines and SOPs.

2.4 Alignment of PEPFAR investments geographically to disease burden

In COP16, PEPFAR Indonesia pivoted to working in only 8 districts in 2 provinces: Papua and Jakarta. Papua has the highest HIV prevalence in the country at 2.3% (with estimated PLHIV of 88,041), while Jakarta has the highest total number of PLHIV (105,182) and a high concentration of KP.¹⁹ In COP17, PEPFAR Indonesia plans to continue working in the same 5 districts in Jakarta to achieve epidemic control.

In Papua, the HIV epidemic among native Papuans appears to be centered in the highland areas (e.g., Jayawijaya and surrounding districts) compared to lowland Papuan groups (e.g., Mimika and Jayapura), according to HIV testing yield data from selected VCT clinics. In COP17, PEPFAR Indonesia will transition out of direct service delivery in Papua and instead, refocus on above-site level activities. These above-site activities will assist in HIV commodities forecasting and VL roll out at the provincial level in Jayapura, which is responsible for ART distribution and VL implementation in the highlands, and improve the quality and use of HIV program data at the provincial level, including the provision of

¹⁹ 2014 MoH AEM projections

feedback to district health offices. In Papua, PEPFAR Indonesia will continue to support the local government on data quality and use for programming. Additionally, PEPFAR Indonesia will work with the government to bring ART services closer to highland communities through alternative ART dispensing and multi-month scripting. Clinical data suggest high rates of attrition among those on ART in the highlands, as most patients travel to the lowland areas (Mimika and Jayapura) to receive ART due to a lack of quality HIV treatment and care services in the highlands. In addition, above-site activities will focus on improving the quality and use of HIV program data in highland districts, including timely and complete reporting of clinical cascade data at HIV facilities to better document the extent of the HIV epidemic in these difficult-to-reach communities.

2.5 Stakeholder Engagement

Host country government. To achieve control of the HIV epidemic, it is critical that PEPFAR provides support to national and local governments in Jakarta and Papua and other local institutions sharing the responsibility for building a sustainable national response. This year, the USG consulted with the head of the National AIDS Program (NAP) at the MOH, the Secretary of the NAC, the Indonesian military's Surgeon General's Office (SG), 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 discussions also covered how USG activities would coordinate with current and proposed activities under the GF Concept Note, as the MOH and NAC are two of the Principal Recipients. In addition to that, PEPFAR Indonesia also continued to work closely with Spiritia, a national CSO that is a GF PR.

Global Fund and other external donors. Since Australian support to Indonesia's health sector ended in June 2016, there are now only two key external donors to the national HIV response in Indonesia, namely the GF and PEPFAR. The USG is intricately involved with the GF, holding a seat on the CCM, and participating on the CCM's Oversight Committee. In addition, USG representatives also participate as members of the CCM's Technical Working Groups (TWGs, one for each GF disease area and HSS). PEPFAR Indonesia is currently heavily engaged in consultations with the CCM and TWGs to ensure that activities proposed in COP17/18 are complementary to the GF funding request, due in May 2017.

Civil Society. PEPFAR Indonesia has been engaged in ongoing discussions and collaboration with CSOs, most recently focused on recommendations from the national HIV review combined with the findings of the Epidemiological Review, to set appropriate targets and improve program achievements. In the COP17 development process, PEPFAR Indonesia held two consultation meetings with CSOs, in addition to attending regular meetings with local CSOs led by implementing partners, and CSO meetings led by the Indonesia AIDS Coalition, an advocacy CSO for PLHIV and HIV programs. The first meeting, held in January 2016, was attended by CSOs managing PEPFAR funding, CSOs managing GF funding, and CSOs managing AIDSCare Health Foundation funding. The second meeting, in February 2017, was conducted in partnership with the GF and attended by service delivery, advocacy, and human rights CSOs [REDACTED].

Highlights from the discussion include the following:

- The need for innovation to reach prevention targets, especially because of the current restrictive environment. This includes a critical need to extend quality health services to include SW and PWID
- How to continue to increase clinical and programmatic capacities of local governments and higher-performing public and private clinics, and to increase efficiency through task sharing and specialization
- The need for multi-month scripting to increase treatment retention, along with the implications for supply chain management and CSO involvement in supporting monthly drug distribution and transportation
- Community-based HIV screening and mobile clinic testing from health centers to communities to improve testing coverage and reach a new pool of KP
- The role of all partners in implementing SUFA (test and start) for PLHIV, especially treatment readiness and adherence
- Opportunities for human rights and HIV CSOs and networks to work together to address stigma and challenge discrimination using legal recourse
- Critical need to improve TB/HIV collaboration including the availability of HIV testing at TB clinics

Participants also discussed challenges resulting from the substantial decentralization to provincial and district governments, whose capacity is frequently low and among whom coordination is often chaotic or weak. This has resulted in a plethora of laws and policies that inhibit the work of CSOs. The ongoing CSO strengthening has resulted in leaders from this sector now bringing examples to the attention of program decision makers, and a willingness to challenge the laws to secure a more enabling environment. This is a significant step forward and allows PEPFAR Indonesia to plan with CSO partners at a higher level.

PEPFAR Indonesia has used this feedback in its planning process and is committed to regularly consulting with this group. PEPFAR Indonesia will meet after the COP submission to determine how best to address CSO concerns and recommendations.

Private Sector. Historically, the private sector has not participated in the National HIV Response in Indonesia in a major way. However, two Key Population friendly clinics in Jakarta, [REDACTED], provide quality HIV services for PEPFAR targeted populations. In FY18 and FY19, PEPFAR Indonesia will continue to engage these private clinics and will 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.

3.0 Program Activities for Epidemic Control

3.1 Description of strategic outcomes

The strategic outcomes are based upon the priorities identified in the Indonesia NSP 2015-2019.

