



## **FY 2015 Indonesia Country Operational Plan (COP)**

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on [www.PEPFAR.gov](http://www.PEPFAR.gov), reflect the approved FY 2015 COP for Indonesia.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

**Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.**

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

- 3) *Sustainability Index and Dashboard*

**Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on [www.PEPFAR.gov](http://www.PEPFAR.gov) in the “FY 2015 Country Operational Plan Budget and Target Report.”**

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**TARGETED ASSISTANCE OR TECHNICAL  
COLLABORATION COUNTRY**

**Country Operational Plan (COP) 2015**

**Strategic Direction Summary**

**Indonesia**

Revised May 2015

## **Goal Statement**

### **1.0 Epidemic, Response, and Program Context**

- 1.1 Summary statistics, disease burden and country profile
- 1.2 Investment profile
- 1.3 Sustainability profile
- 1.4 Alignment of PEPFAR investments geographically to burden of disease
- 1.5 Stakeholder engagement

### **2.0 Core, near-core and non-core activities for operating cycle**

### **3.0 Geographic and population prioritization**

### **4.0 Program Activities for Epidemic Control in Priority Locations and Populations**

- 4.1 Targets for priority locations and populations
- 4.2 Priority population prevention
- 4.3 Voluntary medical male circumcision (VMMC)
- 4.4 Preventing mother-to-child transmission (PMTCT)
- 4.5 HIV testing and counseling (HTC)
- 4.6 Facility and community-based care and support
- 4.7 TB/HIV
- 4.8 Adult treatment

### **5.0 Program Activities to Maintain Support in Other Locations and Populations**

- 5.1 Maintenance package of services and expected volume in other locations and populations
- 5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

### **6.0 Cross-cutting Support Necessary to Achieve Sustained Epidemic Control**

- 6.1 Laboratory strengthening
- 6.2 Strategic information (SI)
- 6.3 Health system strengthening (HSS) – clear linkages to program

### **7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals**

#### **Appendix A- Core, Near-core, Non-core Matrix**

#### **Appendix B- Budget Profile and Resource Projections**

#### **Appendix C- Sustainability Index**

#### **Appendix D- Supplemental Tables**

# Goal Statement

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In partnership with host government counterparts, civil society organizations, multilateral agencies and other donors, PEPFAR Indonesia will continue to focus support on the continuum of care to improve linkages between community and clinical services for key populations in select districts in Jakarta and in Papua, to support an effective continuum of response for priority populations. PEPFAR Indonesia will work with the Government of Indonesia (GOI) at a sub-national level to help the country meet its commitment to the ambitious 90-90-90 goals established by UNAIDS. By 2020, 90 % of all people living with HIV will know their HIV status; 90 % of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and 90 % of all people receiving antiretroviral therapy will have viral suppression. In FY 2015, PEPFAR Indonesia will contribute through targeted technical assistance (TA) to the achievement of 80 % of all people living with HIV in targeted areas knowing their HIV status, and 70 % of all people with diagnosed HIV infection in targeted areas receiving sustained antiretroviral therapy.

National program data indicate that key populations are not being adequately reached with prevention interventions as, at most, two-thirds of direct female sex workers and transgender were reached at least once in a year and less than one-third of the estimated men who have sex with men were reached over the same time period. To address this, PEPFAR Indonesia will support the GOI and civil society counterparts to increase the prevention of HIV transmission among key populations by expanding the reach of civil society organizations (CSOs) that target key populations in 8 high-prevalence districts in Jakarta and Papua. These districts represent 19 % of the total PLHIV burden in Indonesia as well as the majority (6%) of key populations. The PEPFAR military program will focus on 4 military hospitals within three provinces that account for 30% of the total military population in Indonesia.

To assist the national AIDS program in its efforts to reach and access HIV-infected key populations, PEPFAR Indonesia will focus on making an impact on sustainability and efficiency through organizational support and technical capacity building of CSOs that provide services to key populations. CSOs have unique access and skills in working with key populations and function as a critical arm of the national response. PEPFAR Indonesia will also work with local governments to identify sustainable funding for CSOs to ensure they are able to maintain critical outreach and referral activities after donor funding ends, and ensure that national health insurance (JKN) covers HIV care and treatment services. Technical advisors seconded to the AIDS subdirectorates at the Ministry of Health will mentor government staff to strengthen their capacity in surveillance and data analysis to improve the collection and utilization of data.

## 1.0 Epidemic, Response, and Program Context

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### 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 GoI 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 G20 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 at 3.0%.

The national HIV prevalence rate among adults aged 15-49 years is estimated at 0.4% (691,040 PLHIV).<sup>1</sup> With the exception of Papua and West Papua provinces, which have a low-level generalized epidemic (estimated HIV prevalence of 2.3%)<sup>2</sup>, Indonesia continues to experience a concentrated HIV epidemic. While there are concerns about the overall quality of surveillance and size estimation data, available data demonstrate an estimated prevalence rate among direct Female Sex Workers (DFSW) of 7.0%; 1.6% among indirect FSW (IDFSW); 21.9% among waria (transgender); 8.5% among Men who have Sex with Men (MSM); and 41.2% among People Who Inject Drugs (PWID) in 2013.<sup>3</sup>

The 2015 Asian 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/Transgender Group (TG) and 32% among FSW.<sup>4</sup>

(Please see Table 1)

Table 1: 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
<b>FSW</b>	21,524	21,030	20,606	20,576	20,559	20,562	20,588
<b>Discordant couples</b>	21,971	21,885	21,702	21,527	21,427	21,428	21,520
<b>Casual sex</b>	3,048	2,913	2,754	2,831	2,893	2,947	2,994
<b>MSM</b>	15,800	17,155	18,595	20,173	21,819	23,532	25,308
<b>Needle sharing</b>	2,777	2,459	2,101	2,109	2,160	2,208	2,252

HIV/AIDS in Indonesia continues to be an important national concern. In November 2011, former President Susilo Bambang Yudhoyono, together with other ASEAN leaders, announced Indonesia's commitment to "Getting to Zero," which is a multipronged UNAIDS-supported strategy to halt and reverse the spread of HIV/AIDS. The GOI has also undertaken a new test and treat 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.

<sup>1</sup> 2014 Global AIDS Response Progress Report (GARPR)

<sup>2</sup> 2013 Tanah Papua IBBS for general population (MOH)

<sup>3</sup> 2013 MARPs IBBS (MOH)

<sup>4</sup> 2015 AEM estimates (MOH)

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.<sup>5</sup> Two main targets of the Indonesian response to HIV and AIDS<sup>6</sup> were to “achieve coverage of 80% of key affected populations and the general population in Tanah Papua and PLHIV with at least 60% of those reached practicing safe behavior.” However, the quality and comprehensiveness of the national prevention package of services for key populations remain suboptimal. According to the 2012 UNAIDS Global AIDS Response Progress Reporting (GARPR) report and NAC data, two thirds of direct FSW and TG had been contacted, but less than one-third 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.

Furthermore, 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 Integrated Behavior Biological Surveillance (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 (no significant change from 2007 IBBS). Reported condom use during the last commercial sex encounter among waria was the highest for all high risk groups at 80%. However, HIV prevalence in waria remains one of the highest in the country.

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.<sup>7</sup> Mathematically modeling conducted by the MOH in 2011 projected 541,700 individuals will be infected by 2014;<sup>8</sup> however the new 2015 AEM estimated the number PLHIV in 2015 to be 691,040. Among Asia Pacific countries, Indonesia’s share of new HIV infections reached 23% in 2013 for the region, second only to India.<sup>9</sup>

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 50,400 at the end of 2014.<sup>10</sup> 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 <20%.<sup>11</sup> In addition, viral load testing is still currently not available in country and CD4 testing is not always conducted regularly among those currently on ART.

As stated, Indonesia’s HIV epidemic is concentrated and driven by key populations, with the exception of Tanah Papua (West Papua and Papua provinces) where a generalized epidemic with

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<sup>5</sup> 2015 GFATM Concept Note

<sup>6</sup> National AIDS Strategy and Action Plans, 2010-2014 (NAC)

<sup>7</sup> HIV in Asia and the Pacific, UNAIDS Report, 2013

<sup>8</sup> 2012 Indonesia GARPR (MOH, UNAIDS)

<sup>9</sup> 2014 UNAIDS GAP Report

<sup>10</sup> 2012 Indonesia GARPR (MOH, UNAIDS)

<sup>11</sup> 2014 UNAIDS GAP Report

HIV prevalence in 2013 was estimated to be 2.3%.<sup>12</sup> PWID have the highest HIV prevalence amongst key populations in Indonesia. However, the 2015 AEM size estimate for the current number of PWID in Indonesia is 77,286, a sharp downward revision from 219,000 in 2006 and 105,000 in 2009, attributable to a change in the definition of this population. In terms of methodology, prior to 2006, data was extrapolated, and in 2009 was calculated using regression modeling. In 2012, modified regression modeling was used. At the national level, HIV disease burden among PWID has been on the decline, despite the high prevalence rate, with an estimated 2,101 new infections (3% of total new infection) in 2014 compared to 12,981 in 2004.<sup>13</sup>

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

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

HIV prevalence rates in most urban districts where the epidemic had started earlier (e.g. Medan, Jakarta, Bandung, Surabaya and Malang) remain effectively unchanged (41.2% in IBBS 2011 to 44.5% in IBBS 2013). However, there was an increase in HIV prevalence among PWID in less urban districts (Yogyakarta, Tangerang, Pontianak and Makassar) from 7% in IBBS 2009 to 12% in IBBS 2013. The five provinces with the highest estimated number of PWID include West Java (13,925), East Java (12,427), DKI Jakarta (7,534), Central Java (4,417), and North Sumatra (4,149) based on 2014 AEM estimates.

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. In Jayawijaya City (Papua), DFSW had a HIV prevalence of 25%, while national HIV prevalence among them was estimated to be 9% in 2011. Similarly, Batang (Central Java) and Jayapura City (Papua) had HIV prevalence rates of 20.7% and 16.0% among DFSW respectively in the 2011 IBBS. The five provinces with the highest estimated number of DFSW include West Java (18,827), DKI Jakarta (16,008), East Java (15,422) Central Java (13,731), and North Sumatra (9,392) based on 2014 AEM estimates.

HIV prevalence among DFSW from nine less urban districts (IBBS) in 2009 (6.5%) and 2013 (7.5%), respectively, and did not demonstrate a statistically significant increase. The nine districts

<sup>12</sup> IBBS among General Population in Tanah Papua, 2013 (MOH)

<sup>13</sup> 2015 GFATM Concept Note

which participated in the IBBS 2009 and included DFSW among the survey populations were Palembang, Jogjakarta, Tangerang, Pontianak, Samarinda, Bitung, Makassar, Sorong and Mimika . This is confirmed by the results of sero-surveillance (IBBS 2011 and 2013) in 15 districts with more mature epidemics, where HIV prevalence in DFSW was 10.0% and 10.6%, respectively.

Although IFSW in general are harder to reach compared to DFSW, available data demonstrate lower HIV prevalence rates compared to DFSW. On average, HIV prevalence among IDFSW considerably declined from 3.3 (IBBS 2009), to 1.5% (IBBS 2013). However, three of the 13 selected 2011 IBBS sites demonstrated significantly higher rates of HIV compared to other sites. These included Denpasar city in Bali (HIV prevalence: 8.8%), Batang City in East Java (6.9%), and West Jakarta (5.2%). The five provinces with the highest estimated number of IFSW include DKI Jakarta (24,318), West Java (11,312), East Java (10,878), and Central Java (10,422), and West Kalimantan (5,789) based on 2014 AEM estimates.

Based on 2014 population size estimates, there were 1,139,606 MSM in 514 districts in Indonesia. 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), while in smaller cities (Yogyakarta, Tangerang, Makassar) HIV prevalence increased from 2.5% in 2009 to 9.9% in 2013 (IBBS 2009 and 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). 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.<sup>14</sup> The five provinces with the highest estimated number of MSM include West Java (312,151), Central Java (226,969), South Sulawesi (73,444), and East Java (66,729), and East Kalimantan (64,962) based on 2014 AEM estimates.

The military continues to expand its testing and counseling activities throughout its large medical system that is distributed throughout the country, reaching 28,333 individuals in 2014, including a significant bridge population as clients of FSW. Based on IBBS 2012 data, HIV incidence within this group is anticipated to increase because of ongoing high risk behaviors, in particular within 4 months approximately 8% are clients of FSW, self-reported condom usage rates are approximately 34%, and sexually transmitted infections rates are approximately 9% among the IBBS responded 3,182. Recent DoD support of scaling-up HIV counseling and testing within the military has focused in closing gaps at 13 military hospitals in 6 provinces, but will now refocus efforts to target 129,454 total individuals at four military hospitals in 3 high prevalence provinces (DKI Jakarta, West Java and East Java) that contain 30% of the total military population.

HIV prevalence among the estimated 39,512 waria has remained high but fairly stable since 2009, 21.6% and 19.0% in most urban districts and 9.1% to 7.4% in less urban districts.<sup>15</sup> The overall prevalence rates of syphilis (16% to 10%), gonorrhea (38% to 21%) and chlamydia (38% to 27%) among waria have fallen from 2009 to 2013.<sup>16</sup> However, Jakarta city was reported to have a HIV prevalence of 30.8% (and syphilis prevalence of 31.2%) among waria in the 2011 IBBS. The five

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<sup>14</sup> 2015 GFATM Concept Note

<sup>15</sup> 2015 GFATM Concept Note (source listed as: IBBS Among KAPs Report 2009, 2011 and 2013, and Rapid Bio-Behavioral Surveillance 2013)

<sup>16</sup> 2015 GFATM Concept Note

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provinces with the highest estimated number of waria include East Java (4,538), West Java (4,004), Central Java (3,049), North Sumatra (2,981), and South Sulawesi (2,636) based on 2014 AEM estimates.

**Table 1.1.1 Key National Demographic and Epidemiological Data**

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	255,461,700	100%	32,829,213	49.0%	34,101,752	50.95%	95,002,352	50.4%	93,528,383	49.6%	Indonesia Bureau of Statistics, 2010 Census (2015 projection)
Prevalence (%)		0.27%		0.03%		0.03%		0.26%		0.45%	GAPRS 2014 Report
Prevalence (%) Adult		0.40%		N/A		N/A		N/A		N/A	GAPRS 2014 Report
AIDS Deaths (per year)	69,316		1,027		1,073		25,353		41,863		Source: MoH 2014
PLHIV	691,040		11,019		11,523		247,467		421,031		Source: MoH 2014
Incidence Rate (Yr)		0.03%		0.01%		0.01%		0.03%		0.04%	Calculated
New Infections (Yr)	72,067		2,369	N/A	2,482		25,353		41,863		Source: MoH 2015 AEM
Annual births	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Estimated # Pregnant Women per year	5,290,235	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	MOH Program data
% >= 1 ANC visit	5,110,367	96.60%	N/A	N/A	N/A	N/A	N/A	96.6%	N/A	N/A	DHS 2012
Pregnant women needing ARVs	17,987		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	MOH Program data
Pregnant women Receiving ART for PMTCT	1,825	10%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	MOH Program data
Orphans (maternal, paternal, double)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
TB cases (Yr)	331,441		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	MoH Program data
TB/HIV Co-infection	24,858	7.50%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	GAPRS 2014 Report
Males Circumcised	N/A	N/A			N/A	N/A			N/A	N/A	
<b>Key Populations</b>											
Total MSM*	1,139,606										Source: MoH 2015 AEM

MSM HIV Prevalence		8.48%									2013 IBBS
Total DFSW	129,973										Source: MoH 2015 AEM
DFSW HIV Prevalence		7.00%									2013 IBBS
Total IFSW	109,036										Source: MoH 2015 AEM
IFSW HIV Prevalence		1.60%									2013 IBBS
Total PWID	77,286										Source: MoH 2015 AEM
PWID HIV Prevalence		41.20%									2013 IBBS
Total Transgenders	39,512										Source: MoH 2015 AEM
Transgenders HIV Prevalence		21.90%									2013 IBBS
Total Military personnel	434,410	0.18%									2014 DHAPP Annual Report
HIV prevalence of military personnel	1,738	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 1.1.1.a Key and Priority Populations Size Estimate and HIV prevalence by province and Disease Burden (PLHIV) based on available data**

Key Pop	Name of Area	Type of Area	Total Number of District/City	General Adult HIV prev	General Population Size (Census 2010)*	Calculated KP HIV Prevalence (%)	Estimated PLHIV	KP Size Estimate	Pop Size Estimation method	Year	Reference
Direct FSW	West Java	Province	25	0.2%	46,300,543	9.8%	1,850	18,827	AEM 2015	2015	AEM
Direct FSW	DKI	Province	6	1.4%	10,135,030	13.7%	2,200	16,008	AEM 2015	2015	AEM
Direct FSW	East Java	Province	37	0.3%	38,529,481	8.7%	1,336	15,422	AEM 2015	2015	AEM

Direct FSW	Central Java	Province	34	0.3%	32,779,832	12.8%	1,752	13,731	AEM 2015	2015	AEM
Direct FSW	North Sumatera	Province	32	0.3%	13,527,937	5.5%	512	9,392	AEM 2015	2015	AEM
Direct FSW	Riau Islands	Province	7	0.3%	2,031,895	3.2%	106	3,286	AEM 2015	2015	AEM
Direct FSW	Papua	Province	28	3.4%	3,486,432	24.4%	557	2,287	AEM 2015	2015	AEM
Indirect FSW	DKI	Province	6	1.4%	10,135,030	10.0%	2,436	24,318	AEM 2015	2015	AEM
Indirect FSW	West Java	Province	25	1.5%	46,300,543	1.9%	211	11,312	AEM 2015	2015	AEM
Indirect FSW	East Java	Province	37	1.1%	38,529,481	2.8%	301	10,878	AEM 2015	2015	AEM
Indirect FSW	Central Java	Province	34	1.1%	32,779,832	1.7%	176	10,422	AEM 2015	2015	AEM
Indirect FSW	North Sumatera	Province	32	3.1%	13,527,937	6.4%	341	5,320	AEM 2015	2015	AEM
Indirect FSW	Papua	Province	28	0.4%	3,486,432	8.1%	134	1,658	AEM 2015	2015	AEM
Indirect FSW	Riau Islands	Province	7	1.5%	2,031,895	0.5%	8	1,592	AEM 2015	2015	AEM
MSM	West Java	Province	25	1.1%	46,300,543	2.4%	7,488	312,151	AEM 2015	2015	AEM
MSM	Central Java	Province	34	1.4%	32,779,832	8.0%	18,266	226,969	AEM 2015	2015	AEM
MSM	East Java	Province	37	1.5%	38,529,481	2.6%	1,752	66,729	AEM 2015	2015	AEM
MSM	North Sumatera	Province	32	1.5%	13,527,937	8.1%	3,803	47,066	AEM 2015	2015	AEM
MSM	DKI	Province	6	1.1%	10,135,030	29.4%	8,477	28,810	AEM 2015	2015	AEM
MSM	Riau Islands	Province	7	3.1%	2,031,895	8.1%	570	7,044	AEM 2015	2015	AEM
MSM	Papua	Province	28	0.4%	3,486,432	8.3%	522	6,295	AEM 2015	2015	AEM
TG (waria)	East Java	Province	37	1.1%	38,529,481	42.8%	1,941	4,538	AEM 2015	2015	AEM
TG (waria)	West Java	Province	25	3.1%	46,300,543	31.1%	1,247	4,004	AEM 2015	2015	AEM
TG (waria)	Central Java	Province	34	1.5%	32,779,832	50.3%	1,533	3,049	AEM 2015	2015	AEM
TG (waria)	North Sumatera	Province	32	1.5%	13,527,937	37.0%	1,103	2,981	AEM 2015	2015	AEM
TG (waria)	DKI	Province	6	1.4%	10,135,030	62.2%	972	1,562	AEM 2015	2015	AEM
TG (waria)	Papua	Province	28	0.4%	3,486,432	37.9%	385	1,016	AEM 2015	2015	AEM

TG (waria)	Riau Islands	Province	7	1.1%	2,031,895	37.0%	370	1,001	AEM 2015	2015	AEM
PWID	West Java	Province	25	1.5%	46,300,543	40.5%	5,644	13,925	AEM 2015	2015	AEM
PWID	East Java	Province	37	1.1%	38,529,481	50.8%	6,312	12,427	AEM 2015	2015	AEM
PWID	DKI	Province	6	1.4%	10,135,030	75.6%	5,699	7,534	AEM 2015	2015	AEM
PWID	Central Java	Province	34	1.1%	32,779,832	41.3%	1,823	4,417	AEM 2015	2015	AEM
PWID	North Sumatera	Province	32	1.5%	13,527,937	44.5%	1,846	4,149	AEM 2015	2015	AEM
PWID	Riau Islands	Province	7	3.1%	2,031,895	44.0%	239	543	AEM 2015	2015	AEM
PWID	Papua	Province	28	0.4%	3,486,432	33.3%	1	3	AEM 2015	2015	AEM

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

				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	(#)	(#)	(#)
<b>Total population</b>	255,461,700	0.28%	691,040	166,975	50,400	71.3%	–	1,091,997	32,711	17,958
Population less than 15 years	66,930,965	0.03%	22,542	2,016	2,016	–	–	–	–	–
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	–	–	–	–	–	–	–
Military†	434,410	0.40%	1,738	1,298	384	–	–	28,333	697	56
Military††	434,410	0.16%	697	491	145	–	–	28,333	697	56

\* 2014 MOH Quarterly Report on HIV/AIDS (December 2014)

\*\* Estimated KP PLHIV based on 2015 Asian Epidemic Model

† Data based on 2012 IBBS among Indonesia military

†† Data based on 2014 MOH Report on HIV/AIDS Cases in Indonesia

Note: National number for "Ever initiated on ART" is 93,964

**Table 1.1.2.a Cascade of HIV diagnosis, care and treatment (12 months) for National Program by PEPFAR supported Provinces in 2014 (SNU)\***