Under Strategic Outcome 1, PEPFAR Indonesia is to support the Government of Indonesia, communities and implementing partners to improve access to and quality of services across the cascade for targeted populations in PEPFAR priority areas in collaboration with key local, national and international partners towards sustainable services for targeted populations.

The national response has been directed primarily through the GF and GoI for program implementation. However, available resources from GF, GoI and other donors will not be sufficient to support full implementation of the NSP, including the Jakarta Fast Track initiative. The focus of PEPFAR Indonesia in COP 17/18 is to continue to support existing KP friendly clinics that provide quality HIV services to targeted populations, but also to identify and develop plans to expand quality HIV services for targeted populations in the public sector in order to increase ART coverage and services. PEPFAR Indonesia will address identified programmatic testing gaps and use this opportunity to pilot innovative testing models designed for national impact in the provinces of Jakarta and Papua. PEPFAR Indonesia will contribute site level results to the national program. However, sub-analyses of clinical cascade data from PEPFAR Indonesia-supported public facilities vs. non-PEPFAR Indonesia supported public facilities in Papua and Jakarta will be conducted to compare progress made in PEPFAR Indonesia supported sites.

For Strategic Outcome 2, PEPFAR Indonesia is to support the Government of Indonesia, communities and implementing partners to improve data collection, quality and usage to reach 90-90-90 among targeted populations, and to reduce stigma, discrimination and violence against vulnerable populations [REDACTED].

The GoI has set up a data collection system and collects HIV service delivery data; Information System for HIV/AIDS (SIHA). However, data collection is largely for reporting and not for programming purpose; aggregated data submitted to the national government is not being used to improve service provision or quality. There is no system in place to ensure quality and consistency of collected data, even though data validation (especially for the GF-supported program) takes place regularly. PEPFAR Indonesia, in close collaboration with international development partners (WHO and UNAIDS) will use the cascade data to monitor the achievements of both PEPFAR Indonesia- and non-PEPFAR Indonesia-supported clinical sites in the national response toward the 90-90-90 goal. PEPFAR Indonesia will review the GoI's program data critically and discuss with national and international partners to ensure data are consistent and complete.

In health facilities, people associated with HIV are often subject to negative attitudes and discriminatory actions at the hands of healthcare providers. Stigma and discrimination (S&D) in health facilities discourages many from accessing services, disclosing information to providers, and adhering to appropriate medical advice and treatment. To address this, PEPFAR Indonesia will expand its health care provider KP stigma and discrimination reduction capacity building initiative to increase testing uptake and improve treatment adherence for targeted populations.

Site-level activities primarily focus on direct service delivery (DSD) and Technical Assistance Service Delivery Improvement (TA-SDI) core and near-core interventions that demonstrate increased targeted population reach, HIV testing, yield/enrollment, ART initiation, treatment retention, and viral suppression in decentralized service settings across the continuum of HIV prevention, care and treatment (CoPCT). PEPFAR Indonesia assistance is used strategically to fill in critical gaps within the National program and/or to amplify results that move the country towards 90-90-90 goals.

Site-level activities will introduce innovations into the national response – whether they are enhanced outreach and differentiated care approaches, community-based HIV screening, self-testing, SUFA/test and start, multi-month scripting, and systematic viral load testing. Site-level activities further focus on engaging targeted populations to take control of their health and well-being; inspiring influencers like religious leaders and community health workers to integrate HIV prevention and care into their practices, and supporting facility-based health care providers to provide sensitive and accessible HIV services for targeted populations.

Over the course of COP17/18, PEPFAR Indonesia resources will focus on a variety of above-site activities at the national level and in Jakarta and Papua outlined in the FOIT and central funding mechanisms, such as the Jakarta Game Changer. These include:

- Analytical and Advocacy support for the inclusion of comprehensive HIV care into the Universal Health Coverage Program (JKN)
- Support pricing studies for HIV Commodities (including ARVs) to find efficiency and reduce the cost to the National HIV Program
- Support the MoH and provincial and district levels to strengthen forecasting, supply planning, and stock monitoring for ARVs and Rapid Diagnostics
- Finalization of National HIV-Lab Strategy (policy & framework) and establishment and implementation of lab and logistics network, quality assurance, referral, reporting systems
- Support the local government to strengthen high yield testing for targeted populations through mobile testing, community-based screening and routine testing at health facilities
- Operationalize test and start interventions in targeted puskesmas and hospitals in Papua highlands sub-districts
- Support the local government in Papua to retain PLHIV on ART through case management, multi-month scripting, and/or alternative ART distribution model(s)
- Introducing, testing, comparing, rolling out and scaling up evidence-based CoPCT models and innovative approaches to amplify programmatic impact, increase efficiency, promote sustainability, and enhance stakeholder involvement.
- Actualizing implementation of the Jakarta Fast Track Roadmap, and introducing a similar initiative, development of Provincial HIV Strategy in Papua.
- Strengthening the implementation of site-level innovations and data use through the placement of time-bound personnel at site, district, provincial and national levels.
- Enhancing CSO organizational capacity and advocacy efforts.

- Improving the quality of care through the operationalization of clinical mentorship systems, e- and mobile learning and sharing strategies, and the revision, creation and roll out of guidelines, standard operating procedures, training curricula and job aides.
- Tracking the enabling environment for targeted population service access and uptake, and strengthening legal aid services for key populations.
- Supporting the coordinated advocacy work of human rights, vulnerable populations [REDACTED], key and PLHIV associations.
- Increasingly transferring technical, programmatic and financial capacity to national organizations and bodies to position them to better sustain results and advocate for, or leverage, additional resources.

PEPFAR Indonesia's military-to-military engagement program will focus on above site activities. Through this above site approach, technical assistance will include strengthening the existing military healthcare system, capacity building and improving and expanding the military monitoring and evaluation system.