PEPFAR Province	Total Population	Total PLHIV*	MSM Prevalence	TG Prevalence	DFS W Prevalence	IFSW Prevalence	PWID Prevalence	Tested for HIV	Diagnosed HIV Positive	Sero-positivity Yield	Ever Enrolled in Care**	Ever tested Eligibility for ART (CD4 ≤ 500)	Ever Initiated on ART	Newly initiated in 2014	Currently on ART
DKI Jakarta	10,135,030	115,444	29.4%	62.2%	13.2%	10.0%	75.6%	114,510	5,851	5.1%	36,378	26,075	21,647	6,183	12,488
Central Java	32,779,832	74,065	8.0%	50.3%	4.1%	1.7%	41.3%	113,494	2,867	2.5%	9,783	7,851	6,927	1,599	3,242
East Java	38,529,481	71,233	2.6%	42.8%	5.4%	2.8%	50.8%	94,352	4,508	4.8%	24,086	16,514	12,340	2,014	6,128
West Java	46,300,543	70,393	2.4%	31.1%	4.6%	1.9%	40.5%	231,810	3,740	1.6%	13,849	10,806	9,265	1,732	5,243
North Sumatera	13,527,937	26,118	8.1%	37.0%	14.4%	6.4%	44.5%	40,973	1,628	4.0%	8,963	6,137	4,701	496	2,336
Riau Islands	2,031,895	4,995	8.1%	37.0%	1.1%	0.5%	44.0%	30,349	973	3.2%	4,876	3,014	2,758	494	1,582
Papua	3,486,432	88,041	8.3%	37.9%	24.2%	8.1%	33.3%	47,505	3,278	6.9%	18,562	13,916	7,699	889	3,765
Total in PEPFAR-supported provinces	146,791,150	450,289	--	--	--	--	--	672,993	22,845	3.4%	116,497	84,313	65,337	13,407	23,308

\*National MOH Quarterly report 2014 September (cohort data from 2004 onward)

\*\*Total PLHIV in 2015 AEM by province is 733,550 instead of GARPR PLHIV of 691,040

**Table 1.1.2.b Cascade of HIV diagnosis, care and treatment (12 months) for National Program by PEPFAR-supported districts in 2014 (12 month period)**

PEPFAR Municipality/District	Total Population	Total PLHIV	MSM Prevalence	TG Prevalence	DFSW Prevalence	IFSW Prevalence	PWID Prevalence	Tested for HIV**	Diagnosed HIV Positive**	Newly Initiated on ART <sup>†</sup>	Currently on ART <sup>†</sup>
<b>Papua</b>											
Jayapura City	137,744	2,932	8.1%	36.5%	24.3%	6.4%	0.0%	11,743	764	222	-2
Jayapura District	315,872	11,958	8.2%	37.7%	21.2%	8.9%	0.0%	8,048	640	37	-7
Jayawijaya District	223,949	4,817	8.3%	32.1%	18.9%	8.8%	0.0%	6,072	448	349	-4
Mimika District	241,280	13,701	8.2%	45.2%	33.3%	7.3%	0.0%	6,082	141	-4-4	
	918,845	33,408						31945	1993	608	-0
<b>DKI Jakarta</b>											
Central Jakarta	2,841,728	26,618	29.4%	18.1%	0.0%	0.0%	75.6%	26,121	1,520	4434	5669
East Jakarta	2,407,170	27,102	27.8%	0.0%	8.4%	0.0%	71.1%	29,995	1,530	600	1454
North Jakarta	952,525	19,813	15.7%	60.8%	14.7%	0.0%	68.7%	14,624	692	312	1731
South Jakarta	1,735,968	18,764	55.2%	63.8%	22.4%	0.0%	97.8%	15,658	914	324	867
West Jakarta	2,175,400	3,333	0.0%	0.0%	0.0%	0.0%	68.7%	28,112	1,195	531	2742
	10,112,791	95,630						114510	5851	6201	12463
<b>East Java</b>											
Kendiri District	2,446,218	16,259	14.9%	44.7%	12.4%	0.1%	59.5%	6,985	157	67	116
Malang City	2,765,487	1,022	9.4%	37.8%	6.7%	2.2%	44.4%	4,520	359	317	804
Malang District	820,243	1,212	3.9%	41.8%	5.8%	3.5%	39.1%	5,456	218	117	168
Surabaya City	1,499,768	660	10.4%	30.8%	7.5%	2.2%	44.1%	27,254	1,293	827	2067
	7,531,716	19,152						44,215	2,027	1,328	3,155
<b>Central Java</b>											
Banyumas District	1,575,068	3,526	7.3%	45.3%	5.7%	1.4%	1.7%	3,867	246	183	303
Cilacap District	942,142	2,650	7.3%	45.3%	11.9%	1.4%	69.0%	2,341	107	41	115
Kendal District	505,461	3,799	7.3%	45.3%	11.9%	1.4%	174.1%	14,002	96	39	33
Semarang City	1,411,947	1,702	7.3%	45.3%	5.5%	1.4%	26.8%	5,612	351	284	802
Semarang District	911,355	1,438	7.3%	45.3%	11.9%	1.4%	79.7%	6,364	291	38	65
Surakarta District	1,573,593	1,480	7.3%	45.3%	11.9%	1.4%	9.6%	5,835	115	167	557
Tegal District	1,662,248	1,686	7.3%	45.3%	11.9%	1.4%	8.1%	13,700	152	44	35

	8,581,814	16,281						51,721	1,358	796	1,910
<b>West Java</b>											
Indramayu District	1,663,737	4,210	2.2%	26.4%	8.9%	1.7%	39.1%	5,791	481	162	501
Subang District	1,465,157	1,562	2.2%	26.4%	8.9%	1.7%	39.1%	9,350	247	105	116
	3,128,894	5,773						15141	728	267	617
<b>Riau Islands</b>											
Batam City	172,192	1,466	7.3%	33.3%	7.5%	0.2%	39.1%	11,115	647	309	947
Bintan District	226,716	1,538	7.3%	33.3%	7.5%	0.2%	39.1%	585	4	-	-
Tanjungpinang City	1,142,646	620	7.3%	33.2%	7.5%	0.3%	39.1%	8,549	204	127	312
	1,541,554	3,623						20249	855	436	1259
<b>West Papua</b>											
Sorong City	219,958	1,835	7.3%	33.3%	24.8%	4.4%	39.1%	9,465	373	-7-7	
Sorong District	81,486	1,386	7.3%	33.3%	24.8%	4.4%	-3,118	93	32	-2	
	301,444	3,221						12583	466	32	-2
<b>North Sumatra</b>											
Medan City	3,486,432	2,889	7.3%	33.3%	4.8%	5.7%	47.9%	18,588	1,217	467	2118
<b>Total 28 districts</b>											
	35,603,490	179,976						308,952	14,495	10,135	21,522

Note: These calculated prevalences are abnormally high. Need to review the estimates for the TG and the PWID population sizes

Note: Data not available currently. Data is reported aggregated at provincial level only.

\*\*2014 MoH HIV Annual Report (Jan-Dec 2014); Care enrollment and ART eligibility results by district not available

† GFATM Coverage Data (Jan-Dec 2014)

**Table 1.1.2.b Cascade of HIV diagnosis, care and treatment (12 months) for National Program by PEPFAR-supported districts in 2014 (12 month period)**

PEPFAR Municipality/District	Total Population	Total PLHIV	MSM Prevalence	TG Prevalence	DFSW Prevalence	IFSW Prevalence	PWID Prevalence	Tested for HIV**	Diagnosed HIV Positive**	Newly Initiated on ART†	Currently on ART†
<b>Papua</b>											
Jayapura City	137,744	2,932	8.1%	36.5%	24.3%	6.4%	0.0%	11,743	764	222	-
Jayapura District	315,872	11,958	8.2%	37.7%	21.2%	8.9%	0.0%	8,048	640	37	-
Jayawijaya District	223,949	4,817	8.3%	32.1%	18.9%	8.8%	0.0%	6,072	448	349	-

Mimika District	241,280	13,701	8.2%	45.2%	33.3%	7.3%	0.0%	6,082	141	–	–
TOTAL	918,845	33,408	–	–	–	–	–	31945	1993	608	–
<b>DKI Jakarta</b>											
Central Jakarta	2,841,728	26,618	29.4%	18.1%	0.0%	0.0%	75.6%	26,121	1,520	4434	5669
East Jakarta	2,407,170	27,102	27.8%	0.0%	8.4%	0.0%	71.1%	29,995	1,530	600	1454
North Jakarta	952,525	19,813	15.7%	60.8%	14.7%	0.0%	68.7%	14,624	692	312	1731
South Jakarta	1,735,968	18,764	55.2%	63.8%	22.4%	0.0%	97.8%	15,658	914	324	867
West Jakarta	2,175,400	3,333	0.0%	0.0%	0.0%	0.0%	68.7%	28,112	1,195	531	2742
TOTAL	10,112,791	95,630	–	–	–	–	–	114510	5851	6201	12463
<b>East Java</b>											
Kediri District	2,446,218	16,259	14.9%	44.7%	12.4%	0.1%	59.5%	6,985	157	67	116
Malang City	2,765,487	1,022	9.4%	37.8%	6.7%	2.2%	44.4%	4,520	359	317	804
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TOTAL	7,531,716	19,152	–	–	–	–	–	44,215	2,027	1,328	3,155
<b>Central Java</b>											
Banyumas District	1,575,068	3,526	7.3%	45.3%	5.7%	1.4%	1.7%	3,867	246	183	303
Cilacap District	942,142	2,650	7.3%	45.3%	11.9%	1.4%	69.0%	2,341	107	41	115
Kendal District	505,461	3,799	7.3%	45.3%	11.9%	1.4%	174.1%	14,002	96	39	33
Semarang City	1,411,947	1,702	7.3%	45.3%	5.5%	1.4%	26.8%	5,612	351	284	802
Semarang District	911,355	1,438	7.3%	45.3%	11.9%	1.4%	79.7%	6,364	291	38	65
Surakarta District	1,573,593	1,480	7.3%	45.3%	11.9%	1.4%	9.6%	5,835	115	167	557
Tegal District	1,662,248	1,686	7.3%	45.3%	11.9%	1.4%	8.1%	13,700	152	44	35
	8,581,814	16,281	–	–	–	–	–	51,721	1,358	796	1,910
<b>West Java</b>											
Indramayu District	1,663,737	4,210	2.2%	26.4%	8.9%	1.7%	39.1%	5,791	481	162	501
Subang District	1,465,157	1,562	2.2%	26.4%	8.9%	1.7%	39.1%	9,350	247	105	116
TOTAL	3,128,894	5,773	–	–	–	–	–	15141	728	267	617
<b>Riau Islands</b>											
Batam City	172,192	1,466	7.3%	33.3%	7.5%	0.2%	39.1%	11,115	647	309	947
Bintan District	226,716	1,538	7.3%	33.3%	7.5%	0.2%	39.1%	585	4	–	–
Tanjungpinang City	1,142,646	620	7.3%	33.2%	7.5%	0.3%	39.1%	8,549	204	127	312

	1,541,554	3,623	-	-	-	-	-	20249	855	436	1259
<b>North Sumatra</b>											
Medan City	3,486,432	2,889	7.3%	33.3%	4.8%	5.7%	47.9%	18,588	1,217	467	2118
<b>Total 26 districts</b>											
TOTAL	35,302,046	176,755	-	-	-	-	-	296,369	14,029	10,103	21,522

Note: These include all 26 districts where PEPFAR supported in FY14

\*\*2014 MOH HIV Annual Report (Jan-Dec 2014); Care enrollment and ART eligibility results by district not available

† GFATM Coverage Data (Jan-Dec 2014)

## 1.2 National Investment Profile

Funding for HIV programs in Indonesia comes from several domestic and external sources. The national response is predominantly financed by the Ministry of Health mostly finances operational costs at health facilities, base staff salaries, HIV test kits and reagents, and 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 JKN. The GOI thus finances a substantial share of HIV-related treatment costs, however, GOI funding for prevention other than ART is minimal. At present, civil society organizations (CSOs)/nongovernmental organizations (NGOs) are unable to be funded for salaries or operational costs from GOI internal funds, thus funding for these key stakeholders in the national response to HIV have been from international donors, most significantly from PEPFAR, DFAT and the GFATM.

In the past, funding from international resources has been used to support prevention strategies and activities while the GOI covers the bulk of the treatment costs for the national response to HIV. In 2012, the GOI contributed about 29% of the total prevention budget (or about USD 6.8 million). In the 2015-2019 SRAN (National Strategy and Action Plan), prevention is estimated to cost around USD 65 million (accounting for 62% of total resource need), and increase to USD 75.4 million in 2016 (57% of total) and USD 78 million in 2017 (54% of total). Though current prevention spending is still being collected through the 2014 National AIDS Spending Assessment (NASA) exercise, a review of the 2012 NASA indicates that the bulk of prevention funding came from international development partners (71% in 2012).

Though recent data after 2012 on prevention spending is not yet available, it is instructive to look at 2011-2012, the most recent years for which data is available (NASA 2013). Although the prevention gap was USD 81 million in 2011 and USD 91 million in 2012, it was far higher than the treatment gap for these same years at USD 39 million in 2011 and USD 38 million in 2012. Resource needs for treatment for 2015-2017 will be USD 40 million in 2015, rising to USD 52.6 million in 2016 and to USD 66 million in 2017 (unpublished National AIDS Program Strategy (NASP), 2015-2019).

According to the unpublished 2015-2019 NASP, total funding needed for the HIV program from all sources in 2014 - 2017 is USD 459.1 million. With an estimated USD 312.3 million being available, current and anticipated resources covering government and donor support to meet the funding requirement of the NASP remain inadequate. Out of this available resource, the GFATM contribution is more than 50% of the total funding, while other bilateral and multilateral sources accounting for less than 25% (or an average of USD 43.9 million each year). This leads to a financial gap of around USD 162.13 million for the period of the NASP (2015 to 2019).

**Table 1.2.1 Investment Profile by Program Area\***

<b>Program Area</b>	<b>Total Expenditure</b>	<b>% PEPFAR</b>	<b>% GFATM</b>	<b>% GOI</b>	<b>% Other Donors</b>
Clinical care, treatment and support	\$ 29,433,833.93	\$ 304,816.00	\$ 9,830,295.23	\$ 13,208,499.92	\$ 6,090,222.78
Community-based care	\$ 522,515.45	\$491,210.37	\$ 10,564.66	\$ 14,195.23	\$ 6,545.19
PMTCT	\$ 611,301.97	\$ 334,149.55	\$ 93,531.82	\$ 125,674.26	\$ 57,946.34
HTC	\$ 2,022,221.13	\$ 438,870.03	\$ 534,340.32	\$ 717,967.66	\$ 331,043.12
VMMC	-	-	-	-	-
Priority population prevention	\$24,613,833.34	\$ 2,480,533.00	\$7,469,413.51	\$ 10,036,295.50	\$ 4,627,571.33
Key population prevention	\$ 10,136,000.76	\$ 2,065,334.00	\$ 2,723,642.70	\$ 3,659,629.08	\$ 1,687,394.98
OVC	\$ 25,455.34		\$ 8,590.52	\$ 11,542.68	\$ 5,322.14
Laboratory	\$ 633,949.20	\$ 250,549.43	\$ 129,387.57	\$ 173,851.93	\$ 80,160.27
SI, Surveys and Surveillance	\$ 4,768,429.85	\$ 2,075,502.00	\$908,793.97	\$ 1,221,103.21	\$ 563,030.67
HR					
HSS					
Other	\$ 16,949,197.37	\$ -	\$ 5,719,918.69	\$ 7,685,582.55	\$ 3,543,696.13
<b>Total</b>	<b>\$89,716,738.34</b>	<b>9%</b>	<b>31%</b>	<b>41%</b>	<b>19%*</b>

**Table 1.2.2 Procurement Profile for Key Commodities**

Commodity Category	Total Expenditure	% PEPFAR	% GFATM	% GOI	% Other
ARVs	\$ 18,737,342.35	\$ -	\$ -	\$ 18,737,342.35	
Rapid test kits	\$ 1,694,918.93	\$ 111,567.84	\$ 534,340.32	\$ 717,967.66	\$ 331,043.12
Other drugs	\$ 1,775,445.56	\$ 116,868.49	\$ 559,727.15	\$ 752,078.74	\$ 346,771.18
Lab reagents		\$ -	\$ -	\$ -	\$ -
Condoms	\$ 1,220,706.64	\$ 80,352.87	\$ 4,840.10	\$ 517,091.33	\$ 238,422.34
VMMC kits	\$ -	\$ -	\$ -	\$ -	\$ -
Other commodities			\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 23,428,413.48</b>	<b>\$ 308,789.19</b>	<b>\$ 1,478,907.57</b>	<b>\$ 20,724,480.08</b>	<b>\$ 916,236.63</b>

*\*Note: Data in the NASA 2012 is not disaggregated to this level. These numbers were calculated based on proportions from an unpublished disaggregation of the 2008-2010 NASA report*

**Table 1.2.3 Internal USG Program Integration and Leveraging**

	<b>Total Investment</b>	<b>Leveraged Funds</b>	<b>PEPFAR In-country Contribution</b>	<b># of IMs</b>	<b>Notes</b>
USAID MCH	\$20,000,000	\$500,000	\$500,000	1	
USAID Family Planning & Reproductive Health	0	0	0		
USAID TB	\$12,000,000	\$4,684,000	\$600,000	5	
CDC – Global Health Security	0	0	0	0	
NIH			0	0	
FDA			0	0	
Private Sector PPP Contributions				0	
PEPFAR Central Initiatives				0	
<b>Total FY 15</b>	<b>\$32,000,000</b>	<b>\$5,184,000</b>	<b>\$1,100,000</b>	<b>5</b>	

### 1.3 National Sustainability Profile

The GOI is the clear leader of the national response, and continues to increase its financial commitment to the response. PEPFAR/Indonesia collaborates with and supports GFATM-funded activities, particularly by providing the highly skilled, technical assistance needed to develop models, such as the Continuum from Prevention to Care and Treatment, which was designed and tested by the Scaling Up for Most at Risk Populations project. In addition, the Technical Assistance activity areas reflect the Sustainability Index Dashboard or SID prioritization for Core, Near Core and Non-Core activities (SID areas bolded in parentheses after the activities below).

In COP15, PEPFAR/Indonesia focuses on sustainability and efficiencies through support for following activities aimed at strengthening the national program response:

- Continuum of Prevention, Care and Treatment for KP in Jakarta and PP in Papua (**Access and Demand; HRH; Domestic Resource Mobilization – Resource Commitment**)
- SUFA/Decentralization of ART (**Access and Demand; HRH, Quality Management**)
- Strategic Information including SNU program data M&E, surveillance and size estimation, operations research (**Epidemiology; Performance Data**)
- CSO Capacity Building for KP/PLHIV service providers and KP/PLHIV Networks (**Access and Demand; HRH; Policies, Laws, Regulation, Performance Data; Domestic Resource Mobilization – Resource Commitment**)
- Enabling Environment including stigma and discrimination activities, local policies/regulations (**Policies, Laws, Regulation, Domestic Resource Mobilization – Resource Commitment**)
- Condom availability and local Supply Chain for HIV Drugs (**Access and Demand; Commodity Security/Supply Chain**)
- Labs and Medicine Quality (**Quality Management**)
- Military Hospitals and Prevention (**Quality Management, HRH; Domestic Resource Mobilization – Resource Commitment**)

### 1.4 Alignment of PEPFAR investments geographically to disease burden

1.4.1 and 1.4.2 compare PEPFAR expenditures in 2014 to burden of disease by province. FY 2014 Expenditure Analysis (EA) data show that PEPFAR/Indonesia invested funds in 26 of 34 provinces, with an average of \$12.62 per PLHIV. However, in 16 of these provinces, there were no expenditures by PEPFAR partners besides the Indonesian Partnership Fund (IPF), which is a grant to the National AIDS Commission (NAC). Most of the training expenditures were reported by IPF resulting in the minimal amounts in provinces we don't otherwise work in. As part of the EA, partners were asked to report expenditures not simply by SNU where these occurred, but also by benefit. This is particularly important for expenditures related to training since partners were asked to tag training-related expenditures not to where the training was held, but instead where the participants came from. For instance, if training was held in Jakarta but participants came

from five other provinces, the training related expenditures are tagged to the five other provinces, and not Jakarta. The thinking here was that the participants would return to their provinces and the knowledge gained from the training will benefit the provinces.

The EA also looked at all other partner training expenditures to see if this could potentially be an issue in overall expenditures, but this does not appear to be significant. Two additional provinces, Bali and Riau, also have expenditures related to SCMS for 2014. Both the issues with SCMS and the IPF have been discussed and will be addressed in upcoming work plans so that COP15 activities will be focused selectively in the seven priority provinces.

Figure 1.4.1 - There are several considerations to keep in mind when reviewing this graph; (1) # of PLHIV includes ALL PLHIV; however, expenditures only include PEPFAR resources. Hence, there is not a one-to-one relationship between resources and beneficiaries as is more likely the case for a TA/TC country. In order to understand the relationship between resources and beneficiaries, it would be necessary to include all funding streams for the national response, including domestic national and local government resources, other development partners' resources such as DFAT, the UN family and GFATM; (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); and (3) low volume typically drives expenditure per PLHIV up while high volume drives it down (i.e. Jakarta has low expenditure per PLHIV while Riau Islands has high expenditure per PLHIV).

The important matter for discussion and interpretation was whether the range of spending per PLHIV of \$0.72 to \$36.10 is reasonable for PEPFAR Indonesia. The high cost of doing business in Papua per PLHIV (\$31.72) reflects the distance from the center (air travel), lack of infrastructure in the province, limited human resource capacity, etc. Conversely, for Riau islands, the number of PLHIV may be underestimated given the sex work mobility dynamics that drive the province's economy, therefore driving up the cost to \$36.10. USG activities in the province focus on addressing Sex Worker mobility in Indonesia, including developing model interventions for the provision of care and treatment for HIV+ FSW who are only temporary residents.