Expected PEPFAR Indonesia achievements include: (i) increased knowledge about HIV and AIDS among Indonesian National Armed Forces (TNI) personnel; (ii) further strengthened HIV testing services which will also improve monitoring of patterns of HIV infection and better targeting of HIV interventions; (iii) improved treatment adherence of TNI personnel on ART and prevention of HIV transmission to sexual partners; and (iv) established and/or strengthened information systems on HIV prevention, testing and counseling, linkages, targeted project M&E, and improved tools for collecting, analyzing, and disseminating HIV/AIDS IBBS and M&E information.

The TNI, with its own funds, is strengthening HIV prevention efforts at all military bases, and providing HTS and care, support and treatment at over 700 military hospitals/clinics to further reduce the transmission of HIV within the military. In addition, TNI plans to scale-up efforts on prevention, HTS, and M&E have been included in the GoI's National AIDS Strategy (SRAN).

3.2 Site level (rationale, geographic and population prioritization)

Site-level activities primarily focus on direct service delivery (DSD) and Technical Assistance Service Delivery Improvement (TA-SDI) core and near-core interventions that demonstrate increased targeted population reach, HIV testing, yield/enrollment, ART initiation, treatment retention, and viral suppression in decentralized service settings across the CoPCT. Here PEPFAR Indonesia assistance will be used strategically to fill in critical gaps and amplify results that move the country towards 90-90-90 goals, as highlighted in the Jakarta Fast Track approach.

In Jakarta, where the GoI has put forth ambitious AIDS elimination goals that call for coverage saturation, PEPFAR Indonesia will support up to 12 civil society organizations or private sector partners to amplify outreach efforts to identify new PLHIV within hard to reach key sub-populations, with a particular focus on young MSM. In contrast to GF-supported or GoI outreach implementers, PEPFAR resources will be used to field test and roll out the Enhanced Outreach and Differentiated

Care Approach (EOA-DC) that differentiates the outreach contact based on the needs of each KP client, extends coverage through peer driven intervention strategies, and extend support across the CoPCT. Versions of the EOA-DC (called the EOA in Vietnam and the Enhanced Peer Mobilizer Model in Thailand, Laos and other areas) have demonstrated improved programmatic outcomes and facilitated community-facility linkages for greater impact.

PEPFAR Indonesia will further trial innovative models, such as community-based screening, SUFA/test and start, multi-month scripting, and systematic viral load testing, in 36 HTC service delivery points and 22 (COP18) and 28 (COP19) ART service delivery points across five districts in Jakarta. These innovations were highlighted in the National HIV Review conducted in January 2017 and have been approved (in principle) by the Ministry of Health. PEPFAR-Indonesia targeted facilities have been selected as per their current achievement against technical performance thresholds; their ability to expand CoPCT coverage; and their commitment to testing new models of care. The provision of PEPFAR Indonesia DSD and TA-SDI assistance in these facilities will allow PEPFAR Indonesia prime partners to demonstrate programmatic outcomes that can be expanded through above-site support to move Jakarta closer to achievement of ambitious 90-90-90 targets.

3.3 Critical above-site systems investments for achieving sustained epidemic control

PEPFAR Indonesia has identified a set of above-site systems gaps that are critical to address to ensure quality provision of HIV services, including the areas of supply chain management; drug pricing and quality; laboratory; military HIV systems; health financing; human resources for health, data collection and use; and enabling environment.

Supply Chain, and Drug Pricing and Quality. There are a range of gaps that affect the supply chain management system in Indonesia. The most critical gaps include the following: limited technical knowledge and human resources in supply chain management; inadequate recording and reporting of commodity stock data at subnational levels; a lack of data management and data for decision-making at higher levels; rigid budget and procurement guidelines, including HIV cycles for commodity procurement; high commodity prices; and limited numbers of health facilities that initiate and refill ARVs and provide diagnostic services. In 2016, there were reported national-level supply shortages of Tenofovir, Lamivudine, Efavirenz (TLE) fixed-dose combination, facility-level stock-outs of ARVs and widespread medicine rationing. There were also multiple reported stock-outs of diagnostic reagents in Papuan facilities. PEPFAR Indonesia coordinates and works closely with the MoH logistics units to determine and prioritize technical assistance in supply chain management to ensure program results can be achieved and patients can receive the commodities they need. PEPFAR Indonesia provides highly technical support that cannot be easily accessed under national budgets and procurement guidelines. PEPFAR Indonesia is able to share best practices and models in supply chain management from other countries and is working to develop human resources and capacity of staff in the MoH and lower levels to ensure continuity of resources and strategic thinking around supply chain management to support the national HIV program.

Additional gaps include a lack of proficient lab technicians who have the capacity to test ARV drug quality; poor coordination and unclear delineation of roles between the MoH and Indonesia's National Drug Authority (BPOM); and insufficient equipment and materials to test drug quality. PEPFAR Indonesia's investment in this area is critical over the next two years, providing highly technical TA to the BPOM and MoH on medicine quality. Without PEPFAR support, this technical capacity would not exist in Indonesia; BPOM funding is limited for equipment procurement. Additionally, given that 50% of ARVs in the market are locally produced and these medicines are not WHO prequalified and do not meet international standards for good manufacturing practices (GMP), the quality of medicines available on the market can greatly impact the success of the national HIV program. PEPFAR Indonesia leverages GF-funding to procure testing equipment for quality control (QC) labs which are one-off purchases, with PEPFAR Indonesia providing training and capacity building to BPOM and QC labs to ensure sustainability of activities.