Figure 1.4.1 provides a comparison of total expenditures and total PLHIV. It is essentially the same as Figure 2, however, it doesn't control for population size differences. Also, it only includes provinces where PEPFAR will be working in in COP 15.

Figure 1.4.2 sorts spending per PLHIV from largest to smallest by SNUs and graphed it compared to the national level. However, adding the SNU total expenditures does not equal the total expenditures at the national level because the total national expenditure includes all SNU expenditures in addition to any above site-level expenditures tagged to the national level (i.e. HSS expenditures tagged to national).

Overall, expenditures show that 31.2% of expenditures occurred at the National level, with 16.6% expended at above-National level. (i.e., PEPFAR dollars spent outside of Indonesia). For instance, an international NGO with a home office in DC has a finance person who spends 5% of his/her time supporting the field office in Indonesia with finance and admin work). Fifty-seven percent

(57%) was spent in all SNUs of which the major portion (85.4%) was spent in the 7 priority provinces for COP15. One anomaly was the amount spent in the Special Region of Yogyakarta which amounted to 1.1%. While some of this can be explained by the support to the military by DOD, the EA reports that one of USAID's main partners reported significant expenditures in a site where there is no programming. This expenditure was for three TA organization partners that provided in-house training and coaching for SUM II CSO partners in SUM II project sites. Since the three TA organization partners were all based in Yogyakarta, the partner recorded expenditures under the Special Administration Province of Yogyakarta. In the future, we will ensure staff expenses are attributed to the appropriate location. Another outlier is Bali which was due to collaboration between USG, DFAT and the GOI on where to pilot district SCMS activity. The decision was made to work in SCMS in two provinces - one USG-focus province and one DFAT-focus province (Bali).

With the focus on KP and Papua, the results demonstrated that the highest level of expenditures provincially occurred in Papua (30.3%), followed by DKI/Jakarta (7.8%) and East Java (5.8%).

As with the spending per PLHIV and prevalence, further analysis were conducted to look at expenditures related to the focus on KP and Papuans. Twenty two percent of expenditures were spent on KP prevention - MSM (7.4%), SW (12.4%), PWID (2.6%) (DFAT historically funds most PWID activities); and 19.6% on GP prevention with 66% in Papua and 32% at the National/Above National level, likely through the IPF. Further discussions will be needed with IPF to better allocate these funds in 2015.

HTC represented 4.8% of the expenditures, but 84.5% was appropriately targeted to the provinces. The percentages for the SNU are similar for CBCT and FBCT, and PMTCT (for Papua). Future consideration needs to be given to the relative funding for the EA categories as part of the cascade. Surveillance accounted for 13.8% of the budget and HSS SI for 8.7% reflecting support to improve capacity at the center for national IBBS, size estimation of KP and PLHIV and M&E efforts.

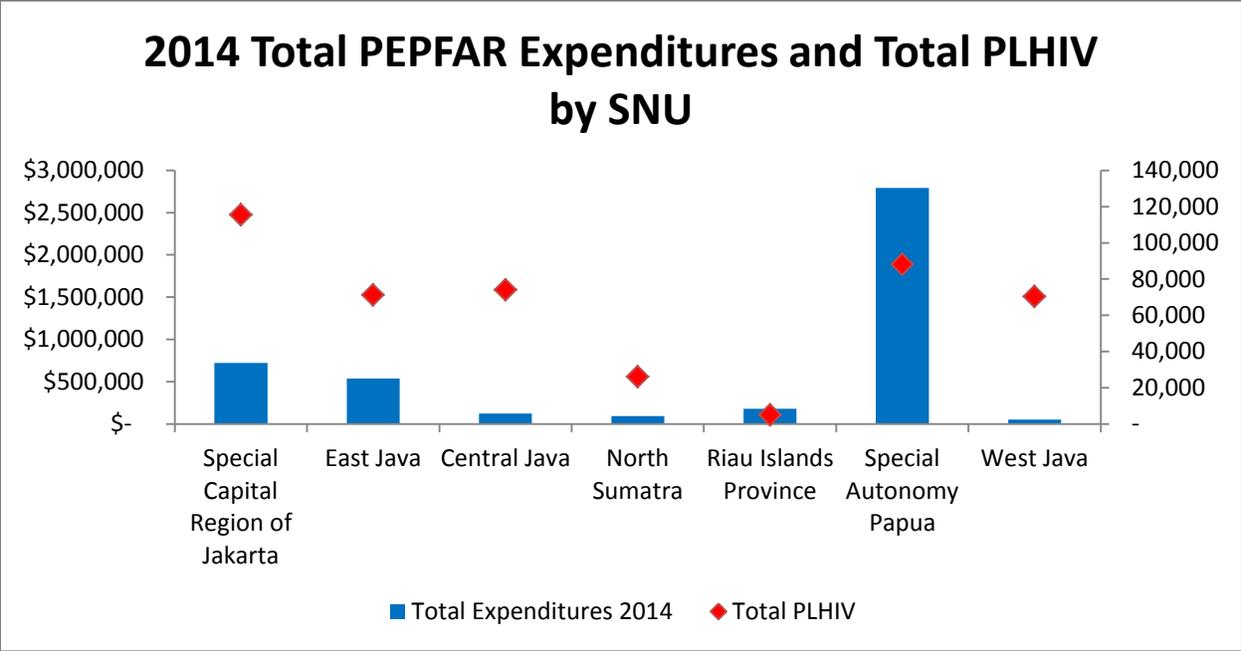


Figure 1.4.1

## 2014 PEPFAR Spend per PLHIV by SNU

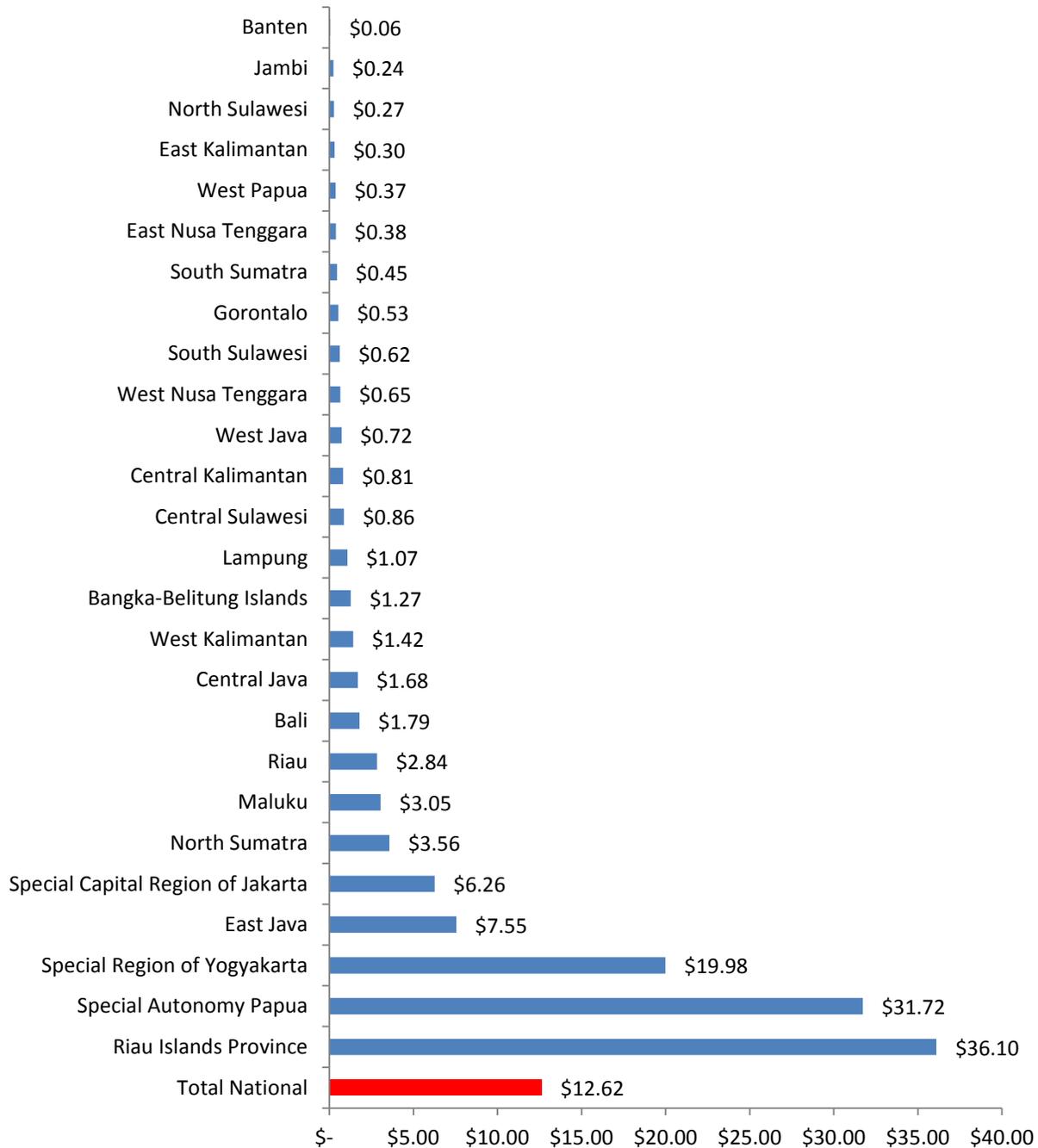


Figure 1.4.2

### 1.5 Stakeholder Engagement

1. Host country government(s)

The small PEPFAR/Indonesia team worked closely with the MOH, National AIDS Commission (NAC), local civil society, and the other donors and development partners in the development of the FY15 COP. Over the course of many years, the PEPFAR team agencies have established consistent communication with their counterparts in the GOI, having worked with them on previous year COPs. For the FY15 COP, U.S. Agency for International Development (USAID) consulted with Dr. Siti Nadia Tarmizi, head of the National AIDS Program (NAP) at the MOH and Dr. Kemal Siregar, head of the NAC, and their teams regarding proposed activities that the USG would undertake to support the new National Strategic Plan, including geographic prioritization, the focused population priorities and the types of activities that would be undertaken. The discussion also centered on how USG activities would coordinate with proposed activities under the in-development GFATM Concept Note since the MOH and NAC are two of the proposed Principle Recipients. The consultations also addressed specifics regarding TA provided to each of these entities (i.e., the placement of the Surveillance Advisor at the MOH and the possible M&E mentorship support for MOH/NAC staff, support for the NAC through IPF and how this should be targeted toward outcomes). The USG team obtained MOH and NAC concurrence on the activities proposed, and shared the final draft of the plan with Drs. Nadia and Kemal. Both also participated in the FY15 COP review held in Bangkok, Thailand in early May 2015.

As the other USG PEPFAR implementer, the Department of Defense (DOD) through the Office of Defense Cooperation (ODC) focuses on technical assistance and training for prevention, care and treatment and M&E of HIV with the Ministry of Defense (MOD) and the Indonesian Military (TNI). The provided technical assistance and training are to support the national HIV program based on MOH guidelines and it is in coordination with NAC.

The productive on-going relationship between USG and the GOI has laid the groundwork for establishing a future Country Health Partnership (CHP) with the host government, if this is determined to be something that PEPFAR/Indonesia must complete in the coming year. Together, the GOI and USG will be able to agree upon processes and structures for joint decision-making on PEPFAR resource allocation. USG program results and financial data are already shared with GOI. USG support to MOH and NAC in the areas of surveillance and M&E will assist the GOI in achieving more transparent and data-driven decision-making. Discussions have been initiated with the NAC regarding the IPF to promote mutually accountable measures of progress through clear indicators, benchmarks or milestones, and identify what those are. The GOI supports the USG activities at both the national (above-site) level and in the prioritized districts as these are aimed at increasing the commitment of local domestic resources to services or system support that directly benefit control of the HIV/AIDS epidemic.

## 2. GFATM and other external donors

The GFATM is an essential partner and important complement to the PEPFAR program. USAID staff participate as members of the country coordinating mechanism (CCM), CCM Oversight Committee and on each of the technical working groups. Through the CCM, the USG in Indonesia is deeply involved in GFATM Concept Note (CN) development under the New Funding Model. The USG support a Global Fund Liaison (GFL) position. The GFL plays a key role in supporting both USG and GFATM investments in the country, and serves as a useful conduit for keeping USG informed and updated about developments on the ground, within the CCM and Principal Recipients (PRs), and more strategically, in terms of changes to and directions of GFATM policy and practice. The liaison plays a key role in the smooth functioning of the GFATM

CCM, the CCM secretariat, and is a key resource for the PRs and Technical Working Groups. The liaison also plays a critically important role in ensuring USG programs are coordinated with GFATM grants and in facilitating communication with the Indonesia Fund Portfolio Manager. As such the COP is more effectively targeted to meet the needs of the national response.

This year, the COP15 planning cycle overlapped with the Indonesian CN development process; the COP being due for submission on April 3, 2015 and the CN submission due on April 1, 2015. While the concurrent submission deadlines significantly increased the pressure on all parties, the direct involvement of the GFL and the MOH Surveillance assignee to the NAP as well as other USG staff, in both the GFATM and COP processes helped assure the alignment and coordination of the proposed CN and COP15 activities.

The development partner community in Indonesia is small, allowing PEPFAR/Indonesia to establish close working relationships with these entities. USG collaborated closely with multilateral partners (including UNAIDS and WHO) in Indonesia and utilized the Country Coordinating Mechanism (CCM), as one of the key ways that USG resources can be more effectively targeted to support the national response. The staff met with UNAIDS and WHO representatives to discuss the focus for COP15 in light of the GFATM CN submission. This close collaboration enabled USG to more clearly identify which activities are best funded through the GFATM, and which through the GOI and/or multilateral partners, as well as through PEPFAR. This approach both avoids duplication of effort and improves technical and allocative efficiency in health financing and services provision.

DFAT has been an important donor for HIV in Indonesia, but recently announced cuts to Australia's foreign assistance budget may result in a significant reduction, or complete elimination, of their support for HIV in Indonesia. It is unknown at this time the extent to which they will continue to support elements of the HIV response in Indonesia. PEPFAR/Indonesia will continue to coordinate closely with DFAT to ensure complementarity of investments in support of the national strategy.

### 3. Civil Society

PEPFAR/Indonesia has historically had a good relationship with civil society organizations in Indonesia, with the limited group of academia, community-based organization (CBO) and network partners responding from requests from the team

The team undertook two separate consultations. The first, on February 20, 2015, was with a group of six CSOs who are supported through current PEPFAR funding and work in several of the priority provinces/districts. The second meeting engaged CSOs who do not currently receive PEPFAR funding and represented academia (3) and national key population and PLHIV networks and NGOs (6). This second group included activist and advocacy groups including groups representing key affected populations, - LGBT/gender and sexual minority, drug user networks, and sex worker organizations- the HIV/AIDS NGO Association and two National PLHIV associations.

During the first meeting, the CSOs provided the PEPFAR team with feedback related to weakness and challenges related to national and activities, such as the rollout of SUFA in the provinces, local interpretation of policy issues related to national health insurance coverage for HIV testing and clinical care, local closures of SW venues and restrictions on condom sales, and issues related to data quality/reporting and data sharing between CSOs and health authorities.

The team decided to use the second PEPFAR COP consultation to engage with civil society in a discussion of how they would like to be engaged throughout PEPFAR's programming cycle, not simply brought in to provide input during an annual COP consultation process. The team conducted a presentation on PEPFAR and its history in Indonesia, including the COP process and how to access past Indonesia COPs on [pepfar.gov](http://pepfar.gov) - no one had ever seen a COP - and the new focus on accountability and transparency. This was followed by a Q&A on PEPFAR. The organizations were asked to help develop the Civil Society Engagement Plan, and asked to provide ideas via email as to how they wanted to see ongoing engagement and dialogue throughout the year (COPs development, reviews, APR/SAPR reviews, ongoing program monitoring and evaluation, etc.). This is Step 1 in developing the Civil Society Engagement Plan. To date, feedback has been received via email from four of the attendees as well as from notes taken during the meeting.

Thus far, the consensus from the group has been to:

- Base the relationship between PEPFAR and CSOs on an equal partnership approach
- Outreach as far as possible. Ensure inclusion and engagement of the community most affected by the epidemic (PLHIV, SW, Gay, Transgender, and drug user). Define CSO broadly to include:
  - National AIDS Affected Network (IPPI, PKNI, GWL-Ina, OPSI)
  - Other AIDS service and advocacy NGOs
  - Academics
  - Other small unregistered communities or forums
- Conduct various types of meetings; regular face-to-face meetings, and meetings via webinar. Have a thematic issue to ensure the meetings are focused. Whenever possible, encourage the community as program beneficiaries to bring documentation related to PEPFAR supported programs that they are involved in, or they know run in their city.
- Publicize projects supported by PEPFAR including the objectives and indicators of success to create more transparency on using development assistance. All this information needs to be easily accessible to the public (website, or Facebook page etc.)
- Utilize ICT platform to ensure CSOs around Indonesia have equal opportunity to participate on the discussion and process. Use existing ICT maps and ICT platforms including: WhatsApp messenger, Facebook page Google Plus+, Live streaming mobile station, webinar software, smartphone mobile applications and of course website.
- Prevent a dependency on foreign aid. Support needs to be replicable by others project/city/provinces and have a high possibility of government buy in to the project in the future.
- Prioritize community monitoring and evidence informed advocacy as these have been less funded in the past. These two interventions actually have a strong connection with quality improvement of service delivery and to increase domestic spending to fund HIV and AIDS response.
- Help address stigma and discrimination, including in key populations, e.g., support for first Indonesia Stigma Index

The PEPFAR/Indonesia team has taken this feedback, utilized it in the planning process, will share it with implementers, and create a draft CSO Engagement Plan for comment. The team will meet after the COP approval to determine how best to address the CSO concerns for engagement given staffing bandwidth. After Headquarters has cleared the SAPR and APR, these results will be

shared with civil society groups as part of the ongoing outreach process. As in the military, the association with CSOs is important to build trust between civilian and military hospitals in gaining access to health services in addition to general hospitals. Civil Society also participated in the FY15 COP review held in Bangkok, Thailand in early May 2015.

#### 4. Private Sector

**Historically, the private sector has not participated in the National HIV Response in Indonesia in a substantive way. However, three private clinics, namely, Ruang Carlo, Clinic Angsamerah and Calvary Clinic, target MSM and FSW and are conducting PreP Operational Research.**

## 2.0 Core, Near-Core and Non-Core Activities

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Per the COP Guidance for Targeted Assistance Countries and those supported through Regional Programs, Indonesia is receiving specific support for key populations and priority technical areas. USG activities largely support capacity building and technical assistance, and also provide direct services for key populations.

With limited PEPFAR funds, the determination of core, near-core and non-core activities reflects the priorities in the Sustainable Index Dashboard (SID). The resulting activities include very limited direct service delivery focused on innovations, demonstrating best practices, and assisting the country in ensuring their response is strategic, data-driven, and state-of-the-art for Key populations and ethnic Papuans in selected geographic areas. The activities also reflect support for national and sub-national above site work aimed at strengthening critical health systems, supporting the development or implementation of health financing schemes and creation of an enabling environment. The PEPFAR/Indonesia team designed their approach to this exercise 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 is the primary goal of PEPFAR programs. The team has taken into account the sustainability of the activities in partnership with national and local governments, civil society, and other development partners, including UNAIDS and the GFATM. See Appendix A for full list of core, near-core, and non-core activities.

## 3.0 Geographic and Population Prioritization

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Based on Indonesia's epidemiologic data, PEPFAR is focusing its efforts in the top 2 provinces (DKI Jakarta and Papua) which represent 28% of the PLHIV burden nationally. This is a reduction in the number of provinces from 8 to 2 when compared to COP 2014. DKI Jakarta, with its 104,595 PLHIV, represents 16% of the national of PLHIV and Papua follows with 80,035 PLHIV and represents 12% of the national HIV burden.

In Jakarta, PEPFAR will work in 5 of the 6 districts where 91% of PLHIV are located. These districts are North Jakarta, Central Jakarta, South Jakarta, East Jakarta and West Jakarta.

In Papua, PEPFAR will concentrate in 3 districts (Jayawijaya, Jayapura and Mimika). Within Papua, these three districts account for 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%.

ART coverage in these provinces (based upon the assumption that all PLHIV need to initiate ART and upon the Strategic Use of Antiviral Use (SUFA) initiative) ranges from 4.3% in Papua to 10.8% in DKI/Jakarta which reflects high unmet need.

According to the AEM, these two provinces also represent 14% of DFSW nationally with a pooled HIV prevalence of 15% (range 3.2% – 24.4%) - higher than the national average of 7.0% for DFSW; for IFSW, 24% of the total population estimate, nationally with an HIV prevalence rate of 9.9% versus the national average of 1.6%; for waria/TG, 7% of the national size estimate with an HIV prevalence rate of 52.6% (31.1% - 62.2%) versus the national rate of 21.9%. For MSM, 3% of the national population estimate with an HIV prevalence rate ranging from 25.6% in DKI/Jakarta to around the national average of 8.48% in the other provinces. PWID in the focus provinces represent 10% of the national total, with a prevalence rate of 75.6% (range 33.2% - 75.6%) versus the national rate of 41.2%.

The geographic choices are also based on one of the highest priorities in the SRAN 2015-2019 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 rollout districts where TA provision will play a vital role in success in reaching KP and getting them into the cascade.

As a result of this analysis and the country context, PEPFAR/Indonesia has prioritized an appropriate mix of core activities within these provinces which represent 19 % of Indonesia's total PLHIV burden.

The military program will focus on 4 military hospitals in Jakarta, West Java, and East Java. These provinces account for 30 % of the total military population in Indonesia.

## 4.0 Program Activities for Epidemic Control in Priority Locations and Populations

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### 4.1 Targets for priority locations and populations

Although the numbers of PLHIV currently on ART have dramatically increased in recent years, treatment coverage in Indonesia remains low. Treatment targets in the national 2015-2019 strategy called for 50% of people living with HIV 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. With the recent roll out of SUFA, it is stipulated that key populations who are diagnosed as positive are to enter into treatment immediately regardless of CD4 count. However, the time lapse between diagnosis to referral and initiation of ART among KPs for the national program is still unknown and there is no data on the proportion of KP currently on ART, nor any data for retention and 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.

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. No national data is available on the coverage rate for HIV testing among KPs reached. Furthermore, consistent condom use continues to be low among KPs with a third of FSW using condoms during commercial sex in the past week, 24% among MSM and 41% among waria.

In FY2016, PEPFAR/Indonesia will continue to accelerate the roll out of the National Condom Strategy, including condom promotion and use among high risk groups. As a result of PEPFAR's technical support, the number of commercial and subsidized condoms sold and distributed in 2014 was almost 200 million (199,090,482), a significant increase from 2010 (125 million), the year before PEPFAR's technical assistance began.<sup>17</sup> In addition, PEPFAR funds have resulted in a significant increase in quality of condom services at facilities, with 40 health centers achieving 100% of the basic quality assurance criteria, reported no stock outs, and doubling the numbers of condoms distributed through these outlets from 2012 in PEPFAR supported sites.<sup>18</sup> Targeted technical assistance for implementation of the condom social marketing strategy remains a priority for PEPFAR/Indonesia in COP15 in the priority PEPFAR provinces.

During FY2016 PEPFAR will place greater emphasis on increasing the number of KP provided with HIV testing and counseling services, and enrolled on ART. CSOs located in priority districts will continue to provide comprehensive package of prevention services for KP, but outreach will be better targeted and referrals to health facilities at sub district level for HIV testing will be intensified. In FY14, 37% of all KP reached by PEPFAR prevention services received HIV testing and result within the past 12 months (with a 9.4% sero-positivity yield among KP). In FY15 and FY16, PEPFAR/Indonesia will intensify HIV case finding and projects a 90% coverage rate for HIV testing among those reached by PEPFAR program among KP. PEPFAR-funded CSOs will also strengthen coordination with selected Puskesmas by placing a full time community-based peer outreach worker and/or case manager in these public facilities to enhance linkages from outreach to testing, and case management among those tested positive.

Unfortunately, the umbrella care indicator (C2.1.D—individuals receiving a minimum of one care service) was discontinued in FY2014 and therefore the results were not tracked. However, based on past performance (prior to 2013) and PEPFAR's focus in the improvement of the clinical cascade in FY16, community-based care targets (CARE\_COMM) were set such that 75% of those tested positive will be enrolled into community-based care services provided by PEPFAR-funded CSOs to ensure that individuals are linked to clinical services in public hospitals and clinics where ART are provided, and those who are on ART are adhering to treatment.

After the successful introduction/support of KP-friendly private clinics to provide comprehensive clinical services (including the initiation of ART)in DKI Jakarta, PEPFAR will continue to strengthen the linkages of CSOs and these clinics and the direct provision of ART services will increase from 71 PLHIV in FY14 to 1,237 in FY16 (please see Table 4.1.1). One of the two private clinics (Ruang Carlo) has seen an exponential increase of HIV testing among MSM/TG over the

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<sup>17</sup> Nielsen Retail Marketing Reports, 2010-2013 and PEPFAR FY14 APR

<sup>18</sup> FY14 APR

past year (from 4,670 in 2013 to 10,768 in 2014)<sup>19</sup> as a result of innovative recruitment methods using social media (promotional video/short film posted on YouTube) and almost all recently diagnosed PLHIV are placed on ART shortly after. Furthermore, technical support will be provided to one FBO clinic in Papua for clinical care and ART services in FY16 for FSW and general population. FY14 was the first year in which PEPFAR/Indonesia supported the use of private clinics for ART initiation. Due to initial startup costs and the small number of individuals who were initiated on treatment in FY14, the unit expenditure (UE) per PLHIV on ART was higher than expected. However, given the increasing projected number of individuals who will be on treatment in FY15 and FY16, the expected unit cost will decrease substantially in future years.

**Table 4.1.1 ART Targets in Priority Sub-national Units (SNU) for Epidemic Control**

Sustained Sites	Key or Priority Population	Tested for HIV (FY16) (LINKAGES)	Tested for HIV (FY16) (DERAP)	Identified Positive (in FY16)*(LINGKAGES)	Identified Positive (in FY16)*(DERAP)	Enrolled on ART (in FY16)** (LINKAGES)	Enrolled on ART (in FY16)** (DERAP)
Klinik Kalvari	All KP/PP	282	188	53	35	0	0
PKR Kotaraja	FSW/MSM	537	358	101	67	0	0
Puskesmas ABEPURA	FSW/PP	132	199	25	37	0	0
Puskesmas ASOLOGAIMA	PP	68	101	13	19	0	0
Puskesmas HAMADI	PP/FSW	97	145	18	27	33	22
Puskesmas HOM-HOM	PP/FSW	383	574	72	108	0	0
Puskesmas KOTARAJA	PP/FSW	222	333	42	63	75	50
Puskesmas WAENA	PP/FSW	160	240	30	45	0	0
Puskesmas WAMENA KOTA	KP/FSW	0	1167	0	219	0	0
RS Mitra Masy.Timika	PP	0	215	0	40	35	23
RSU Abepura	All KP/PP	508	762	95	143	171	114
RSU Jayapura	All KP/PP	1872	802	352	151	436	291
RSUD Kab. Mimika	All KP/PP	169	253	32	48	57	38
Angsamerah	MSM/FSW	202	50	38	9	41	27
Kios Atma Jaya	PWID	800	533	150	100	218	145
Klinik YKB	FSW	87	22	16	4	0	0
Lapas Kelas 1 Cipinang	PWID	561	841	105	158	0	0
PKBI Jakarta Timur	FSW	0	428	0	80	0	0
Puskesmas LIMAU ASRI	PP/KP	101	151	19	28	0	0
Puskesmas TIMIKA KOTA	PP/FSW	0	215	0	40	35	23
Puskesmas Cengkareng	PWID/FSW	799	1199	150	225	269	179
Puskesmas Ciracas	FSW	359	539	67	101	0	0

<sup>19</sup> Ruang Carlo 2014 Clinical data (partially reported to PEPFAR proportionate to funding)

Puskesmas Gambir	PWID	192	288	36	54	65	43
Puskesmas Grogol Petamburan	FSW	398	596	75	112	134	89
Puskesmas Jatinegara	FSW/MSM	145	218	27	41	49	33
Puskesmas Johar Baru	FSW	0	189	0	35	0	0
Puskesmas Kebayoran Baru	MSM/FSW	128	193	24	36	0	0
Puskesmas Kebon Jeruk	FSW/MSM	593	890	112	167	0	0
Puskesmas Kramat Jati	FSW	549	824	103	155	185	123
Puskesmas KWAMKILAMA	PP/FSW/KP	101	151	19	28	34	23
Puskesmas Pancoran	MSM/PWID	209	314	39	59	0	0
Puskesmas Pasar Minggu	PWID	169	253	32	48	57	38
Puskesmas Pasar Rebo	MSM/TG	879	586	165	110	239	159
Puskesmas Penjaringan	FSW	0	1248	0	235	204	136
Puskesmas Senen	FSW	480	720	90	135	161	108
Puskesmas Setia Budi	PWID	0	571	0	107	93	62
Puskesmas Taman Sari	FSW	145	217	27	41	49	32
Puskesmas Tambora	PWID	0	1094	0	206	179	119
Puskesmas Tanah Abang	PWID/FSW	110	165	21	31	37	25
Puskesmas Tanjung Priok	FSW	392	588	74	111	132	88
Puskesmas Tebet	FSW/PWID	355	533	67	100	120	80
Puskesmas TIMIKA JAYA	PP/FSW	101	151	19	28	34	23
RS Fatmawati	All KP/PP	580	871	109	164	195	130
	All KP/PP	84	126	16	24	28	19
<b>RS Duren Sawit</b>							
RS Gatot Subroto	All KP/PP	593	890	112	167	200	133
RSUD Cengkareng	All KP/PP	55	82	10	15	18	12
RSUD Koja	All KP/PP	550	826	103	155	185	124
RSUD Tarakan	All KP/PP	167	250	31	47	56	37
RSUD Wamena	All KP/PP	68	101	13	19	23	15
Ruang Carlo	MSM/TG	479	120	90	23	98	65

**Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Sustained Districts (FY16)**

Sustained Sites	Key or Priority Population	Tested for HIV (FY16) (LINKAGES)	Tested for HIV (FY16) (DERAP)	Identified Positive (in FY16) *(LINKAGES)	Identified Positive (in FY16)* (DERAP)	Enrolled on ART (in FY 2016) (DERAP DSD)	Enrolled on ART (in FY 2016) LINKAGES DSD	Enrolled on ART (in FY 2016) DERA P TA	Enrolled on ART (in FY 2016) LINKA GESTA
Klinik Kalvari	All KP/PP	282	188	53	35	0	0	14	0

PKR Kotaraja	FSW/MSM	537	358	101	67	0	0	27	0
Puskesmas ABEPURA	FSW/PP	132	199	25	37	0	0	15	0
Puskesmas ASOLOGAIMA	PP	68	101	13	19	0	0	8	0
Puskesmas HAMADI	PP/FSW	97	145	18	27	0	22	11	20
Puskesmas HOM-HOM	PP/FSW	383	574	72	108	0	0	43	0
Puskesmas KOTARAJA	PP/FSW	222	333	42	63	0	50	25	45
Puskesmas WAENA	PP/FSW	160	240	30	45	0	0	18	0
Puskesmas WAMENA KOTA	KP/FSW	0	1167	0	219	0	0	88	0
RS Mitra Masy.Timika	PP	0	215	0	40	23	0	16	21
RSU Abepura	All KP/PP	508	762	95	143	0	114	57	103
RSU Jayapura	All KP/PP	1872	802	352	151	291	0	60	262
RSUD Kab. Mimika	All KP/PP	169	253	32	48	0	38	19	34
Angsamerah	MSM/FSW	202	50	38	9	27	0	4	25
Kios Atma Jaya	PWID	800	533	150	100	145	0	40	131
Klinik YKB	FSW	87	22	16	4	0	0	2	0
Lapas Klas 1 Cipinang	PWID	561	841	105	158	0	0	63	0
PKBI Jakarta Timur	FSW	0	428	0	80	0	0	32	0
Puskesmas LIMAU ASRI	PP/KP	101	151	19	28	0	0	11	0
Puskesmas TIMIKA KOTA	PP/FSW	0	215	0	40	23	0	16	21
Puskesmas Cengkareng	PWID/FSW	799	1199	150	225	0	179	90	161
Puskesmas Ciracas	FSW	359	539	67	101	0	0	40	0
Puskesmas Gambir	PWID	192	288	36	54	0	43	22	39
Puskesmas Grogol Petamburan	FSW	398	596	75	112	0	89	45	80
Puskesmas Jatinegara	FSW/MSM	145	218	27	41	0	33	16	29
Puskesmas Johar Baru	FSW	0	189	0	35	0	0	14	0
Puskesmas Kebayoran Baru	MSM/FSW	128	193	24	36	0	0	14	0
Puskesmas Kebon Jeruk	FSW/MSM	593	890	112	167	0	0	67	0
Puskesmas Kramat Jati	FSW	549	824	103	155	0	123	62	111
Puskesmas KWAMKILAMA	PP/FSW/KP	101	151	19	28	0	23	11	20
Puskesmas Pancoran	MSM/PWID	209	314	39	59	0	0	24	0
Puskesmas Pasar Minggu	PWID	169	253	32	48	0	38	19	34
Puskesmas Pasar Rebo	MSM/TG	879	586	165	110	159	0	44	143
Puskesmas Penjaringan	FSW	0	1248	0	235	136	0	94	122
Puskesmas Senen	FSW	480	720	90	135	0	108	54	97
Puskesmas Setia Budi	PWID	0	571	0	107	62	0	43	56
Puskesmas Taman Sari	FSW	145	217	27	41	0	32	16	29
Puskesmas Tambora	PWID	0	1094	0	206	119	0	82	107
Puskesmas Tanah Abang	PWID/FSW	110	165	21	31	0	25	12	22

Puskesmas Tanjung Priok	FSW	392	588	74	111	0	88	44	79
Puskesmas Tebet	FSW/PWID	355	533	67	100	0	80	40	72
Puskesmas TIMIKA JAYA	PP/FSW	101	151	19	28	0	23	11	20
RS Fatmawati	All KP/PP	580	871	109	164	0	130	66	117
RS Duren Sawit	All KP/PP	84	126	16	24	0	19	10	17
RS Gatot Subroto	All KP/PP	593	890	112	167	0	133	67	120
RSUD Cengkareng	All KP/PP	55	82	10	15	0	12	6	11
RSUD Koja	All KP/PP	550	826	103	155	0	124	62	111
RSUD Tarakan	All KP/PP	167	250	31	47	0	37	19	34
RSUD Wamena	All KP/PP	68	101	13	19	0	15	8	14
Ruang Carlo	MSM/TG	479	120	90	23	65	0	9	59

**Table 4.1.4. Prevention Interventions for Key Populations to Facilitate Epidemic Control**

Priority Province	Sustained Districts	FY2014 APR	FY2016 Target		Is GFATM and/or HCG Proving Prevention Intervention for KP in the SNU
			DERAP	Linkages	
DKI Jakarta	North Jakarta	102	520	5,968	Y
	South Jakarta	55	2,713	464	Y
	Central Jakarta	2,119	2,840	1,461	Y
	East Jakarta	1,513	2,184	3,000	Y
	West Jakarta	2,468	1,391	4,201	Y
				-	
Papua	Jayapura	715	929	154	Y
	Mimika	689	281	121	Y
	Jayawijaya	362	201	1,063	Y
		8,023	11,059	16,432	

**Table 4.1.4.a. Prevention Interventions for MSM/TG to Facilitate Epidemic Control**

Priority Province	Sustained District	FY2014 APR	FY2016 Target		Is GFATM and/or HCG Proving Prevention Intervention for KP in the SNU
			Linkages	Derap	

DKI Jakarta	North Jakarta	0	200	133	Y
	South Jakarta	0	3354	2223	Y
	Central Jakarta	909	2936	1944	Y
	East Jakarta	898	1599	1066	Y
	West Jakarta	1538	160	107	Y
					Y
Papua	Jayapura	0	144	96	Y
	Mimika	0	0	0	Y
	Jayawijaya	0	0	0	Y
			8393	5569	

**Table 4.1.4.b. Prevention Interventions for FSW to Facilitate Epidemic Control**

Priority Province	Sustained District	FY2014 APR	FY2016 Target		Is GFATM and/or HCG Proving Prevention Intervention for KP in the SNU
			Linkages	Derap	
DKI Jakarta	North Jakarta	102	490	327	Y
	South Jakarta	0	0	0	Y
	Central Jakarta	0	0	0	Y
	East Jakarta	439	1194	796	Y
	West Jakarta	930	1749	1166	Y
					Y
Papua	Jayapura	715	1250	833	Y
	Mimika	689	327	218	Y
	Jayawijaya	362	301	201	Y
			5311	3541	

**Table 4.1.4.c. Prevention Interventions for PWID to Facilitate Epidemic Control**

Priority Province	Sustained District	FY2014 APR	FY2016 Target		Is GFATM and/or HCG Proving Prevention Intervention for KP in the SNU
			Linkages	Derap	
DKI Jakarta	North Jakarta	0	90	60	Y
	South Jakarta	55	729	486	Y
	Central Jakarta	1210	1332	888	Y
	East Jakarta	176	480	320	Y
	West Jakarta	0	175	117	Y
					Y
Papua	Jayapura	0	0	0	Y
	Mimika	0	0	0	Y

	Jayawijaya	o	o	o	Y
			2806	1871	

**Table 4.1.4.b. Prevention Interventions for FSW to Facilitate Epidemic Control**

Priority Province	Sustained District	FY2014 APR	FY2016 Target		Is GFATM and/or HCG Proving Prevention Intervention for KP in the SNU
			Linkages	Derap	
Papua	Jayapura	o	3,317	2,411	Y
	Mimika	o	5,307	3,625	Y
	Jayawijaya	o	4,644	2,809	Y
			13,268	8,845	Y

As has been mentioned throughout this document, limited national program data and surveillance data of questionable quality present a major challenge to accurately assess the gaps and needs of the national HIV program at the SNU level. While HIV prevalence data is available at the national and SNU level, the reliability of these estimations is unclear. To address this, PEPFAR will provide direct TA to the MOH to improve the quality of the national program data and surveillance data. One senior M&E advisor and one surveillance expert will be seconded to the MOH to help improve the flow and quality of routine program data from the service delivery level to the district, provincial and national level, and to strengthen the quality of KP surveillance including size estimates needed for appropriate KP programming and prioritization.

All sites, supported by PEPFAR in Indonesia, including CSOs, private and public sector sites, will receive supervision and support for quality assurance and quality improvements through implementation of the Site Improvement through Monitoring System (SIMS). PEPFAR will work with partners to develop systems to track and use program results to monitor progress.

<b>Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Sustained Districts (FY 16)</b>			
Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Military	4917	880	475

\*The estimated numbers are based on MOH reported data in FY2014

\*Expected ART enrollment in FY16 is 0.4%

**Table 4.1.4 Target Populations for Prevention Interventions to Facilitate**

<b>Epidemic Control</b>			
<b>Target Populations</b>	<b>Population Size Estimate (priority SNU)</b>	<b>Coverage Goal (in FY16)</b>	<b>FY16 Target</b>
<b>Military</b>	<b>129,454</b>	<b>5.13</b>	<b>6640</b>

\*The target population is reach through peer to peer education by increasing HIV knowledge

**Table 4.1.5 Not applicable**

**Program Area Summaries 4.2-4.10**

**4.2 Priority and Key population prevention**

Based on priority and key population data, the state and district level context, and the core, near-core and non-core analysis, PEPFAR/Indonesia proposes to focus its bilateral assistance and partnership with GOI on activities that will prevent HIV transmission among key populations and expanding the reach of civil society organizations that target the key populations in scale up districts to reach 90/90/90.

The PEPFAR/Indonesia program works to provide innovative and locally effective interventions based on the Comprehensive Package of Interventions for Key Populations described in the PEPFAR Technical Considerations and in-line with the interventions listed and described in the WHO Consolidated KP Guidelines. 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/Indonesia funds (i.e., needle and syringe programs, OST) 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 which have been elucidated by the NAC TWG. PEPFAR/Indonesia works to improve the quality and delivery of interventions undertaken to support improvements along the HIV cascade. The goal is for this package to be accepted and funded through domestic resources at both the national and district levels. PEPFAR/Indonesia ensures participation of key populations in the development, implementation, and monitoring of programs.

Components of the comprehensive KP intervention packages provided for KP under the PEPFAR/Indonesia program include:

1. Peer education and community-based outreach
2. Sexual and drug use assessment and risk reduction counseling
3. Linkages to Sexually Transmitted Infection (STI) prevention, screening and treatment
4. Provision of Condoms and condom-compatible lubricants
5. Linkages to and provision of HIV Testing and Counseling (HTC)
6. Increasing access to and support to maintain adherence for Antiretroviral Therapy (ART) for KP living with HIV
7. Support for Prevention and management of co-infections and co-morbidities including
  - a. Tuberculosis prevention, screening and treatment
  - b. Hepatitis B & C prevention, screening and treatment, and Hepatitis B Vaccination
8. Building an Enabling Environment: Critical Enablers for KP Programs
  - a. Supportive legislation and policies
  - b. Addressing Stigma and Discrimination

### c. Community empowerment

These activities will be conducted via a mixture of direct service delivery and technical assistance. PEPFAR/Indonesia's decision to focus on this area is based upon the current coverage gaps in the continuum of care cascade for key populations. In order to accelerate the uptake of interventions aimed at reducing HIV transmission and access to care and treatment, and to improve the effectiveness of interventions supported through other financing mechanisms (i.e. GFATM). PEPFAR/Indonesia is focusing on proving success in selected districts in provinces at highest risk. This includes a substantial focus on expanding the use of condoms among high risk groups and working with the government at the national and local level to target interventions to high risk groups and high prevalence areas.

PEPFAR/Indonesia's strategy is fully in line with the national strategy and priorities, and has the following objectives:

- Build capacity of local government and non-governmental organizations (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/Indonesia will support civil society organizations (CSOs) to advocate for and leverage resources while sustaining the quality of their programs and expanding their reach to key populations with priority HIV interventions.
- PEPFAR/Indonesia 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.
- Stigma and discrimination and gender-related discrimination remain important obstacles to providing quality services for HIV/AIDS and controlling the epidemic.
- PEPFAR/Indonesia also assists in strengthening HIV prevention activities in the military through the USG's Office of Defense Cooperation (ODC), NAC and the Indonesia Armed Forces Surgeon General Office (TNI PUSKES). ODC will coordinate and implement training on peer to peer education to increase comprehensive HIV knowledge linked to testing, care and treatment, and increased condom use.

See Appendix A for details on the core prevention package for each priority population.

### 4.3 Voluntary medical male circumcision (VMMC)

According to the FY15 COP Guidance, doing the right things means improving site monitoring, strengthening program quality, and scaling-up core interventions—ART, PMTCT, VMMC and condoms. While the majority of Indonesians are circumcised, this is not the case for the ethnic Papuan population. Key findings from the 2013 IBBS survey indicate that 2.9% of ethnic Papuans are HIV-infected, higher than the 0.4% prevalence found among non-Papuans. 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. Similar to HIV prevalence, active syphilis prevalence was significantly higher among Papuans, 5.7% compared to 0.8% among non-

Papuans. Non-circumcision also was highly correlated to active syphilis, with 4.8% of uncircumcised men currently infected with syphilis compared to only 1.1% of circumcised men.