Laboratory. Currently there is no national HIV Laboratory Strategy resulting in gaps in viral load testing as there is limited and unreported testing without a network of standardized policies, guidelines, quality assurance, or referral systems. Without a Strategy, it is impossible to measure VL testing at the site level. At the request of the GoI, PEPFAR Indonesia has dedicated COP 16 resources to assist the GoI in developing an HIV Laboratory Strategy. The GoI made this request due to insufficient technical expertise and the positive support received from the USG in the development of a TB Laboratory Strategy. It has been agreed with the GF that they will support implementation of the Strategy once completed. In COP17/18, PEPFAR Indonesia will continue to provide TA to the MoH in the implementation of the Strategy. Since the GoI is the lead in implementing the HIV Laboratory Strategy, once developed, all activities will be government-led and government-owned, not requiring a transition.

Military systems. The critical gaps in the Indonesian military HIV program include the lack of military hospitals providing testing and treatment services; the number of hospitals reporting in the national reporting system; and the lack of sufficient funding for UN peacekeeping HIV prevention programming. There are currently 124 military hospitals across 36 provinces, of which 23 are providing testing and counseling, with 13 of those providing care and treatment. Additionally, only 23 of the 124 military hospitals are reporting HIV data using the national reporting system SIHA (System Information HIV/AIDS). Additional gaps include a lack of HIV education trainers, information, education, and communication (IEC) materials and budget allocated for local deployments or to recruit military medical doctors. PEPFAR Indonesia investment in this area is critical over the next five years, as there are insufficient national and military financial resources to support these gaps. In FY17 PEPFAR Indonesia will strengthen the TNI's HIV program for UN deployment peacekeepers and for locally deployed troops in provinces. Beginning in FY18, PEPFAR Indonesia will assist the TNI in advocating for gradually increased GoI funds to fully support by 2021, the HIV program for the UN peacekeepers and locally deployed troops.

Health financing. Indonesia is transitioning from relying on the GF for the provision of HIV care to both centrally-funded programs and the single payer social health insurance system (JKN). Currently, the nationally-funded program covers: outreach services (70% GF funded); drugs (first-line ARVs,

second-line is GF funded); and a centrally-funded ARV supply chain system. While the JKN intends to facilitate KP access to testing and clinical care for HIV and TB and other OI-related services (except Hepatitis C), JKN referral policies, inexplicit provider payments for HIV-related services, and a variation of supply side readiness across districts still creates gaps for KP to access HIV services. In COP17/18 PEPFAR Indonesia will continue to work with various GoI stakeholders, including the MoH and the National Social Security Council (DJSN), and the World Bank to support the improved operation of systems to sustain HIV services including identifying potential financial support for CSOs.

HRH. HRH gaps in Indonesia include the following: chronic, uneven distribution of human resources, hiring freezes of civil servants and frequent turnover of personnel at District Health Offices and primary care facilities. These gaps result in inadequate human resources and inadequate skill mixes required for providing HIV services. In addition, CSOs have been relied upon to provide HIV outreach services with international donor resources rather than government funding. This has been a significant issue in remote areas like Papua. In Jakarta, there is clear guidance to identify the required skill mix, but with the introduction of JKN most healthcare workers focus on curative care rather than on promotion and prevention. In HIV care, there is little attention to outreach and treatment adherence. PEPFAR Indonesia was asked by the GoI to invest in a set of specific, time-limited activities to help them address these issues. TA from PEPFAR Indonesia will assist in mapping HRH gaps, and capacitate the national and local governments in Jakarta and Papua to develop comprehensive strategies to design and manage their HIV programs. Currently, no other donors are providing resources for HRH activities in Indonesia.

Data collection and use. Despite the existence of extensive monitoring data, the culture of data use for continual quality improvement and programmatic prioritization, and for enhanced coordination across funding initiatives, remains limited. Facilities may not report into SIHA on a regular basis, nor use their data for quality assurance/improvement. There are few venues by which to review program data across implementers, nor is data visualized in ways that make it easy for implementers to assess gaps, identify opportunities, and prioritize resources. Vertical information systems in outreach (JAIS), in care and treatment (SIHA), and in TB (SITT) inhibit analyses across the CoPCT or across diseases. In addition, outreach implementers have limited understanding of programmatic data and, as a result, intervention prioritization and targeting are based on simplistic programmatic mapping and coverage data, rather than on cascade performance. To address this critical gap, in COP17/18 PEPFAR Indonesia will continue to provide this above-site TA to the MoH, both GoI and private clinics, and CSOs. In addition, PEPFAR Indonesia will imbed an M&E advisor in the MoH's sub-directorate AIDS to build national capacity through mentoring of MoH staff. In collaboration with other international partners, primarily UNAIDS and WHO, PEPFAR Indonesia will utilize and improve reports (including routine KP disaggregation) from existing information systems both at the service delivery level and the national level.

[REDACTED]

3.4 Description of how PEPFAR will support greater sustainability

From a financial perspective, PEPFAR Indonesia provides less than 10% of the funding needed for the national HIV response in Indonesia. The central government is the clear leader as it provides about two-thirds of the needed financial support. The Global Fund provides about one-quarter of the required funding providing supporting the implementation and achievement of SUFA in priority sites through GoI and CSO PRs.

PEPFAR Indonesia's focus on sustainability and efficiencies is aimed at strengthening the national program by expanding the government's reach and access to targeted populations by improving the collaboration among CSOs, health facilities and local governments in designing, implementing, and monitoring the HIV program. PEPFAR Indonesia also promotes the analysis and use of data that allows partners to monitor program progress and take necessary corrective actions for HIV epidemic control.

To support the sustainability of the military HIV program, TA will be provided to military hospitals to adopt and support the MoH national program on SUFA and SIHA by increasing the number of military hospitals reporting on testing, care, and treatment. Additionally, TA will be provided to support updating and strengthening the current formal military HIV policy (2012), with approval from senior leadership.

The extent to which local government funding has contributed to the increase of domestic HIV funding is unclear because resource tracking is not systematically documented. PEPFAR Indonesia will engage the national and local governments to more effectively utilize existing funds and advocate for increased HIV financial resources, particularly to allocate funding for CSOs that provide critical services to KPs. CSOs have unique access and skills in working with KPs starting from prevention to ensuring retention in treatment. PEPFAR Indonesia will continue close engagement with civil society, particularly in improving coordination among CSOs to deliver quality and accessible services for targeted populations.

Universal health coverage (UHC/JKN) is another great opportunity to reform and refocus the national HIV response and address challenges in maintaining sustainable HIV services. The UHC principles, which call for the delivery of a comprehensive package of health services that respond to the burden of disease, can support the integration and quality of HIV services, improve equity in HIV service access, build coherence across different health areas, help address the social and economic determinants of HIV, strengthen health and community systems, and contribute to human rights. In COP17/18 PEPFAR Indonesia will continue to support jointly-funded PEPFAR and non-PEPFAR programming to ensure Indonesia's national health insurance scheme (JKN) covers comprehensive HIV, TB and MCH services.

4.0 Management and staffing considerations

[REDACTED]

APPENDIX A

A.1 Planned Spending in 2017

Table A.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$1,384,000	\$8,616,000	\$10,000,000

Table A.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	\$1,673,078
IDUP	Injecting and Non-Injecting Drug Use	\$84,152
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	\$560,229
HBHC	Adult Care and Support	\$586,570
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	\$2,207,570
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	
HLAB	Lab	\$244,432
HVSI	Strategic Information	\$1,718,330
OHSS	Health Systems Strengthening	\$1,379,916
HVMS	Management and Operations	\$161,723
TOTAL		\$8,616,000

A.2 Resource Projections

For resource projections in 2017, PEPFAR Indonesia worked with partners and stakeholders to identify and prioritize activities for COP 17/18 and developed funding projections based on those activities using historical costing information. PEPFAR Indonesia also compared figures and total estimated costs with the PBAC used in the development of COP 16, and assumed comparable figures for COP 17/18.

APPENDIX B

Focused Outcome and Impact Table (FOIT), saved as a separate excel worksheet

Focus Outcome and Impact Table

Overview	Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)	Year 2 Budget
Strategic Outcome 1: Support the Government of Indonesia, communities and implementing partners to improve access to and quality of services across the cascade for targeted populations in PEPFAR priority areas in collaboration with key local, national and international partners towards sustainable services for targeted populations.									
Measurement of Strategic Outcome 1									
	Service delivery and quality improvement: key populations	Expand high yield testing strategies for key populations through enhanced mobile testing systems, community-based screening, routine testing and oral fluid self testing strategies. Linked to game changer funding.	uwy6@cdc.gov	DSD and TA-SDI assistance maintained at 36 facilities /service delivery points, achieving a target of 41,347 individuals tested Mobile testing, community screening and self-testing scale up plans developed and initiated (see game changer) TB clients routinely tested for HIV in all targeted hospitals or puskesmas 6,202 new PLHIV diagnosed, contributing to 68% (n=9292) of Jakarta's first 90 annual Fast Track target	HTS_TST, HTS_TST_POS			\$450,000	\$450,000
	Service delivery and quality improvement: key populations	Operationalize test and start interventions in targeted puskesmas. Linked to game changer funding.	Number of service delivery points (with ability to initiate ART and report directly into SIHA) increased from 16 facilities to 22 facilities Test and start expansion plan drafted with MOH SOPs, lab procedures and task shifting SOW finalized; model(s) tested at up to 10 facilities 6,689 PLHIV newly initiated on ART, contributing to 67% (n=10,035) of second 90 annual Fast Track target	Number of service delivery points (with ability to initiate ART and report directly into SIHA) increased from 22 facilities to 28 facilities Test and start expansion plan endorsed by MOH, with at least 50% of targeted facilities implementing test and start procedures 5,582 PLHIV newly initiated on ART, contributing to 47% (n=11,888) of second 90 annual Fast Track target	HTS_TST_POS, TX_NEW			\$300,000	\$300,000
	Service delivery and quality improvement: key populations	Sustain PLHIV on ART through case management, multi-month scripting, and/or alternative ART distribution model(s). Linked to game changer funding.	Multi-month scripting and/or alternative ART delivery model(s) implemented in 1 district, with loss to follow up reduced by at least 10% in targeted facilities 12,225 PLHIV current on ART across 22 facilities	Multi-month scripting and/or alternative ART delivery model(s) expanded to 3 districts, with loss to follow up reduced by at least 15% in targeted facilities 14,751 PLHIV current on ART across 28 facilities	TX_CURR, TX_RET			\$575,000	\$575,000
	Service delivery and quality improvement: key populations	Support district to intensify reach through Enhanced Outreach Approach and Differentiated Care (EOA-DC), modified for remote and geographically dispersed areas.	EOA-DC engagement strategy developed and initiated in 3 highland sub-districts.	EOA-DC engagement strategy operationalized in 3 highlands sub-districts.			need indicator of success	\$300,000	\$300,000