While PEPFAR/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 VMCC activities funded by other donors or the GOI. PEPFAR/Indonesia will work with local partners, through Linkages Implementing Mechanism to identify an appropriate approach to increasing the practice of circumcision in Papua, taking into account the tremendous political and cultural sensitivities. To the extent possible with limited funding and after extensive discussions with other stakeholders, USG will determine how it can facilitate and support technical assistance for VMCC as part of Papuan-based activities in the 4 districts where PEPFAR will work. These activities will be conducted in accordance with the Technical Consideration for the FY15 COP.

#### **4.4 Preventing mother-to-child transmission (PMTCT)**

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 counseling (HTC)**

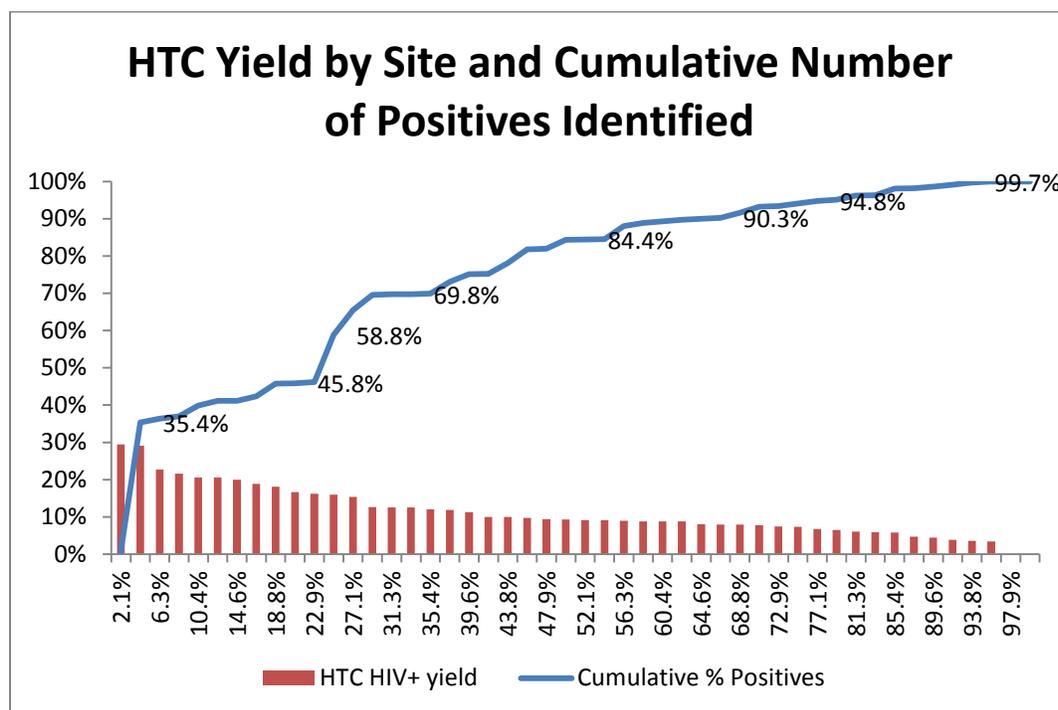
HIV testing is part of the Comprehensive package of prevention, care and treatment (CoPCT) for KP, as well as being the gateway to the clinical service cascade for PLHIV.

The recent MOH policy on SUFA which is scaling up in 75 priority districts over the next several years, presents an opportunity to increase the number of key populations and other high-risk group members in high prevalence districts to initiate early antiretroviral treatment. While HIV testing coverage in Indonesia increased to more than one million tests in 2014, uptake remains quite low among KPs (MSM 8%, PWID 32%, Transgender 33%, and Sex Worker 58%). 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 HCT and ART for simple cases of HIV. Utilizing primary healthcare as a testing venue, in both the public and private sectors, supported by adequate fiscal, infrastructural and human resources will increase the access of KP, other risk groups, and PLHIV to healthcare. Indeed 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. In scaling up the HCT, DoD has assisted 7 military hospitals to be listed as satellite in MOH. In keeping with PEPFAR/Indonesia's technical assistance model, USG will provide technical assistance for SUFA. In 18 of the districts where SUFA is being rolled out, the PEPFAR program is actively supporting CSOs to work with clinical sites to reach key populations, providing technical support to intensify HIV case finding among key populations and improving linkages for those tested positive to enroll into ART.

In addition to working with KP, PEPFAR/Indonesia will also support increased uptake of HTC and HTC yield amongst TB patients and pregnant women in selected districts in Papua as further described in sections 4.4 and 4.7. Below is the HTC site yield figure (Figure 4.5.1) based on FY14 APR. In total, 48 sites were included with 1,748 newly identified positive among 12,421 individual tested (positivity yield of 14.1%). Please see appendix D for breakdown of HTC yield by site.

Figure 4.5.1 FY14 PEPFAR HTC Site and Sero-positivity Yield



**In total, PEPFAR’s sub-national and site level support will test 37,229 individuals and estimated a HIV positivity yield of 10.9%.**

#### 4.6 Facility and community-based care and support

Providing accessible and quality care, support and treatment services for PLHIV is one of the objectives in the draft National Strategic and Action Plan (SRAN) 2015-2019. In FY 2013, the MOH launched the SUFA initiative to accelerate ART coverage and maximize the prevention benefits of ART by expanding eligibility criteria to all PLHIV in several key populations. This is aligned with MOH’s plan to decentralize HIV treatment and care from hospitals to health centers, and from health facilities to community-based providers of services and support, as HIV treatment and care services currently remain highly concentrated in hospitals, particularly those in large cities.

To improve care provided to key populations, PEPFAR/Indonesia will support the continuum of care model in order 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.

CSOs in Indonesia play a key role in establishing the networks necessary to link KP to health facilities to access care, support and treatment services once they are diagnosed with HIV. In Papua, PEPFAR/Indonesia will aggressively increase identification of new PLHIV on ARV and prioritize support for an effective continuum of response for PLHIV.

Implementation of a Technical and Operational Performance Package of Support will be provided in 8 targeted intervention districts, working with CSOs and other key stakeholders, both government and non-government, at the provincial and district levels. This approach ensures that leaders and champions of KP and PLHIV are at the center of USG work and engaged in designing and implementing program activities. Under the USG-supported programs in the last decade, strides have been made to expand the reach of community case management services, including adherence support for PLHIV from health facilities to communities through partnership arrangements between health facilities and local organizations. The TA model is not confined to merely intervening on the CSO side to ensure key populations access high quality of services and keeping them on treatment. In the targeted intervention sites, USG will support efforts to promote more holistic care, support and treatment for HIV-positive individuals, and improvements in opportunistic infections management at the site level. Current PEPFAR/Indonesia 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.

The PEPFAR DOD program collaborates with TNI and FHI360 in rolling out the training curriculum for PLHIV including psycho-social counseling of HIV-positive TNI personnel and their dependents, and care, support and treatment counseling. Materials and curriculum from MOH are tailored to the Indonesian military.

#### **4.7 TB/HIV**

PEPFAR Indonesia will provide technical assistance to government providers and CSOs to improve the referral of PLHIV for TB testing and provide support for TB treatment and successful cure in Papua – where there are much higher rates of co-infection – address TB/HIV integrated services, and TB/HIV is a component of USAID’s much larger TB program.

TB/HIV integration is also an important priority for the MOH, and is a requirement for the current GFATM concept note. Indonesia is among the top five global TB disease burden countries, while HIV prevalence remains relatively low, except in Papua. Although TB/HIV collaborative activities (TBCA) began in Indonesia in 2007, only 2.9% of TB patients in 2014 were with 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.

Additionally, FHI360 will introduce TB/HIV collaborative approaches and activities to the Indonesian military hospitals to increase HIV testing and counseling among TB patients and ensure all TB/HIV co-infected patients receive ART and CPT.

#### **4.8 Adult treatment**

In 2013, the MOH developed and 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 key populations 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 GOI and the GFATM.

Support for the SUFA initiative is built into the proposed USG activities, particularly through grants to local civil society organizations, technical assistance for improved drug quality assurance, and technical assistance to build epidemiologic analytical capacity. PEPFAR will provide technical assistance in the 8 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 the strategic use of ARVs and the continuum of care.

PEPFAR/Indonesia will support a key component of the PEPFAR Quality Strategy to increase acceptability and accessibility of clinical services that promote linkages, engagements and retention. Specific activities in FY15 will be harmonized with those in the GFATM CN 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 is a non-core activity and therefore the PEPFAR program will not support any Pediatric Treatment.

#### **Supply Chain and Logistics**

Indonesia is an archipelago of 17,000 islands, and has decentralized most administrative and procurement functions to the district level. In addition to the distances to be covered, and the number of distribution sites to be managed, infrastructure can be very basic and unreliable in much of the country. Supply chain for health commodities, drugs and supplies presents an

enormous challenge for all health programs. USG has assisted the MOH to address these challenges.

Supply chain management strengthening activities that have been initiated in the last two years will be further amplified and expanded upon. Working closely with the HIV/AIDS Sub-directorate in the MOH, PEPFAR has developed a set of activities involving (a) an initial assessment of ARV logistics management capacity in selected provinces and districts, which will feed into (b) further development of a detailed work plan for strengthening province- and district-level ARV recording, reporting and inventory control, as well as ARV forecasting and procurement management. This will in turn improve the overall quality of ART services and the HIV clinical program in country, as proposed in the PEPFAR Quality Strategy.

In addition, USG funding is contributing to the Ministry-wide implementation of the “One Gate” policy – an effort to coordinate drug procurement and supply chain management across all MOH disease programs – as well as a 5-year Supply Chain Management National Strategy. These activities should reduce inefficiencies and duplication of effort in procurement and supply chain management, and will provide further impetus to effective ARV decentralization throughout the country. PEPFAR Indonesia will continue providing critical assistance to the GoI to sustain the availability of commodities in the central support districts to ensure there will be no interruption of services.

## 5.0 Program Activities to Maintain Support for Other Locations and Populations

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### **5.1 Maintenance package of services in other locations and populations**

HIV-related services have increased significantly in terms of the number and distribution of services in the past 4 years. The number of STI services increased by nearly 8-fold from 92 in 2010 to 801 in 2014, as well as other services such as 385 HCT to 1,391, MMT from 65 to 87, ART from 195 to 455, and PMTCT from 29 to 116 in the same period of time. Increasing the number and distribution of HIV-related services has resulted in an increase in program coverage, however the majority of these services are still vertical, which is influenced by an ad-hoc program that still does not have mandatory HIV/ AIDS minimum service standards. The GOI plans to develop these standards by 2017 with implementation by 2019. It is anticipated that the national health insurance (JKN) will cover all HIV/ AIDS care and treatment services.

The MOH issued regulation No. 21/2013, updated the roles and responsibilities of all key stakeholders as well as activities to support the HIV and AIDS continuum of care. The regulation clearly emphasis GoI responsibility to provide key medicines and medical supplies, while district government has the responsibility to determine the status of the epidemic as well as the obligation to fund and implement prevention, care, support and treatment programs.

### **5.2 Transition plans for redirecting PEPFAR support to priority locations and populations**

As a TA/TC program, PEPFAR Indonesia historically has supported a program targeted towards key populations in the highest prevalence districts/provinces, including two provinces in Papua. As agreed with the National AIDS Program, PEPFAR Indonesia will transition out of 20 of 28

districts to increase focus on the remaining PEPFAR supported, and highest prevalence, 8 districts. As some of the sites in the central support districts already receive funding from the GFATM and support from the NAC and MOH, PEPFAR funding and support ended with the end of the SUM I project on March 31, 2015. PEPFAR Indonesia will work closely with NAC and MOH to monitor the transitioned sites and, if requested by the NAC and MOH, may provide limited short-term TA to help ensure successful transitions. PEPFAR Indonesia will continue its negotiation with the Global Fund and the GoI to take over responsibilities in the transitioned districts to prevent disruption of the critical services for key populations and PLHIV.

## 6.0 Cross-cutting Support Necessary to Achieve Sustained Epidemic Control

### 6.1 Laboratory strengthening

Activities to improve the drug quality in Indonesia will help to improve health system strengthening at the National, Provincial and District levels through support to strengthen surveillance systems and monitoring tools and utilization of evidence collected from these systems to positively impact GOI programming and policies. PEPFAR Indonesia will support GOI's participation in ASEAN efforts to strengthen and harmonize pharmaceutical technical requirements for registration, good manufacturing practices (GMP) audits and bioavailability and bioequivalence testing.

Historically, access to the public sector distribution and service delivery points by the BPOM (National Agency for Drug and Food Control) inspectors for conducting ongoing post-marketing surveillance of ARV medicines has been quite limited, due to both policy and practical constraints. Although the central QC laboratory of BPOM (PPOMN) is currently recognized by the GFATM to conduct quality control testing on ARVs procured with GFATM monies, there has been limited testing in the recent past. However, given the vast infrastructure of the national BPOM system, currently with a national QC laboratory supported by 31 provincial quality control laboratories, there is a great potential for increasing the testing capacity of the Indonesian government for ensuring quality of ARVs supplied through the public program.

PEPFAR Indonesia will apply a multifaceted approach to engaging public and private sector stakeholders to ensure that ARVs provided by the public programs are quality assured to international standards, and routinely inspected and controlled for quality by the BPOM regulatory authority. PEPFAR Indonesia will help assure the quality and safety of priority essential medicines in Indonesia by strengthening the capacity of BPOM to test and monitor the quality of post-production medicines, and better manage the growing challenge posed by substandard and counterfeit medicines.

Activities	Impact on clinical cascade:					Deliverables		Budget Codes	Associated IMs
	HIV testing	In Care	On ART	Retained	Adhering	2015	2016		
Build QA/QC and regulatory capacity and strengthen technical expertise of the National Agency for Drug and Food Control (BPOM) throughout the national system, with focus on USAID/PEPFAR-priority provinces on post-marketing surveillance.						<ul style="list-style-type: none"> <li>PEPFAR Indonesia overall strategic implementation plan reviewed, accepted, and adopted into National Strategic Action Plan of BPOM 2015-2019, with inputs from USAID/PEPFAR</li> <li>Implementation and training plan developed and adopted by BPOM for priority provinces.</li> <li>Capacity building of BPOM and MOH through on-site (national and provincial) training workshops</li> </ul>	<ul style="list-style-type: none"> <li>Review and adoption of PEPFAR Indonesia work plan activities into BPOM national strategic framework for QC capacity building</li> <li>Conduct external Quality audit/review prior to WHO PQ inspection and to enforce CAPAs</li> <li>On-site follow up on TA from 2015 workshops (Implementation and training plan) adopted by BPOM for priority provinces</li> <li>Capacity building activities of BPOM and MOH through training workshops</li> </ul>		17586

## 6.2 Strategic information (SI)

Quality of data to inform decision making for Indonesia's HIV program is a core priority for PEPFAR. As part of the assessment of the continuum of service cascade, PEPFAR Indonesia will focus its core SI activities on:

1. Surveillance for priority key populations, including updating of size estimations for key populations and questions assessing key populations currently in care and treatment to improve access to services
2. Technical assistance to improve data availability and use to be able to report on all key indicators in the continuum of response and use data for strategic planning and program planning
3. Review and improvement of the national HIS for HIV surveillance given that current HIV information systems and data are fragmented which inhibits effective strategic planning and program planning
4. Promote efficient and timely reporting between and within institutions to facilitate follow up, enforcement, and strategic interventions for use by the P2PL program, BINFAR, and MOH

Activities	Impact on clinical cascade:				Sustainability Index Elements	Deliverables		Budget Codes	Associated IMs
	In Care	On ART	Retained	Adhering		2015	2016		
<b>Surveillance</b>									
Conduct IBBS in PWID and MSM/TG	X	X	X	X			<ul style="list-style-type: none"> <li>IBBS conducted which includes survey questions regarding care and treatment</li> </ul>	HVSI	17006
Conduct IBBS in PWID and MSM/TG/FSW	X	X	X	X			<ul style="list-style-type: none"> <li>Preparation for IBBS which will include survey questions regarding care and treatment</li> </ul>	HVSI	17006
Conduct mapping and key population size estimation for PWID/MSM/TG and FSW	X	X	X	X			<ul style="list-style-type: none"> <li>Mapping and PSE conducted in all districts supported by PEPFAR</li> </ul>	HVSI	17006
<b>Data Availability and Use</b>									
Technical support for strengthening the capacity of program managers, HIV sentinel surveillance District epidemiologists, M&E officers and other relevant staff involved in data generation, quality management and analysis for use	X	X			<ul style="list-style-type: none"> <li>1.1 – Epi and Health Data</li> </ul>		<ul style="list-style-type: none"> <li>Conduct training for all HIV sentinel surveillance districts program staff on data generation, quality and analysis</li> <li>Conduct supervision visits to y sustained districts</li> </ul>	HVSI	17006
<b>Health Information Systems</b>									
Review and improvement of the national HIS for HIV surveillance	X	X	X		<ul style="list-style-type: none"> <li>1.3 – Performance Data</li> </ul>	<ul style="list-style-type: none"> <li>Finalize requirements and pilots in 3 Districts</li> </ul>	<ul style="list-style-type: none"> <li>Full roll-out to minimum all 141 priority districts and sentinel all PEPFAR supported district and sentinel surveillance districts</li> </ul>	HVSI	17006

## 6.3 Health System Strengthening (HSS)

Indonesia has mobilized unprecedented levels of political commitment to respond to HIV since 2006, and significant domestic and international funding has been secured to support a greatly expanded national response. However, Indonesia has not met its SRAN 2010-2014 objectives nor its HIV-

relevant MDG 2015 targets. Recent reviews suggest that the strategies being employed to contain HIV in Indonesia are by and large appropriate. However, they are not seeing their full impact for a variety of reasons, mainly due to weak program management and limited resource allocation for key population sub-groups among whom epidemic growth is currently the most robust.

In response, Indonesia has proposed a re-focused effort concentrating on strengthening established systems and more efficient leveraging of domestic and international resources. In 2012, public health spending across all levels of government was US\$43 per capita. Total expenditure on health in Indonesia has already grown significantly over the past decade, at an annual average rate of 15.3% between 2007 and 2012. Over this period, government expenditure on health has also risen faster, at an annual average rate of 17.3%, than total expenditure on health. Yet, despite these impressive numbers in absolute terms, both total health expenditure and government health expenditure as a percentage of GDP have stayed roughly constant at around 3% and 1% respectively. This is the fifth-lowest health-spending-to-GDP ratio in the world.

From a governance and public financial management perspective, while decentralized health sector decision-making combined with large fiscal transfers from center to sub-national levels were intended to empower and support local governments to efficiently and effectively design and implement health programs and interventions, health financing flows are much more complex and difficult to manage, marked by multiple vertical intergovernmental financing channels, each with different rules and procedures. A high level of out-of-pocket spending is a persistent and serious problem for the sector.

Of considerable promise is the potential for a sizeable share of national HIV program costs to be absorbed by the new universal health insurance scheme (Jaminan Kesehatan Nasional (JKN)) initiated in January 2014 and to be fully rolled-out by 2019. Currently, insurance coverage is limited to diagnosis and treatment of STIs and opportunistic infections. The GOI, with support from the World Bank, is working on estimating the cost structure for including HIV into the insurance package.

PEPFAR Indonesia plans on studying how JKN payments to health centers (Puskesmas and private health clinics) are being utilized. The implementation research will seek to answer questions such as - how are primary care facilities making decisions around the use of their JKN capitation payments to reach out to key populations and improve targeting and coverage of HIV prevention activities; to what extent are primary care facilities assuming the “gatekeeper” role in response to JKN and how is this affecting referrals to higher levels of care; and how is JKN incentivizing behavior change, altering provision of primary care services, and impacting HIV care. This activity will be co-funded with MCH and TB funds and will provide PEPFAR Indonesia with rich data to continue to advocate for increased domestic spending on HIV services for specific target populations – MSM, TG, PWID, and FSW and priority populations.

Strengthening the national health system is a long term vision of the country guided by the National Long Term Development Plan (2005-2025) that is organized orderly by four consecutive National Medium Term Development Plans. The Medium Term Development Plan for Health (2015-2019) has now been formally adopted by the new Government. PEPFAR Indonesia will:

1. Provide advanced, ongoing technical support to the local manufacturer and importer of ARVs, Kimia Farma, by engaging in cGMP and WHO PQ projects, in addition to working on supporting interventions with a focus on quality control at provincial and district supply chains until full decentralization of the public National AIDS program distribution of ARVs has been accomplished
2. Facilitate partnerships with international organizations and donors, such as UNAIDS, WHO, DFAT, and partner NGOs on areas relevant to ARV quality
3. Provide leadership in the area of ARV medicines quality in Indonesia, thereby ensuring that patients are receiving the best quality medicines possible, and contributing to the overall success of the PEPFAR-funded programs to stave off the rise in the HIV epidemic
4. Provide technical assistance to BPOM in the area of medicines registration and regulation, quality assurance, and advanced capacity building of the institution's organizational structure to help BPOM achieve international standards
5. Conduct implementation research to study how primary care facilities are using JKN capitation payments to increase access to HIV prevention and care services for target populations.