Focus Outcome and Impact Table

Overview	Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)	Year 2 Budget
	Service delivery and quality improvement: key populations	Support district to develop and operationalize test and start strategy in targeted puskesmas and hospitals	District strategy to operational test and treat developed and implemented in 3 facilities in Jayawijaya facilities.	Test and start expansion plan endorsed by PHO/DHO, and implemented in 6 facilities in Jayawijaya facilities			need indicator of success	\$350,000	\$350,000
	Service delivery and quality improvement: key populations	Support district to strengthen high yield testing for targeted populations through mobile testing & community-based screening	Mobile HIV testing services carried out in 12 areas in 3 sub-districts. Community-based HIV screening model developed and initiated as part of mobile testing strategy	Mobile HIV testing services carried out in 24 areas in 3 sub-districts Community-based HIV screening model endorsed by PHO/DHO(s) and scale up plan developed and initiated Routine testing model outcomes shared with scale up plan developed for Jayawijaya district				\$250,000	\$250,000
	Systems: Institutional Capacity Building	Strengthen coordination; foster data transparency and collaborative QA/QI efforts; rollout of CoPCT guidelines; and strategize interventions	Provincial and district-level annual targets developed; road map finalized; partner and CoPCT QI consultations take place semi-annually; cascade generator utilized for quarterly analyses; up to 5 time bound staff placed at site, district and provincial levels to improve comprehensive HIV response functions and trial innovations; At least 5 Papua-specific guidelines, SOPs, curricula, and/or job aides prepared and rolled out with USG TA	Provincial and district-level annual targets developed; road map finalized; partner and CoPCT QI consultations take place semi-annually; cascade generator utilized for quarterly analyses; at least 1 time-bound staff supported through GOI funding;	Diagnosed_NAT (Papua)	Program Indicator	Number/type of CoPCT guidelines, SOPs, curricula and job aides	\$150,000	\$150,000
	Systems: Health workforce	Improve quality of care by strengthening clinical mentoring system(s)	Clinical mentors identified and structure formalized; clinical mentoring plans developed using cascade generator data	Clinical mentorship system endorsed by PHO/DHO				\$175,000	\$100,000
	Systems: Health workforce	Facilitate policy revisions to ensure adequate HIV skills mix is recruited and retained at sites.	Support the completion of National Health Workforce Accounts to obtain data and identify distribution and retention gaps of specific skills mix requirements for HIV service provision targeting Jakarta and Papua.	Use data and analysis of HRH data to complete negotiation with national and local governments in Jakarta and Papua for reducing vacancies for key HIV related skills mix in facilities.	HRH_STAFF	National Indicator	Vacancy rates for key HIV related skills mix in DKI Jakarta and Papua.	\$100,000	\$100,000
	Systems: Governance (including policy)	To place time bound staff to provide strategic and technical guidance for HIV program implementation.	Review completed, data available, and submitted to MoH on select program implementation	Data used by stakeholders to develop programs				\$400,000	\$400,000

Focus Outcome and Impact Table

Overview	Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)	Year 2 Budget
	Systems: Laboratory	Support National HIV-Lab Strategy (policy & framework) and lab establishment/implementation of network, referral, reporting systems	Developed laboratory policy adopted with national guidelines and standards including: mandatory regulation, certification and accreditation.	National guidelines and standards known at facility level, Increasing percentage of certified and accredited laboratories. Increasing percentage of of laboratory				\$100,000	\$100,000
	Systems: Laboratory	Support (TA) establishment and implementation of a Quality Assurance System at national, provincial and district levels	Developed Laboratory Quality Management (LQM) Plan including training modules, QA managers in place, and QA guidelines & standards produced and disseminated to laboratories at all levels including PEPFAR districts.	Increasing level of monitoring with QA systems developed showing improving lab performance based on QA standards at all levels including PEPFAR districts.				\$100,000	\$100,000
	Systems: Supply chain and essential medicines	Support pricing studies for HIV Commodities (including ARVs) to find efficiency and reduce the cost to the National HIV Program	Study completed and data disseminated to relevant stakeholders; policy developed to support price reductions	Data used by stakeholders to negotiate lower price, policy approved. Average Price of ARVs reduced by 20% from 2017 procurement.				\$100,000	\$100,000
	Systems: Supply chain and essential medicines	Support the MoH and provincial and district levels to strengthen forecasting, supply planning, and stock monitoring for ARVs and Rapid Diagnostics	Forecast and supply plan developed; quarterly reviews of stock data and forecast conducted to ensure proper reporting and sufficient stock at all levels.	Forecast and supply plan developed by MoH and PHO (with little oversight), quarterly reviews of stock data and forecast conducted to ensure proper reporting and sufficient stock at all levels.				\$541,630	\$541,630
	Systems: Supply chain and essential medicines	Support Post-Market Surveillance of ARVs at national/provincial level drug authorities to identify and remove poor quality medicines in the market	Joint sampling and testing of medicines conducted between MoH and the National Drug Authority (BPOM); PMS data shared between BPOM and MoH, Lab capacity strengthened to test ARV Quality	PMS data received and used by MoH to inform procurement and product recall, Procurement policy and practices updated to reflect data, Lab capacity strengthened to test ARV Quality				\$600,000	\$600,000
	Systems: Supply chain and essential medicines	Support collaboration and planning between ARV manufacturers and distributors with the MoH to ensure availability of ARVs at reduced prices.	ARV Forecast and supply plan shared and discussed in stakeholder meeting (with Manufacturers, distributors and MoH) to facilitate planning for ARV procurement and production, opportunity to negotiate and discuss reduced price and drug quality in a stakeholder forums	Year 2 meeting: ARV Forecast and supply plan shared and discussed in stakeholder meeting (with Manufacturers, distributors and MoH) to facilitate planning for ARV procurement and production, opportunity to negotiate and discuss reduced price and drug quality in a stakeholder forums				\$50,000	\$50,000
	Systems: Supply chain and essential medicines	Support PLHIV Community in development of Early Warning and Stock Monitoring system	Model Developed, SOPs and tools designed	Model strengthened				\$150,000	\$150,000
	Systems: Health Financing	Conduct analyses for the National Social Security Council for the inclusion of comprehensive HIV care into the Universal Health Coverage Program (JKN)	Support analyses of the JKN claim database to show the behavior of HIV patient and providers. Use analysis to advocate for policy and regulatory changes at the national health insurance level to ensure better access and improved utilization of HIV services.	Monitor and evaluate the effectiveness of pilot financial and behavioral incentives. Facilitate the revision of regulations and policies under the Social Security Law (2004/14)		National Indicator	USAID will use the JKN claims data base to track changes in client and provider behaviors. Additionally, disease specific accounts will be institutionalized to track HIV public and private expenditures.	\$500,000	\$500,000
	Systems: Health Financing	To support a provider payment mechanism to incentivise provision of quality HIV care under JKN.	Conduct a BPJS provider payment assessments (primary care and hospital) and pilots to determine the right mix of financial and behavioral incentives to ensure better testing yield, treatment initiation and adherence	Complete negotiation with national and local governments in DKI Jakarta and Papua in implementing policies on portability and equity of HIV service to all key population and to support an improved provider payment mechanism to incentivise provision of quality HIV care.				\$400,000	\$0
	Systems: Supply chain and essential medicines	Coordination with MoH, MoD & Surgeon General's Office on ARV and HIV commodity supply chain	<ul style="list-style-type: none"> • One coordination meeting conducted with TNI SG, MoH and MoD with minutes distributed to DoD HQ and in-country program manager for review and discussion with implementing partner on success and challenges. • Develop strategy for viral load POCT support at higher volume TNI ART sites through MOH collaboration 	<ul style="list-style-type: none"> • One coordination meeting conducted with TNI SG, MoH and MoD with minutes distributed to DoD HQ and in-country program manager for review and discussion with implementing partner on success and challenges. 				\$4,305	\$4,305

Focus Outcome and Impact Table

Overview	Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)	Year 2 Budget
	Systems: Governance (including policy)	Collaborate with military leadership to strengthen HIV policy and conduct advocacy event to raise awareness among high ranking military officers	<ul style="list-style-type: none"> • Update existing 13 Aug 2012 formal military HIV policy and approved by senior leadership including: <ul style="list-style-type: none"> o WHO Test & Start policy o 100% testing of UN peacekeepers and locally deployed troops (duty area) pre and post deployment with 100% linkage to treatment o Formalized anti-stigma and anti-discrimination policy inclusion o 100% of TB cases and 100% of STI receive PITC • Coordination with CSOs and provincial health office for persons testing HIV+ at recruitment • Disseminate a report on HIV policy strengthening and development • Documentation of training results, list of recommendations and strategy • 18 out of 23 military hospitals providing HTS will be able to provide care and treatment for HIV+ personnel and plan and timeline will be distributed to improve current TNI HIV testing coverage • One advocacy event/workshop conducted with 50 high ranking TNI officers in attendance • HIV related promotion materials produced and disseminated within 	<ul style="list-style-type: none"> • 100% testing of UN peacekeepers and locally deployed troops (duty area) pre and post deployment with 100% linkage to treatment • 100% of TB cases and 100% of STI receive PITC • Coordination with CSOs and provincial health office for persons testing HIV+ at recruitment • Documentation of training results, list of recommendations and strategy • 23 out of 23 military hospitals providing HTS will be able to provide care and treatment for HIV+ personnel • Measure TNI PLHIV attrition to civilian care at baseline and two years after implementation of formal anti-stigma and anti-discrimination policy • One advocacy event/workshop conducted with 50 high ranking TNI officers in attendance • HIV related promotion materials produced and disseminated within training for medical and non-medical high-ranking military leaders/decision makers to support policy implementation discussions • Assist the military with requesting funds from the government for UN 		Other	<ul style="list-style-type: none"> • Number of UN peacekeepers tested pre and post deployment • Number of locally deployed personnel tested pre and post deployment • Number of HIV+ UN peacekeepers and number linked to treatment • Number of HIV+ locally deployed personnel and number linked to treatment • Number of military hospitals providing HIV and treatment services • Number of high ranking TNI officers in attendance at advocacy event 	\$23,979	\$23,979
	Systems: Institutional Capacity Building	Trainings conducted on PITC, treatment literacy, infectious diseases, HIV education and HIV knowledge	<ul style="list-style-type: none"> • One military education ToT conducted for 15 TNI personnel to prepare participants to train TNI UN peacekeepers to aid in dissemination of HIV and AIDS information • IEC training material printed • Ten comprehensive HIV knowledge trainings conducted for 300 non-medical military peacekeeper and locally deployed troops (duty area) commanders 	<ul style="list-style-type: none"> • One military education ToT conducted for 15 TNI personnel to prepare participants to train TNI UN peacekeepers to aid in dissemination of HIV and AIDS information • IEC training material printed • Ten comprehensive HIV knowledge trainings conducted for 300 non-medical military peacekeeper and locally deployed troops (duty area) commanders 		Other	<ul style="list-style-type: none"> • Number of TNI personnel trained on HIV education ToT • 75% improved knowledge of TNI personnel on knowledge related to HIV and AIDS, training module development and effective training • 75% trained educators 	\$142,716	\$142,716