Activities	Impact on clinical cascade:				Sustainability Index Elements	Deliverables		Budget Codes	Associated IMs
	In Care	On ART	Retained	Adhering		2015	2016		
<b>Supply Chain Management</b>									
HIV SCM Pilot Project to support ARV decentralization:		x			<ul style="list-style-type: none"> <li>• 2.6—13.7</li> </ul>	<ul style="list-style-type: none"> <li>• Management of District warehouses improved</li> <li>• ARV Supply and Distribution mechanism in place</li> <li>• Information system for HIV/AIDS Utilized</li> <li>• ARV reporting system functioning</li> </ul>	<ul style="list-style-type: none"> <li>• SCM Self-Assessment process completed</li> <li>• ARV Supply and Distribution mechanism improved</li> <li>• ARV reporting system functioning</li> <li>• Information system for HIV/AIDS evaluated</li> </ul>	OHSS	14355
Develop HIV SCM Capacity Building Program at MOH	x				<ul style="list-style-type: none"> <li>• 3.11—19</li> </ul>		<ul style="list-style-type: none"> <li>• Competency mapping</li> <li>• Develop curriculum</li> <li>• Training of Trainers</li> </ul>	OHSS	14355
<b>Service Delivery: Quality Management</b>									
Provide Technical Assistance to local pharmaceutical manufacturer (Kimia Farma) towards achieving WHO Prequalification for ARV medicines.	X	X			<ul style="list-style-type: none"> <li>• 2.6—13.7;</li> <li>• 3.11—19</li> </ul>	CAPA on initial ARV manufacturing facility assessment (2014) either closed or in process initial post-marketing surveillance testing for ARVs sampled from KF central warehouse conducted by BPOM QC lab	<ul style="list-style-type: none"> <li>• Support assessment/audit visit to API manufacturers for HIV medicines (outside Indonesia)</li> <li>• Facilitate ongoing communication amongst stakeholders on cGMP status, deficiencies, or other pertinent information for procurement and policy</li> </ul>	OHSS	17586

							decisions		
Implementation Research to help inform the rollout of the GOIs JKN and to strengthen Indonesia's progress toward UHC.					•	Data on the use of JKN capitation payments for HIV prevention are care services.	Qualitative data from implementation research around advocacy for use of JKN capitation payments to increase access to HIV prevention and care services for target groups.	OHSS	17854

## 7.0 Staffing Plan

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[REDACTED]

# APPENDIX A

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**Table A.1 Program Core, Near-core, and Non-core Activities for COP 15**

<b>Level of Implementation</b>	<b>Core Activities</b>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
Site level	<p>Support learning sites for delivery of the Continuum of Prevention, Care and Treatment Interventions for key populations: HTC, Care and Treatment in sustained districts 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>Saturate coverage of key populations in saturated districts with community services; delivering routine outreach referrals, community care and retention.</p> <p>Strengthen KP/PLHIV/CSO/Network capacity to advocate with local authorities and providers for budget allocations and quality service provision for key and priority populations</p>	Priority Populations (STI and TB patients, sero discordant couples and clients of sex workers)	

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Sub-national 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>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 (Access and Demand; HRH and Quality Management)</p>
National level	<p>Strategic Information including SNU program data M&amp;E, surveillance and size estimation, operations research (Epidemiology; Performance Data)</p> <p>Conduct assessment of stigma and discrimination in high prevalence key population districts with low HTC uptake and low HTC yield and create recommendations</p> <p>Continuum of Prevention, Care and Treatment for KP/PP (Access and Demand; HRH; Domestic Resource Mobilization – Resource Commitment)</p>

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15**

<b>HTC</b>	<b>Core Activities</b> <ul style="list-style-type: none"> <li>Support increase uptake of HTC and HTC yield amongst key populations in high priority states and districts</li> <li>Train HTC counselors in provision of counseling to key populations</li> </ul>	<b>Near-core Activities</b> <ul style="list-style-type: none"> <li>Support the national level government for operational research on community testing for MSM and FSWs in selected district</li> </ul>	<b>Non-core Activities</b>
<b>Care and Treatment</b>	<b>Core Activities</b> <ul style="list-style-type: none"> <li>Technical assistance to sustained districts and municipalities to increase new ART patients already registered in care</li> <li>Support operationalization of ART retention indicator in selected districts with further expansion</li> <li>Pilot interventions to measure and increase yield of HIV prevention, diagnosis, care and treatment cascade amongst key populations</li> </ul>	<b>Near-core Activities</b> <ul style="list-style-type: none"> <li>Targeted laboratory quality improvement focused on priority districts and municipalities</li> </ul>	<b>Non-core Activities</b>
<b>Prevention</b>	<b>Core Activities</b> <ul style="list-style-type: none"> <li>Support Ministry of Health to develop an M&amp;E System to capture- reach-test-treat-retain cascade for KPs</li> </ul>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
<b>TB/HIV</b>	<b>Core Activities</b> <ul style="list-style-type: none"> <li>Provide technical assistance and conduct pilot to test innovative strategies on intensified case finding in key population program and ART centers</li> <li>Provide technical assistance to increase co-located HIV/TB testing facilities in designated microscopy centers</li> </ul>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
<b>Cross-cutting</b>	<b>Core Activities</b>	<b>Near-core Activities</b> <ul style="list-style-type: none"> <li>Provide laboratory capacity to support clinical monitoring at each stage of the continuum</li> </ul>	<b>Non-core Activities</b>
<b>Laboratory</b>			
<b>Strategic Information</b>	<ul style="list-style-type: none"> <li>KP surveillance and programmatic data collection, analysis and use</li> <li>Creation/re-operationalization of retention indicator and system for collection</li> <li>Creation of VL monitoring indicator and system for collection</li> </ul>		
<b>Health System Strengthening</b>	<ul style="list-style-type: none"> <li>Provide technical assistance to the ARV drug supply chain system</li> </ul>		

## APPENDIX B

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### **B.1 Planned Spending in 2016**

*[REDACTED]*

### **B.2 Resource Projections**

PEPFAR Indonesia used the expenditure analysis, historical data and information from implementing partners to establish FY 2016 budgets by implementing mechanism and PEPFAR budget codes. Expenditure analysis data was reviewed to get a better understanding of FY 2014 spending patterns by program area, cost category, and geographical location. Implementing mechanism unit expenditures by province were also reviewed and determined to be appropriate given access, distance and transportation within focus districts.

## APPENDIX C

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# Sustainability Analysis for Epidemic Control: INDONESIA

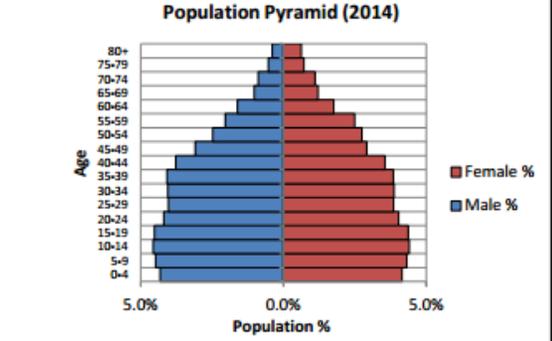
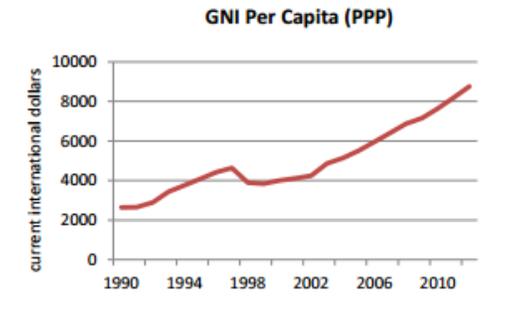
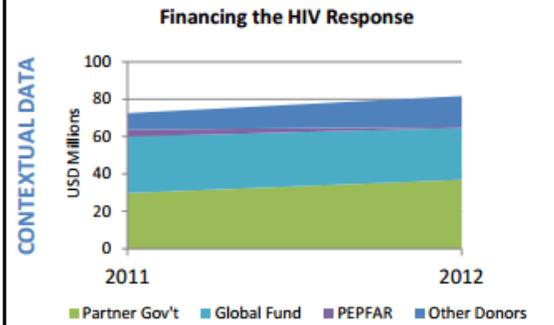
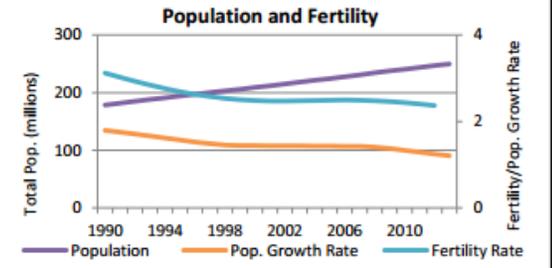
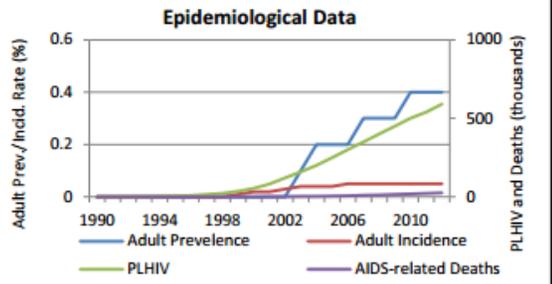
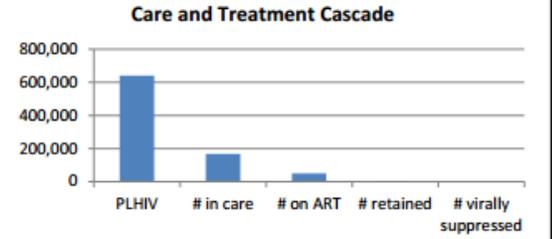
Epidemic Type: Concentrated  
 Income Level: Low Middle Income  
 PEPFAR Categorization: Targeted Assistance  
 COP 15 Planning Level:



SUSTAINABILITY DOMAINS and ELEMENTS

Institutionalized Data Availability	Score
1. Epidemiological and Health Data	11.8
2. Financial/Expenditure Data	13.8
3. Performance Data	13.0
Domestic Program and Service Delivery	Score
4. Access and Demand	10.8
5. Human Resources for Health	10.8
6. Commodity Security and Supply Chain	13.7
7. Quality Management	9.0
Health Financing and Strategic Investments	Score
8. DRM: Resource Generation	14.0
9. DRM: Resource Commitments	7.5
10. Allocative Efficiency	16.0
11. Technical Efficiency	19.0
Accountability and Transparency	Score
12. Public Access to Information	19.0
13. Oversight and Stewardship	15.0
Enabling Environment	Score
14. Policies, Laws, and Regulations	14.0
15. Planning and Coordination	20.0

## CONTEXTUAL DATA



### HTC Site Yield Figure:

Subnational Unit 1	Subnational Unit 2	Site Name	# of sites	# Positive	# Tested	Percent of positives	HTC HIV+ yield	Cumulative % sites	Cumulative % Positives
			48	1748	12421	100.0%	14.1%	100.0%	100.0%
Kepulauan Riau	Tanjung Pinang City	Tanjung Pinang City	1	15	51	0.9%	29.4%	2.1%	0.9%
Papua	Mimika	Mimika District	1	603	2073	34.5%	29.1%	4.2%	35.4%
Papua	Mimika District	Rumah Sakit Mitra Masyarakat	1	17	75	1.0%	22.7%	6.3%	36.3%
North Sumatera	Medan City	Puskesmas Teladan	1	11	51	0.6%	21.6%	8.3%	37.0%
Papua	Jayapura City	Jayapura City	1	51	248	2.9%	20.6%	10.4%	39.9%
Central Java	Semarang city	Semarang City	1	22	107	1.3%	20.6%	12.5%	41.1%
DKI Jakarta	East Jakarta	Puskesmas CAKUNG	1	1	5	0.1%	20.0%	14.6%	41.2%
North Sumatera	Medan City	Puskesmas Helvetia	1	20	106	1.1%	18.9%	16.7%	42.3%
Kepulauan Riau	Batam City	Batam City	1	60	331	3.4%	18.1%	18.8%	45.8%
DKI Jakarta	East Jakarta	Puskesmas MATRAMAN	1	1	6	0.1%	16.7%	20.8%	45.8%
Central Java	Tegal District	Puskesmas BANGUN GALIH	1	6	37	0.3%	16.2%	22.9%	46.2%
Papua	Jayawijaya District	Jayawijaya District	1	221	1386	12.6%	15.9%	25.0%	58.8%
Papua	Jayapura City	Jayapura District	1	117	760	6.7%	15.4%	27.1%	65.5%
DKI Jakarta	Central Jakarta	Klinik Ruang Carlo	1	71	564	4.1%	12.6%	29.2%	69.6%
Central Java	Tegal District	Puskesmas KRAMAT	1	3	24	0.2%	12.5%	31.3%	69.7%
DKI Jakarta	East Jakarta	Puskesmas KRAMAT JATI	1	1	8	0.1%	12.5%	33.3%	69.8%
DKI Jakarta	East Jakarta	Puskesmas DUREN SAWIT	1	3	25	0.2%	12.0%	35.4%	70.0%
East Java	Malang City	Malang City	1	55	463	3.1%	11.9%	37.5%	73.1%
East Java Province	Malang City	Puskesmas Dinoyo	1	36	320	2.1%	11.3%	39.6%	75.2%
DKI Jakarta	East Jakarta	Puskesmas CIRACAS	1	1	10	0.1%	10.0%	41.7%	75.2%
East Java	Surabaya City	Surabaya City	1	50	502	2.9%	10.0%	43.8%	78.1%
DKI Jakarta	South Jakarta	Klinik Angsamerah	1	65	671	3.7%	9.7%	45.8%	81.8%
Kepulauan Riau	Batam City	Puskesmas Lubuk Baja	1	3	32	0.2%	9.4%	47.9%	82.0%
DKI Jakarta	Central Jakarta	Administrative City of Central Jakarta	1	42	450	2.4%	9.3%	50.0%	84.4%
DKI Jakarta	East Jakarta	RSKO CIBUBUR	1	1	11	0.1%	9.1%	52.1%	84.4%
Papua	Mimika District	RSUD Mimika	1	1	11	0.1%	9.1%	54.2%	84.5%
East Java	Kediri District	Kediri District	1	61	682	3.5%	8.9%	56.3%	88.0%

Central Java	Banyumas District	Banyumas District	1	15	170	0.9%	8.8%	58.3%	88.8%
East Java Province	Malang City	Puskesmas Kendal Sari	1	8	91	0.5%	8.8%	60.4%	89.3%
East Java Province	Malang City	RS Syaiful Anwar	1	8	91	0.5%	8.8%	62.5%	89.8%
East Java Province	Malang	Puskesmas TUREN	1	4	50	0.2%	8.0%	64.6%	90.0%
East Java Province	Malang City	RSI Malang	1	5	63	0.3%	7.9%	66.7%	90.3%
East Java	Malang District	Malang District	1	24	304	1.4%	7.9%	68.8%	91.6%
DKI Jakarta	East Jakarta	Administrative City Of East Jakarta	1	28	360	1.6%	7.8%	70.8%	93.2%
Central Java	Tegal District	Puskesmas Jatibogor	1	2	27	0.1%	7.4%	72.9%	93.4%
DKI Jakarta	South Jakarta	Administrative City Of South Jakarta	1	13	178	0.7%	7.3%	75.0%	94.1%
Kepulauan Riau	Bintan District	Bintan District	1	12	178	0.7%	6.7%	77.1%	94.8%
West Java	Subang District	Subang District	1	6	93	0.3%	6.5%	79.2%	95.1%
DKI Jakarta	West Jakarta	Administrative City of West Jakarta	1	19	314	1.1%	6.1%	81.3%	96.2%
Central Java	Cilacap District	Puskesmas KESUGIHAN 2	1	2	34	0.1%	5.9%	83.3%	96.3%
North Sumatera	Medan City	Medan City	1	31	534	1.8%	5.8%	85.4%	98.1%
West Java	Indramayu district	Indramayu District	1	2	43	0.1%	4.7%	87.5%	98.2%
DKI Jakarta	North Jakarta	Klinik YAP	1	7	157	0.4%	4.5%	89.6%	98.6%
DKI Jakarta	North Jakarta	Administrative City of North Jakarta	1	9	235	0.5%	3.8%	91.7%	99.1%
Central Java	Semarang City	Klinik Griya Asa	1	10	279	0.6%	3.6%	93.8%	99.7%
Kepulauan Riau	Batam City	Klinik YKIE	1	5	148	0.3%	3.4%	95.8%	100.0%
East Java Province	Malang City	Puskesmas Arjuno	1	0	32	0.0%	0.0%	97.9%	100.0%
East Java Province	Malang City	Puskesmas Kendal Kerep	1	0	31	0.0%	0.0%	100.0%	100.0%

### Indonesia COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Banyumas	-	-	-	-	-
Batam City	-	-	-	-	-
Bintan District	-	-	-	-	-
Central Jakarta	4,380	919	1,831	1,052	2,009
East Jakarta	12,067	2,091	2,097	311	327
Indramayu	-	-	-	-	-
Jayapura City	6,828	556	557	577	585
Jayapura District	-	-	-	-	-
Jayawijaya District	2,704	516	559	341	395
Kediri District	-	-	-	-	-
Kendal District	-	-	-	-	-
Malang City	-	-	-	-	-
Malang District	-	-	-	-	-
Medan City	-	-	-	-	-
Mimika District	1,635	257	262	370	394
North Jakarta	2,748	485	489	1,015	1,020
Semarang City	-	-	-	-	-
Sorong	-	-	-	-	-
South Jakarta	3,676	685	724	1,063	1,123
Subang	-	-	-	-	-
Surabaya City	-	-	-	-	-
Tanjungpinang City	-	-	-	-	-
West Jakarta	3,186	549	555	898	911
Other_ Indonesia	4,917	-	-	-	-
<b>Total</b>	<b>42,141</b>	<b>6,058</b>	<b>7,074</b>	<b>5,627</b>	<b>6,764</b>

## Indonesia COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Banyumas	-	-	-
Batam City	-	-	-
Bintan District	-	-	-
Central Jakarta	-	7,108	-
East Jakarta	-	5,457	-
Indramayu	-	-	-
Jayapura City	5,728	2,323	-
Jayapura District	-	-	-
Jayawijaya District	7,453	502	-
Kediri District	-	-	-
Kendal District	-	-	-
Malang City	-	-	-
Malang District	-	-	-
Medan City	-	-	-
Mimika District	8,932	608	-
North Jakarta	-	1,300	-
Semarang City	-	-	-
Sorong	-	-	-
South Jakarta	-	6,796	-
Subang	-	-	-
Surabaya City	-	-	-
Tanjungpinang City	-	-	-
West Jakarta	-	3,475	-
Other_ Indonesia	-	-	-
<b>Total</b>	<b>22,113</b>	<b>27,569</b>	-



## HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

<b>Dark Green Score (17-20 pts)</b> (sustainable and requires no additional investment at this time)
<b>Light Green Score (13-16.9 pts)</b> (approaching sustainability and requires little or no investment)
<b>Yellow Score (7-12.9 pts)</b> (emerging sustainability and needs some investment)
<b>Red Score (0-6.9 pts)</b> (unsustainable and requires significant investment)

# Sustainability Analysis for Epidemic Control: INDONESIA

**Epidemic Type:** Concentrated  
**Income Level:** Low Middle Income  
**PEPFAR Categorization:** Targeted Assistance  
**COP 15 Planning Level:**

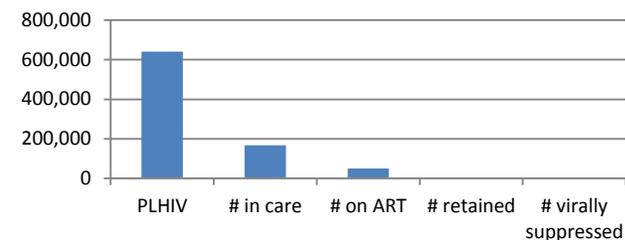


SUSTAINABILITY DOMAINS and ELEMENTS

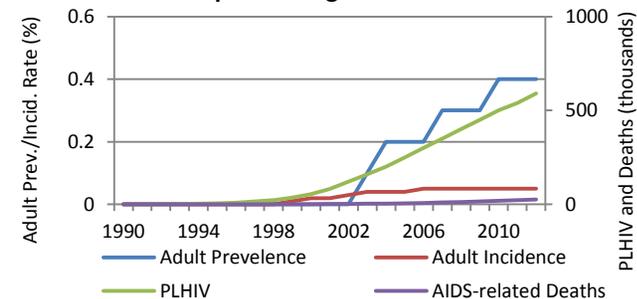
Institutionalized Data Availability		Score
1. Epidemiological and Health Data	Yellow	11.8
2. Financial/Expenditure Data	Light Green	13.8
3. Performance Data	Light Green	13.0
Domestic Program and Service Delivery		
4. Access and Demand	Yellow	10.8
5. Human Resources for Health	Yellow	10.8
6. Commodity Security and Supply Chain	Light Green	13.7
7. Quality Management	Yellow	9.0
Health Financing and Strategic Investments		
8. DRM: Resource Generation	Light Green	14.0
9. DRM: Resource Commitments	Yellow	7.5
10. Allocative Efficiency	Light Green	16.0
11. Technical Efficiency	Dark Green	19.0
Accountability and Transparency		
12. Public Access to Information	Dark Green	19.0
13. Oversight and Stewardship	Light Green	15.0
Enabling Environment		
14. Policies, Laws, and Regulations	Light Green	14.0
15. Planning and Coordination	Dark Green	20.0