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Strategic Outcome 2: Support the Government of Indonesia, communities and implementing partners to improve data collection, quality and usage to reach 90-90-90 among targeted populations, and to reduce stigma, discrimination and violence against vulnerable population [REDACTED].									
Measurement of Strategic Outcome 2									
	Service delivery and quality improvement: key populations	Intensify, reach & sustain young KPs via EOA-DC, incl socmed & targeted communication. Case mgmt. Linked to game changer funding.	Number of outreach implementers increased from 8 to 12 organizations with an intensified focus on young MSM; 51,685 KPs reached.	Outreach TA-SDF assistance extended to GF SRs/SSRs, maintaining a total target of 53,285 KPs reached (disaggregated by FSW and MSM)	KP_PREV	Program Indicator	Proportion KPs reached that test for HIV; Proportion KPs tested that are diagnosed as HIV positive. Proportion	\$475,000	\$475,000
	Systems: Strategic information	Conduct analyses of programmatic data to better understand Papua highlands HIV epidemic, improve data use by provincial and district health offices	Conduct patient audit in selected facilities to articulate residency patterns Review and collate existing programmatic data across highlands and prepare feedback report with priority recommendations	Conduct sexual network analysis in selected Papua highlands areas		Program Indicator	Number/type of programmatic analyses conducted	\$150,000	\$0
	Service delivery and quality improvement: key populations	Support local government to sustain PLHIV on ART through case management, multi-month scripting, and/or alternative ART distribution model(s)	Multi-month scripting and/or alternative ART delivery model(s) implemented in 3 sub-districts, Case management roles and responsibilities introduced to include patient navigation, patient advocacy, and multi-month scripting logistics support	Multi-month scripting and/or alternative ART delivery model(s) expanded to an additional 3 sub-districts, Case management roles and responsibilities systematized to include patient navigation, patient advocacy, and multi-month scripting logistics support	TX_CURR, TX_REX			\$475,000	\$441,000
	Service delivery and quality improvement: key populations	Pilot viral load testing for PLHIV on ART for 12 months. Linked to game changer for Jakarta.	Jakarta: Viral load testing operationalized for PLHIV on ART for 12 months in targeted facilities, with 30% of eligible KP PLHIV availing viral load testing Papua: Viral load testing operationalized for Papua highlands	Jakarta: Viral load testing operationalized for PLHIV on ART for 12 months in targeted facilities; with 50% of eligible KP PLHIV availing viral load testing Papua: Viral load testing operationalized for Papua highlands	TX_PVLS			\$540,794	\$540,794
	Service delivery and quality improvement: key populations	Strengthen integrated GBV service linkages in clinical services targeted populations. Linked to game changer in Jakarta.	GBV service referral system integrated into 3 facility operations	GBV service referral system integrated into 5 facility operations				\$570,000	\$570,000
	Systems: Strategic information	Strengthen implementation of the Community-Based Outreach Management System (COMS) among USG-supported outreach organizations. Linked to game changer funding in Jakarta.	Client management database rolled out and utilized among all USAID-supported implementers EOA-DC mobile application developed and introduced to targeted USG-funded CSOs	Client management database fully operational among all USAID-supported implementers EOA-DC mobile application rolled out to all USG-funded CSOs and selected GF implementers as appropriate		Program Indicator	Proportion of USAID-supported CSOs with data variance of less than 5%	\$100,000	\$100,000
	Systems: Strategic information	Embed SI Advisor and M&E Specialist in MOH/SubDit HIV to mentor MOH staff, and strengthen and produce HIV data collected thru SIHA	Data quality system is developed & subdit HIV staff capacity to analyze and utilize data is improved	Subdit HIV staff capacity and national HIV data is improved, and data is utilized for decision making.				\$500,000	\$500,000
	Systems: Supply chain and essential medicines	Collaborate with MOH/PHO to develop/pilot innovative models to deliver ARVs (multi-month scripts & drug delivery through networks)	Joint Supply Chain and Community assessment completed. Drug delivery model developed.	Drug delivery model implemented, model assessed and scaled up in select sites.				\$100,000	\$100,000
	Systems: Supply chain and essential medicines	Support implementation of HIV Lab logistics system and specimen transports system. Linked to game changer in Jakarta.	Support MOH to implement Lab logistics system in Jakarta and Papua.	Year 1 implementation reviewed and revised based on results.				\$108,370	\$108,370

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	Systems: Institutional Capacity Building	Conduct trainings on monitoring and evaluation, reporting, data collection and data analysis	<ul style="list-style-type: none"> • One three-day training conducted on improving the existing monitoring and evaluation tools (including measures of success) for 15 TNI personnel from each military unit • One two-day workshop conducted on monitoring and evaluation tools' usage for 15 participant from TNI health Provider • One two-day workshop conducted on data analyses for 15 TNI data manager from each military unit • Once two-day workshop conducted on disseminating the findings of monitoring and evaluation and how to present results of data analysis for 15 TNI data decision makers • One three-day monitoring and evaluation workshop conducted together with TNI team on data collection to ensure quality of recording and reporting data • One refresher training conducted on national reporting and recording system (SIHA) for 15 TNI health provider data managers from each unit • One evaluation meeting conducted at end of each phase on programmatic outcomes with 25 TNI participants 	<ul style="list-style-type: none"> • One three-day meeting conducted on improving the existing monitoring and evaluation tools for 15 TNI personnel from each military unit • One two-day workshop conducted on monitoring and evaluation tools' usage for 15 participant from TNI health Provider • One two-day workshop conducted on data analyses for 15 TNI data manager from each military unit • Once two-day workshop conducted on disseminating the findings of monitoring and evaluation and how to present results of data analysis for 15 TNI data decision makers • One three-day monitoring and evaluation workshop conducted together with TNI team on data collection to ensure quality of recording and reporting data • One refresher training conducted on national reporting and recording system (SIHA) for 15 TNI health provider data managers from each unit • One evaluation meeting conducted at end of each phase on programmatic outcomes with 25 TNI participants • Increase number of military hospitals 		Other	<ul style="list-style-type: none"> • Number of TNI personnel trained on monitoring and evaluation tools • 75% knowledge increase of TNI personnel on M&E tools • Number of TNI health providers trained on monitoring and evaluation tool usage • 75% knowledge increase of TNI health providers on M&E tool usage • Number of TNI data managers trained on data analysis • 75% knowledge increase of TNI data managers on data analysis • Number of TNI HIV program decision makers participating in workshop of data dissemination and findings • Number of TNI 	\$50,000	\$50,000