## CONTEXTUAL DATA

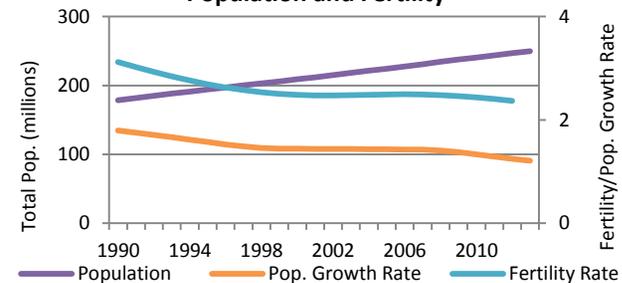
### Care and Treatment Cascade



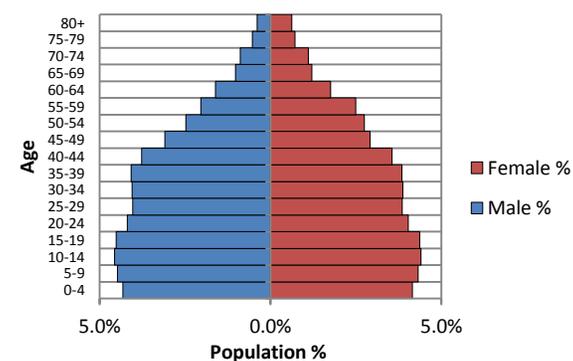
### Epidemiological Data



### Population and Fertility

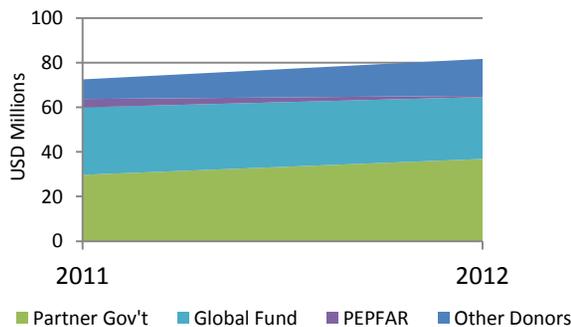


### Population Pyramid (2014)

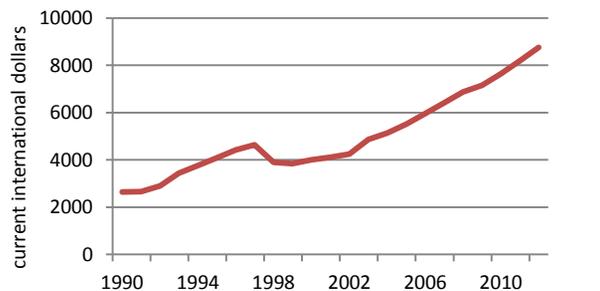


CONTEXTUAL DATA

### Financing the HIV Response



### GNI Per Capita (PPP)



## Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

**1. Epidemiological and Health data:** Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.

			Source of data	Notes/Comments
<p><b>Q1. Who leads:</b> Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?</p>	<p><input checked="" type="radio"/> A. Host Country Government/other domestic institution</p> <p><input type="radio"/> B. External agency with host country government</p> <p><input type="radio"/> C. External agency, organization or institution</p> <p><input type="radio"/> D. Not conducted</p>	4.5		<p>Representatives from the Coordinating Ministry of Human Development and Culture, National AIDS Commission and civil society met on February 17 to complete the SID Discussion. The following additional meetings occurred to complete the SID: meeting with UNAIDS and meeting with MOH. Response to Question no. 1: The MOH convenes international partners such as DFAT, WHO, UNAIDS, and representatives from Universities to discuss planning and implementation of HIV/AIDS epidemiological surveillance.</p>
<p><b>Q2. Who finances:</b> Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?</p>	<p><input type="radio"/> A. 80-100% of the total cost of latest survey was financed by Host Country Government</p> <p><input type="radio"/> B. 60-79% of the total cost of latest survey financed by Host Country Government</p> <p><input checked="" type="radio"/> C. 40-59% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> D. 20-39% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> E. 10-19% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> F. 0-9% of the total cost of latest survey financed by Host Country Government</p>	3		<p>In country budget with sources of funding from most recent DHS HIV/AIDS Section, AIS, key population surveys, or other population-based survey</p>
<p><b>Q3. Comprehensiveness of Prevalence and Incidence Data:</b> Does Host Country Government collect HIV prevalence and or incidence data?</p>	<p><input type="radio"/> No, the government does not collect HIV prevalence or incidence data</p> <p><input checked="" type="radio"/> Yes, the government collects (check all that apply):</p> <p><input checked="" type="checkbox"/> A. HIV prevalence</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data analyzed for trends</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data made publicly available</p> <p><input type="checkbox"/> B. HIV incidence</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input type="checkbox"/> Sub-national data</p>	2.3		<p>Prevalence for HIV is collected by the MOH regularly through different surveys, including the HIV sero surveillance survey. However, data on incidence is not collected directly and the country uses the Asian Epidemiologic Model to determine HIV incidence in the country.</p>

	<input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed for trends <input type="checkbox"/> Data made publicly available			
<b>Q4. Comprehensiveness of Viral Load Data:</b> Does Host Country Government collect viral load data?	<input checked="" type="radio"/> No, the government does not collect viral load data <input type="radio"/> Yes, the government collects viral load data (check all that apply): <input type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed to understand trends	0	In country source such as government report:	Per the national ART guidelines, currently viral load is not conducted routinely for monitoring of patients on ART. VL is not recommended to monitor ART patients due to limited facilities and patient inability to pay. It is only used to diagnose therapy failure (page36; National guidance for management for ART among adults, 2011). Therefore, there is no valid baseline data at this time. However, it is planned to use VL to monitor ART patients in 2016 and 2017 if the country's new funding model of the Global funds application is successful.
<b>Q5. Key Populations:</b> Does the Host Country Government conduct size estimation studies for key populations?	<input type="radio"/> No, the host country government does not conduct size estimation studies for key populations <input checked="" type="radio"/> Yes, the government conducts key population size estimates (check all that apply): <input checked="" type="checkbox"/> Men who have sex with men (MSM) <input checked="" type="checkbox"/> Female sex workers <input checked="" type="checkbox"/> Transgender <input checked="" type="checkbox"/> People who inject drugs (PWID) <input type="checkbox"/> Government finances at least 50% of the size estimation studies <input checked="" type="checkbox"/> Government leads and manages the size estimation studies	2	Title of the report is 2012 Size Estimation of Key Affected Population, MOH, 2014.	In country source such as government report: Ministry of Health, 2012 Population Size Estimation (PSE) Report for MSM, TG, Indirect Sex Workers, Direct Sex Workers, and PWID (MoH). There is a new PSE activity being planned to be implemented in 2015.
<b>Epidemiological and Health Data Score:</b>		11.8		

<b>2. Financial/Expenditure data:</b> Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.		Source of data	Notes/Comments
<b>Q1. Expenditure Tracking:</b> Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	<input type="radio"/> No, it does not have a national HIV/AIDS expenditure tracking system <input checked="" type="radio"/> Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): <input checked="" type="checkbox"/> A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input checked="" type="checkbox"/> B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening	2 In country source, such as government HIV/AIDS expenditure tracking policy, strategy or SOP: 2013 National Spending Assessment Report. <a href="http://www.kebijakanidsindonesia.net/jdownloads/Publikasi%20Publication/national_aids_spending_assessment_nasa_20112012_indonesia_final_report.pdf">http://www.kebijakanidsindonesia.net/jdownloads/Publikasi%20Publication/national_aids_spending_assessment_nasa_20112012_indonesia_final_report.pdf</a>	In country source, such as government HIV/AIDS expenditure tracking policy, strategy or SOP: 2013 National Spending Assessment Report. <a href="http://www.kebijakanidsindonesia.net/jdownloads/Publikasi%20Publication/national_aids_spending_assessment_nasa_20112012_indonesia_final_report.pdf">http://www.kebijakanidsindonesia.net/jdownloads/Publikasi%20Publication/national_aids_spending_assessment_nasa_20112012_indonesia_final_report.pdf</a>

	<input type="checkbox"/> C. Collected sub-nationally <input type="checkbox"/> D. Collected annually <input type="checkbox"/> E. Data is made publicly available			
<b>Q2. Quality of Expenditure Tracking:</b> Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others:	<input type="radio"/> No, they are not using any international standards for tracking expenditures  Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model. <input checked="" type="radio"/>	5	Based on 2013 National Spending Assessment Report published by National AIDS Commission	In country citations for latest NHA, NASA, government expenditure tracking report, global fund new funding model for country
<b>Q3. Transparency of Expenditure Data:</b> Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?	<input type="radio"/> No, they do not make expenditure data available to the public Yes, check the one that applies: <input type="radio"/> A. Annually <input checked="" type="radio"/> B. Bi-annually <input type="radio"/> C. Every three or more years	3	Based on 2013 National Spending Assessment Report published by National AIDS Commission	NASA is conducted every two years.
<b>Q4. Economic Studies:</b> Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?	<input type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS <input checked="" type="radio"/> Yes, check all that apply: <input checked="" type="checkbox"/> A. Costing studies or analyses <input checked="" type="checkbox"/> B. Cost-effectiveness studies or analyses <input checked="" type="checkbox"/> C. Efficiency studies or analyses <input type="checkbox"/> D. Cost-benefit studies or analyses	3.75	Based on Investment Case Analysis Report.	
<b>Financial/Expenditure Data Score:</b>		<b>14</b>		

<b>3. Performance data:</b> Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.		Source of data	Notes/Comments
<b>Q1. Collection of service delivery data:</b> Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?	<input type="radio"/> No, the government does not have an HIV/AIDS service delivery data collection system <input checked="" type="radio"/> Yes, service delivery data are collected/reported for (check all that apply): <input checked="" type="checkbox"/> A. For HIV Testing <input checked="" type="checkbox"/> B. For PMTCT <input checked="" type="checkbox"/> C. For Adult Care and Support <input type="checkbox"/> D. For Adult Treatment <input type="checkbox"/> E. For Pediatric Care and Support <input checked="" type="checkbox"/> F. For Pediatric Treatment <input type="checkbox"/> G. For AIDS-related mortality	4	HIV/AIDS service delivery HMIS policy/SOP and latest report citation: Most of HIV service data are collected and reported through the quarterly HIV MOH Report. The last one is the Quarter 4 of 2014. The link for the data is <a href="http://www.aidsindonesia.or.id/list/7/Laporan-Menkes">http://www.aidsindonesia.or.id/list/7/Laporan-Menkes</a>
<b>Q2. Analysis of service delivery data:</b> Does the host country government routinely analyze service delivery data to measure performance?	<input type="radio"/> No, the government does not routinely analyze service delivery data to measure performance <input checked="" type="radio"/> Yes, service delivery data are being analyzed to measure (check all that apply):	3	For each check, in-country source of latest data:  Coverage is still an issue since the denominator is not currently agreed upon. The data is not representative of national amounts and sometimes health facilities

<p><b>Q2. Analysis of service delivery data.</b> Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?</p>	<p><input type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence</p> <p><input type="checkbox"/> B. Results against targets</p> <p><input checked="" type="checkbox"/> C. Coverage</p> <p><input checked="" type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT)</p> <p><input checked="" type="checkbox"/> E. AIDS-related death rates</p>			<p>and sometimes nearn facilities consider loss to follow up of 6 months or above as death, contributing to AIDS related death rates. Indonesia has not scaled up the use of viral load suppression, therefore we could not measure the adherence based on international standard.</p>
<p><b>Q3. Comprehensiveness of service delivery data:</b> Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?</p>	<p><input type="radio"/> No</p> <p><input checked="" type="radio"/> Yes, service delivery data are being: (check all that apply):</p> <p><input checked="" type="checkbox"/> A. Collected at least quarterly</p> <p><input checked="" type="checkbox"/> B. Collected by age</p> <p><input checked="" type="checkbox"/> C. Collected by sex</p> <p><input checked="" type="checkbox"/> D. Collected from all clinical sites</p> <p><input type="checkbox"/> E. Collected from all community sites</p> <p><input type="checkbox"/> F. Data quality checks are conducted at least once a year</p>	4	<p>In country source, such as the latest HMIS report or presentation on HIV/AIDS services: The link for the data is <a href="http://www.aidsindonesia.or.id/list/7/Laporan-Menkes">http://www.aidsindonesia.or.id/list/7/Laporan-Menkes</a></p>	<p>The link for the data is <a href="http://www.aidsindonesia.or.id/list/7/Laporan-Menkes">http://www.aidsindonesia.or.id/list/7/Laporan-Menkes</a></p>
<p><b>Q4. Transparency of service delivery data:</b> Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?</p>	<p><input type="radio"/> No, they do not make program performance data available to the public</p> <p>Yes, check the one that applies:</p> <p><input checked="" type="radio"/> A. At least annually</p> <p><input type="radio"/> B. Bi-annually</p> <p><input type="radio"/> C. Every three or more years</p>	2	<p>In country source of where HIV/AIDS service delivery data are available to public, such as a website:<a href="http://www.aidsindonesia.or.id/list/7/Laporan-Menkes">http://www.aidsindonesia.or.id/list/7/Laporan-Menkes</a></p>	<p>The data is available at website of NAC. The link is <a href="http://www.aidsindonesia.or.id/list/7/Laporan-Menkes">http://www.aidsindonesia.or.id/list/7/Laporan-Menkes</a></p>
<b>Performance Data Score:</b>		<b>13</b>		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

## Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIV/AIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

<b>4. Access and Demand:</b> There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.		<b>Source of data</b>	<b>Notes/Comments</b>
<p><b>Q1. Access to ART:</b> What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input checked="" type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing ART.</p>	<p>Q1 Score: 0</p>	<p>In country source, i.e., SIMS, readiness assessments:</p>
<p><b>Q2. Access to PMTCT:</b> What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input checked="" type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.</p>	<p>Q2 Score: 2</p>	<p>In country source, i.e., readiness assessments:</p>
<p><b>Q3. Who is delivering HIV/AIDS services:</b> What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p>	<p>Q3 Score: 3</p>	<p>The data is available at website of NAC. The link is <a href="http://www.aidsindonesia.or.id/ist/7/Laporan-Menkes">http://www.aidsindonesia.or.id/ist/7/Laporan-Menkes</a></p>
<p><b>Q4. Access to ART:</b> What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p>	<p>Q4 Score: 2</p>	<p>The data is available at website of NAC. The link is <a href="http://www.aidsindonesia.or.id/">http://www.aidsindonesia.or.id/</a></p>

<p><b>Q4. Services to key populations:</b> What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input checked="" type="radio"/> B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p>		<p>ist/7/Laporan-Menkes</p>	
<p><b>Q5. Uptake of services:</b> What percent of PLHIV are currently receiving ART? _____%</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of PLHIV are currently receiving ART</p> <p><input type="radio"/> B. 50-79% of PLHIV are currently receiving ART</p> <p><input checked="" type="radio"/> C. 20-49% of PLHIV are currently receiving ART</p> <p><input type="radio"/> D. Less than 20% of PLHIV are currently receiving ART</p>	<p>Q5 Score</p> <p>2</p>	<p>Based on quarterly report from Ministry of Health, Quarter 4 2014. The data is available at website of NAC. The link is <a href="http://www.aidsindonesia.or.id/ist/7/Laporan-Menkes">http://www.aidsindonesia.or.id/ist/7/Laporan-Menkes</a>.</p>	<p>In country program data as of September 2014 indicates that 53, 64 % (50.400 are currently accessing ART out of 119.017 eligible for ART)</p>
<p><b>Q6. Rights to Access Services:</b> Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations.</p> <p><input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply):</p> <p><input checked="" type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> educates key populations about their legal rights in terms of access to</p> <p><input type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS</p> <p><input checked="" type="checkbox"/> national law exists regarding health care privacy and confidentiality protections</p> <p><input type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>Q6 Score</p> <p>1.8</p>	<p>In country source, i.e., government strategy/plan/SOP, HIV/AIDS Human Rights assessment report: 2014, Global AIDS Response Progress Reporting</p>	<p>Examples of government regulation for accessing the service: Amended narcotics law (Law 27/2009) guarantees the provision of medical and social rehabilitation for PWID. In 2013 the Ministry of Home Affairs issued Instruction no.444.24/2259/SJ 2013 on Institutional Strengthening and Community Empowerment for the AIDS Response at Provincial and District Levels. The Ministry of Public Works issued a policy letter as well as Decree No 3/2013 on the AIDS Response in Construction Sites, while the Ministry of Manpower and Transmigration released its VCT at work policy. While these initiatives reflect the improvement in political support and a strengthening of the multisectoral response, monitoring implementation of policies and laws remains a challenge, particularly at the provincial and district levels.</p>
<p><b>Access and Demand Score</b></p>			<p><b>10.8</b></p>	

<p><b>5. Human Resources for Health:</b> HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.</p>	Source of data	Notes/Comments		
<p><b>Q1. HRH Sufficiency:</b> Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> This information is not available</p> <p><input type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p> <p><input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply)</p> <p><input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand</p> <p><input type="checkbox"/> HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites</p>	<p>Q1 Score: 0</p>	<p>In country HRH assessments; HRIS data; in country training assessments; SIMS Above site SF tool "HRH Staffing CEE"</p>	
<p><b>Q2. HRH Transition:</b> What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input type="radio"/> B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date.</p> <p><input checked="" type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>Q2 Score: 3</p>	<p>In country PEPFAR HRH transition plan and documentation:</p>	<p>The assessment is only for PEPFAR priority sites; two private providers in Jakarta. Regarding investment from the Global Fund, there is an incentive and salary top up for health personnel in their sites. The Global Fund plans to remove all incentives and starting in FY 15 the amount for salary top-us will be decreased. The concept note is under development, but GF is phasing out salary top-ups.</p>
<p><b>Q3. HRH Financial reform:</b> Has financial reform been undertaken in the last 5 years to address government financing of health workers?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No financial reform has been undertaken in the last 5 years to address government financing of health workers</p> <p><input checked="" type="radio"/> B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply):</p> <p><input checked="" type="checkbox"/> Wage reform to increase salaries and or benefits of health workers</p> <p><input type="checkbox"/> Increase in budget allocation for salaries for health workers</p>	<p>Q3 Score: 1</p>	<p>In country source, i.e. report on HRH reform or civil service reform.</p>	<p>The wage reform to increase salary is mostly applicable for isolated areas with hardship.</p>
	<p>Check the one answer that best describes the current situation:</p>	<p>Q4 Score: 1.8</p>	<p>SIMS Above Site-SF Tool, "Pre-Career Education" CEE-2015</p>	<p>Higher education in Indonesia includes</p>

<p><b>Q4. Pre-Service:</b> Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p>	<p><input type="radio"/> A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input checked="" type="checkbox"/> content updated for all HIV/AIDS services</p> <p><input checked="" type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input type="checkbox"/> updated curriculum is problem based/competency based</p> <p><input type="checkbox"/> updated curriculum includes practicums at high volume clinical/ social services sites</p> <p><input type="checkbox"/> institutions that track students after graduation</p>		<p>Service Education CEE or if other country team knowledge. The publication in the National AIDS Commission: the link <a href="http://www.aidsindonesia.or.id/elib/home/koleksi/19/0/5">http://www.aidsindonesia.or.id/elib/home/koleksi/19/0/5</a></p>	<p>Indonesia, including faculty of medicine, is regulated by the Ministry of National Education. HIV/AIDS is not a mandatory subject for Faculty of Medicine, but some universities (including University of Indonesia) offer HIV/AIDS as an elective subject. The same principles apply to School for Midwives and Nurses, which are regulated by the Ministry of Health.</p>
<p><b>Q5. In-Service:</b> To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training.</p> <p><input type="radio"/> B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented.</p> <p><input type="radio"/> C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date.</p> <p><input checked="" type="radio"/> D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.</p>	<p>Q5 Score: 0</p>	<p>Country Team Knowledge; SIMS Inservice Training CEE</p>	
<p><b>Q6. HRIS:</b> Does the government have a functional Human Resource Information System (HRIS) for the health sector?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No, there is no HRIS</p> <p><input checked="" type="radio"/> B. Yes, the government does have a HRIS (check all that apply)</p> <p><input checked="" type="checkbox"/> The HRIS is primarily funded by host country institutions</p> <p><input type="checkbox"/> There is a national interoperability strategy for the HRIS</p> <p><input type="checkbox"/> The government produces HR data from the HRIS at least annually</p> <p><input checked="" type="checkbox"/> The government uses data from the HRIS for HR planning and management</p>	<p>Q6 Score: 1</p>	<p>National HRIS document and the link is <a href="http://ropeg.kemkes.go.id/documents/PMK%20No.%2073%20ttg%20Jabatan%20Fungsional%20Umum%20di%20Kementerian%20Kesehatan.pdf">http://ropeg.kemkes.go.id/documents/PMK%20No.%2073%20ttg%20Jabatan%20Fungsional%20Umum%20di%20Kementerian%20Kesehatan.pdf</a></p>	
	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p>	<p>Q7 Score: 4</p>	<p>National Budget</p>	

<p><b>Q7. Domestic funding for HRH:</b> What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?</p>	<p> <input type="radio"/> A. Less than 20%  <input type="radio"/> B. 20-49%  <input type="radio"/> C. 50-79%  <input checked="" type="radio"/> D. 80% or more </p>			
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**Human Resources for Health Score**

**10.8**

<p><b>6. Commodity Security and Supply Chain:</b> The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.</p>		<p><b>Source of data</b></p>	<p><b>Notes/Comments</b></p>	
<p><b>Q1. ARV domestic financing:</b> What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p> <input type="radio"/> This information is not known  <input type="radio"/> A. 0-9% obligated from domestic public sources  <input type="radio"/> B. 10-29% obligated from domestic public sources  <input type="radio"/> C. 30-79% obligated from domestic public sources  <input checked="" type="radio"/> D. 80% or more obligated from domestic public sources </p>	<p>Q1 Score: 3</p>	<p>Data from NASA, NHA, or Supply Chain management . The link to presentation from MOH:  <a href="http://www.google.com/url?sa=t&amp;rct=j&amp;q=&amp;esrc=s&amp;frm=1&amp;source=web&amp;cd=1&amp;ved=0CB4QFjAA&amp;url=http%3A%2F%2Fpag.ias2013.org%2FPAGMaterial%2FPPT%2F624_591%2FIndonesia.pptx&amp;ei=LzAJVZVL4YKx8gdgM&amp;usg=AFQjCNFIDT-def9MqYsGI5v1MANYZnr8yQ">http://www.google.com/url?sa=t&amp;rct=j&amp;q=&amp;esrc=s&amp;frm=1&amp;source=web&amp;cd=1&amp;ved=0CB4QFjAA&amp;url=http%3A%2F%2Fpag.ias2013.org%2FPAGMaterial%2FPPT%2F624_591%2FIndonesia.pptx&amp;ei=LzAJVZVL4YKx8gdgM&amp;usg=AFQjCNFIDT-def9MqYsGI5v1MANYZnr8yQ</a> </p>	
<p><b>Q2. Test Kit domestic financing:</b> What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p> <input type="radio"/> This information is not known  <input type="radio"/> A. 0-9% obligated from domestic public sources  <input type="radio"/> B. 10-29% obligated from domestic public sources  <input checked="" type="radio"/> C. 30-79% obligated from domestic public sources  <input type="radio"/> D. 80% or more obligated from domestic public sources </p>	<p>Q2 Score: 2</p>	<p>Same as above:  <a href="http://www.google.com/url?sa=t&amp;rct=j&amp;q=&amp;esrc=s&amp;frm=1&amp;source=web&amp;cd=1&amp;ved=0CB4QFjAA&amp;url=http%3A%2F%2Fpag.ias2013.org%2FPAGMaterial%2FPPT%2F624_591%2FIndonesia.pptx&amp;ei=LzAJVZVL4YKx8gdgM&amp;usg=AFQjCNFIDT-def9MqYsGI5v1MANYZnr8yQ">http://www.google.com/url?sa=t&amp;rct=j&amp;q=&amp;esrc=s&amp;frm=1&amp;source=web&amp;cd=1&amp;ved=0CB4QFjAA&amp;url=http%3A%2F%2Fpag.ias2013.org%2FPAGMaterial%2FPPT%2F624_591%2FIndonesia.pptx&amp;ei=LzAJVZVL4YKx8gdgM&amp;usg=AFQjCNFIDT-def9MqYsGI5v1MANYZnr8yQ</a> </p>	
<p><b>Q3. Condom domestic financing:</b> What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p> <input type="radio"/> This information is not known  <input type="radio"/> A. 0-9% obligated from domestic public sources  <input checked="" type="radio"/> B. 10-29% obligated from domestic public sources  <input type="radio"/> C. 30-79% obligated from domestic public sources  <input type="radio"/> D. 80% or more obligated from domestic public sources </p>	<p>Q3 Score: 1</p>	<p>In country source, i.e., NHA, MOH, Condom assessment report, NASA report: NASA 2012 report</p>	
<p><b>Q4. Supply Chain Plan:</b> Does the country have an agreed-upon national supply chain plan with</p>	<p> <input type="radio"/> A. No, there is no plan or thoroughly annually reviewed supply chain SOP  <input checked="" type="radio"/> B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) </p> <p> <input type="checkbox"/> Human resources  <input checked="" type="checkbox"/> Training  <input checked="" type="checkbox"/> Warehousing  <input checked="" type="checkbox"/> Distribution </p>	<p>Q4 Score: 3.7</p>	<p>National supply chain plan/SOP:</p>	<p>There is a document for supply chain management but not yet updated.</p>

<p>an implementation plan or a thorough annually-reviewed supply chain SOP?</p>	<input checked="" type="checkbox"/> Reverse Logistics <input checked="" type="checkbox"/> Waste management <input checked="" type="checkbox"/> Information system <input checked="" type="checkbox"/> Procurement <input checked="" type="checkbox"/> Forecasting <input checked="" type="checkbox"/> Supply planning and supervision				
<p><b>Q5. Stock:</b> Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?</p>	<input type="radio"/> A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time <input checked="" type="radio"/> B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time <input checked="" type="checkbox"/> Both public and (if they exist in the country) private storage facilities at central level <input checked="" type="checkbox"/> Both public and (if they exist in the country) private storage facilities at intermediate level	<p>Q5 Score: 3</p>	<p>In country source, i.e., supply chain assessment report, LMIS data: There is IOMS so at the national level there is information on commodity stock but might not complete. The link is</p>		
<p><b>Q6. Assessment:</b> Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment?  (If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)</p>	<input type="radio"/> A. No assessment has been conducted nor do they have a system to oversee the supply chain <input checked="" type="radio"/> B. Yes, an assessment was conducted but they received below 80% <input type="radio"/> C. No assessment was conducted, but they have a system to oversee the supply chain that reviews: <input type="checkbox"/> Commodity requirements <input type="checkbox"/> Commodity consumption <input type="checkbox"/> Coordinates procurements <input type="checkbox"/> Delivery schedules <input type="radio"/> D. Yes, an assessment was conducted and they received a score that was 80% or higher	<p>Q6 Score: 1</p>	<p>In country Assessment Report. PEPFAR Indonesia has funded an assessments on the SCM issues in 4 provinces was done in early 2014 which gives relatively good idea of the strengths (IOMS) and weaknesses (warehouse management, stock of ARVS, impact of decentralization, etc) of the ARV management situation.</p>		
<b>Commodity Security and Supply Chain Score</b>		<b>13.7</b>			
<p><b>7. Quality Management:</b> Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.</p>			<b>Source of data</b>	<b>Notes/Comments</b>	
	<input type="radio"/> A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH	<p>Q1 Score: 2</p>	<p>In country sources, i.e., QM/QI strategic plan/SOP, QM/QI</p>		

<p><b>Q1. Existence of System:</b> Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?</p>	<p><input checked="" type="radio"/> Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply):</p> <p><input checked="" type="checkbox"/> Routinely reviews national HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Routinely reviews district/regional HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Prioritizes areas for improvement</p>		<p>Assessment Report: Link to Minimum Standard for Care at district level is:  <a href="http://www.litbang.depkes.go.id/sites/download/regulasi/kepmenkes/KMK_no_1457-th-2003.pdf">http://www.litbang.depkes.go.id/sites/download/regulasi/kepmenkes/KMK_no_1457-th-2003.pdf</a></p>	
<p><b>Q2. Strategy:</b> Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?</p>	<p><input type="radio"/> No, there is no HIV/AIDS-related QM/Q strategy</p> <p><input checked="" type="radio"/> B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years)</p> <p><input type="radio"/> C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p>	<p>Q2 Score: 2</p>	<p>QM/QI Strategy document and link is  <a href="http://pppl.depkes.go.id/_asset/_regulasi/100_Permenkes%20No%2021%20Tahun%202013%20Peningkatan%20HIVAIDS.pdf">http://pppl.depkes.go.id/_asset/_regulasi/100_Permenkes%20No%2021%20Tahun%202013%20Peningkatan%20HIVAIDS.pdf</a></p>	
<p><b>Q3. Guidelines:</b> Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?</p>	<p><input type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input checked="" type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <p><input checked="" type="checkbox"/> PMTCT (option B+)</p> <p><input checked="" type="checkbox"/> Adult ART</p> <p><input checked="" type="checkbox"/> Pediatric ART</p> <p><input checked="" type="checkbox"/> Adolescent ART</p> <p><input checked="" type="checkbox"/> Test and treat for specific populations</p>	<p>Q3 Score: 4</p>	<p>Current government SOP/technical guidelines for PMTCT and ART:  <a href="http://pppl.depkes.go.id/_asset/_regulasi/94_PMK%20No.%2051%20ttg%20Pencegahan%20Penerapan%20HIV%20ibu%20ke%20Anak.pdf">http://pppl.depkes.go.id/_asset/_regulasi/94_PMK%20No.%2051%20ttg%20Pencegahan%20Penerapan%20HIV%20ibu%20ke%20Anak.pdf</a></p>	
<p><b>Q4. QI Data use:</b> Does the host country government monitor and use data for HIV/AIDS quality improvement?</p>	<p><input type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input checked="" type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <p><input type="checkbox"/> All sites</p> <p><input type="checkbox"/> Use of data to determine quality of program or services</p> <p><input type="checkbox"/> Making recommendations and action plan for mid-course corrections</p>	<p>Q4 Score: 1</p>	<p>In country sources, i.e., report, presentation, or annual plan indicating use of data for quality improvement:</p>	
<p><b>Q5. Post-transition:</b> Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned</p>	<p><input checked="" type="radio"/> A. No, there is no quality monitoring at sites post-transition</p> <p><input type="radio"/> B. Yes, there is quality monitoring at transition sites. Monitoring includes:</p> <p><input type="checkbox"/> All transition sites</p> <p><input type="checkbox"/> Review of service outcomes</p>	<p>Q5 Score: 0</p>	<p>In country sources, i.e., post-transition report or documentation:</p>	

from a direct implementation role?

Client feedback on changes in quality

Quality improvement action plan

C. PEPFAR/other donors have never supported direct service delivery in the country

Quality Management Score

9

**THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN**

## Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

<b>8. Domestic Resource Mobilization: Resource Generation:</b> The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.		<b>Source of data</b>	<b>Notes/Comments</b>
<b>Q1. Domestic budget:</b> Is there a budget line item for HIV/AIDS in the national budget?	<input type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget  <input type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget  <input checked="" type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries  <input type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 4	In country source, i.e. national budget, budget summary or report for 2014:  HIV budget is included in the following technical ministries: MOHA, Ministry of Public Works, Ministry of Transportation, Ministry of Defense, Ministry of Justice and Human Rights, Ministry of Tourism and Ministry of Religion
<b>Q2. Budgetary Framework:</b> Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	<input type="radio"/> A. No  <input type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program  <input checked="" type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 6	In country source, i.e. national budget, budget summary or report for 2014:
<b>Q3. Fiscal Policy:</b> Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	<input checked="" type="radio"/> Yes  <input type="radio"/> No	Q3 Score: 4	OGAC-provided data sheet (follows tab E)  derived from: <a href="http://www.mcc.gov/pages/s-election/scorecards">http://www.mcc.gov/pages/s-election/scorecards</a>
<b>Q4. Domestic public revenue:</b> What was annual domestic government revenue as a percent of	Check the appropriate box for your country's income category:  <u>FOR LOW INCOME</u> <input type="radio"/> A. More than 16.4% (i.e. surpasses category mean) <input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean) <input type="radio"/> C. Less than 14.8%, (less than 90% of category mean)  <u>FOR LOW MIDDLE INCOME</u>	Q4 Score: 0	OGAC-provided data sheet (follows tab E)  Original Source: IMF Government Finance Statistics  Based on the discussion with National AIDS Commission on February 17, 2015

GDP in the most recent year available? (domestic revenue excludes external grants)	<input type="radio"/> D. More than 22.3% (i.e. surpasses category mean) <input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean) <input checked="" type="radio"/> F. Less than 20.1% (less than 90% of category mean) <b>FOR UPPER MIDDLE INCOME</b> <input type="radio"/> G. More than 27.8% (i.e. surpasses category mean) <input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean) <input type="radio"/> I. Less than 25.0% (less than 90% of category mean)			
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**Score for Domestic Resource Mobilization: Resource Generation: 14**



<b>9. Domestic Resource Mobilization: Resource Commitments:</b> Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.		<b>Source of data</b>	<b>Notes/Comments</b>
<b>Q1. Benchmarks for health spending:</b>  <b>African countries:</b> Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)?  <b>Non-African countries:</b> Is government health expenditure at least 3 percent of GDP?	<input type="radio"/> A. Yes  <input checked="" type="radio"/> B. No	Q1 Score: 0	OGAC-provided data sheet (follows tab E)  Original sources: WHO and World Bank  Based on discussion, although there is no specific allocation for health in the constitution. In FY 13, the budget for HIV/AIDS at the national level was 4% of the national budget
<b>Q2. Domestic spending:</b> What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%	<input type="radio"/> A. Less than 10% <input type="radio"/> B. 10-24% <input checked="" type="radio"/> C. 25-49% <input type="radio"/> D. 50-74% <input type="radio"/> E. 75% or Greater	Q2 Score: 5	2013 NASA  Based on FY 2013 NASA Report
	<input type="radio"/> A. None or information is not available  <input type="radio"/> B. 1-9%	Q3 Score: 2.5	In country source, i.e., NASA data, national expenditure analysis report:  Based on 2013 NASA Report. Funding for Key Population is 33% while for PLHIV is 40% of the budget

<p><b>Q3. Key population spending:</b> What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?</p>	<p><input type="radio"/> 10-24%</p> <p><input checked="" type="radio"/> 25-49%</p> <p><input type="radio"/> 50-74%</p> <p><input type="radio"/> 75% or Greater</p>			
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<b>Score for Domestic Resource Mobilization: Resource Commitments:</b>	<b>7.5</b>
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10. <b>Allocative Efficiency:</b> The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).	Source of data	Notes/Comments		
<p><b>Q1. Data-driven allocation:</b> Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?</p>	<p><input type="radio"/> A. No, data are not used annually</p> <p><input checked="" type="radio"/> B. Yes, data are used annually. Check all that apply:</p> <p><input checked="" type="checkbox"/> Epidemiological data are used</p> <p><input checked="" type="checkbox"/> Health/service delivery data are used</p> <p><input checked="" type="checkbox"/> Financial data are used</p> <p><input checked="" type="checkbox"/> There is integrated analysis across data streams</p> <p><input checked="" type="checkbox"/> Multiple data streams are used to model scenarios</p>	<p>Q1 Score: 10</p>	<p>Link to budgeting process in Indonesia  <a href="http://www.setneg.go.id//index.php?option=com_perundangan&amp;id=3112&amp;task=detail&amp;catid=1&amp;Itemid=42&amp;tahun=2004">http://www.setneg.go.id//index.php?option=com_perundangan&amp;id=3112&amp;task=detail&amp;catid=1&amp;Itemid=42&amp;tahun=2004</a></p>	<p>The MOH and other technical ministries submit budget planning annually to the National Planning Agency (Bappenas). Approval for the annual budget is approved by legislature.</p>
<p><b>Q2. Geographic allocation:</b> Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?</p>	<p><input type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites</p> <p><input type="radio"/> B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input checked="" type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p>	<p>Q2 Score: 5</p>	<p>In country government source, i.e., presentation, Investment Case Analysis Report, 2013 draft</p>	<p>Will provide source of data</p>

	<input type="radio"/> E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients			
<b>Q3.Data driven reprogramming:</b> Do host country government policies/systems allow for reprogramming investments based on new or updated program data during the government funding cycle?	<input type="radio"/> A. No, there is no system for funding cycle reprogramming <input checked="" type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used <input type="radio"/> C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data <input type="radio"/> D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 1	Investment Case Analysis Report, 2013 draft	Reprogramming of this funding is mostly based on policy and the budget's ability to absorb funds.
<b>Allocative Efficiency Score:</b>		<b>16</b>		

<b>11. Technical Efficiency:</b> Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.		Source of data	Notes/Comments
<b>Q1. Unit costs:</b> Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services?  (note: full score of five points can be achieved without checking all disaggregate boxes).	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes (check all that apply): <input checked="" type="checkbox"/> Annually <input checked="" type="checkbox"/> For HIV Testing <input checked="" type="checkbox"/> For Care and Support <input checked="" type="checkbox"/> For ART <input checked="" type="checkbox"/> For PMTCT <input type="checkbox"/> For VMMC <input type="checkbox"/> For OVC Service Package <input checked="" type="checkbox"/> For Key population Interventions	Q1 Score: 5	In country source, i.e., government document, report or presentation, Investment Case Analysis Report, 2013 draft

<p><b>Q2. Improving efficiency:</b> Which of the following actions is the Host Country Government taking to improve technical efficiencies?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions</li> <li><input type="checkbox"/> Streamlining management to reduce overhead costs</li> <li><input checked="" type="checkbox"/> Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling</li> <li><input checked="" type="checkbox"/> Improving procurement competition</li> <li><input checked="" type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public)</li> <li><input checked="" type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact</li> <li><input checked="" type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact</li> <li><input checked="" type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs</li> </ul>	<p>Q2 Score: 3</p>	<p>In country sources for each checked.</p>	<p>Pooled procurement for ARV, condoms, reagents and needles</p>
<p><b>Q3. Loss ratio:</b> Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>Q3 Score: 3</p>	<p>In country source, i.e., national HIV/AIDS, 2013 NASA Report</p>	
<p><b>Q4. Benchmark prices:</b> Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?</p>	<p>Check boxes that apply:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> They are not paying for any ARVs</li> <li><input type="checkbox"/> They are not paying for any test kits</li> <li><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs</li> <li><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits</li> </ul>	<p>Q4 Score: 4</p>	<p><a href="http://apps.who.int/hiv/amds/price/hdd/Default.aspx">http://apps.who.int/hiv/amds/price/hdd/Default.aspx</a></p>	
<p><b>Q5. ART unit costs:</b> Have average unit costs for providing ART in the country reduced within the last two years?</p> <p>Unit cost 2 years ago: \$ _____</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>4</p>	<p><a href="#">WHO, Global Price Reporting Mechanism - <a href="http://apps.who.int/hiv/amds/price/hdd/">http://apps.who.int/hiv/amds/price/hdd/</a></a></p>	

Current unit cost: \$ _____				
Technical Efficiency Score:				19

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

## Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. <b>Public Access to Information:</b> Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.	Source of data	Notes/Comments
<p><b>Q1. OBI:</b> What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)</p>	<p> <input type="radio"/> A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10)  <input checked="" type="radio"/> B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10)  <input type="radio"/> C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10)  <input type="radio"/> D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10)  <input type="radio"/> E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10)  <input type="radio"/> F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget                 </p>	<p>Q1 Score: 7.0</p> <p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index (<a href="http://survey.internationalbudget.org/">http://survey.internationalbudget.org/</a>) and PEFA data (<a href="http://www.pefa.org">www.pefa.org</a>)</p>
<p><b>Q2. National program report transparency:</b> Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?</p>	<p> <input type="radio"/> A. No, the national HIV/AIDS program progress report or presentation of results is not made public  <input checked="" type="radio"/> B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply):                 </p> <p> <input checked="" type="checkbox"/> On Website  <input checked="" type="checkbox"/> Through any type of media  <input checked="" type="checkbox"/> Disseminate print report or presentation of results                 </p>	<p>Q2 Score: 6.0</p> <p>In country source, i.e., last annual national HIV/AIDS progress report or presentation:</p>
<p></p>	<p> <input type="radio"/> A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically                 </p>	<p>Q3 Score: 6.0</p> <p>In country source, i.e., last HIV/AIDS audit report:</p>

<p><b>Q3. Audit transparency:</b> Does the host country government make an annual national HIV/AIDS program audit report publically available?</p>	<p><input checked="" type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:</p> <p><input checked="" type="checkbox"/> On website</p> <p><input checked="" type="checkbox"/> Through any type of media</p> <p><input checked="" type="checkbox"/> Disseminate print report</p>			
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**Public Access to Information Score: 19**

13. Oversight and Stewardship: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.				
			Source of data	Notes/Comments
<p><b>Q1. Availability of Information on Resources Received by Service Delivery Units.</b> PEFA score on PI-23 was C or higher in most recent assessment.</p>	<p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input checked="" type="radio"/> B. PEFA was conducted and score was below C</p> <p><input type="radio"/> C. PEFA was conducted and score was C</p> <p><input type="radio"/> D. PEFA was conducted and score was B</p> <p><input type="radio"/> E. PEFA was conducted and score was A</p>	<p>Q1 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	<p>Score was a D.</p>
<p><b>Q2. Quality and timeliness of annual financial statements.</b> PEFA score for element PI-25 was C or higher in most recent assessment.</p> <p>Actual scores are B, A, B.</p>	<p>Check A or B; if B checked, select appropriate disaggregates:</p> <p><input type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input checked="" type="radio"/> B. PEFA was conducted and score was C or higher for:</p> <p><input checked="" type="checkbox"/> (i) Completeness of the financial statements</p> <p><input checked="" type="checkbox"/> (ii) Timeliness of submission of the financial statements</p> <p><input checked="" type="checkbox"/> (iii) Accounting standards used</p>	<p>Q2 Score: 5.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</p>	
	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p>		<p>In country source, i.e., reports indicating CSO</p>	

<p><b>Q3. Government Channels and Opportunities for Civil Society Engagement:</b> Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p>	<p> <input type="radio"/> A. No, there are no formal channels or opportunities  <input type="radio"/> B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback  <input checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply:         </p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> During strategic and annual planning</li> <li><input checked="" type="checkbox"/> In joint annual program reviews</li> <li><input checked="" type="checkbox"/> For policy development</li> <li><input checked="" type="checkbox"/> As members of technical working groups</li> <li><input checked="" type="checkbox"/> Involvement on evaluation teams</li> <li><input checked="" type="checkbox"/> Giving feedback through social media</li> <li><input checked="" type="checkbox"/> Involvement in surveys/studies</li> <li><input checked="" type="checkbox"/> Collecting and reporting on client feedback</li> </ul>	<p>Q3 Score: 6.0</p>	<p>engagement, policies or SOPs:</p>	
<p><b>Q4. Civil society Enabling Environment:</b> What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society?</p> <p>If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?</p>	<p> <input type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or policies that restrict civil society playing an oversight role  <input type="radio"/> B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government  <input checked="" type="radio"/> C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight         </p>	<p>Q4 Score: 4.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Civicus Enabling Environment Index (<a href="http://civicus.org/eei/">civicus.org/eei/</a>)</p>	
<p><b>Oversight and Stewardship Score:</b></p>		<p>15</p>		

**THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN**

## Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. **Policies, Laws, and Regulations:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

Source of data

Notes/Comments

**Q1. Structural obstacles:** Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?

- A. No, there are no such laws or policies
- B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score):
- Criminalization of HIV transmission
- HIV testing disclosure policies or age requirements
- Non-disclosure of HIV status laws
- Anti-homosexuality laws
- Anti-prostitution legislation
- Laws that criminalize drug use, methadone use or needle exchange

Q1 Score: 6.0

Global AIDS Response Progress Report, 2014

There is no policy at the national level that presents a barrier to implementation of HIV prevention, care and support. However, gaps still remain in local policies and/or regulations that support access to KAP and PLHIV to services. These include recognition of the right to services and policies that are gender sensitive and address stigma and discrimination. Moreover, some local governments have passed regulations relating to HIV, drug use, sex work and male to male sex that are inconsistent with national or international-level guidelines and provisions on human rights. Furthermore, there are numerous reports of actions by legislators, law enforcement agencies and faith-based organizations that abuse and violate the rights of KAPs

**Q2. Access protection:** Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated?

(note: full score of six points possible without checking all boxes)

- A. No, there are no such policies or laws
- B. Yes, there are such policies and laws. Check all that apply:
- For people living with HIV
- For men who have sex with men
- For transgendered persons
- For sex workers
- For people who inject drugs
- For children orphaned or affected by HIV/AIDS
- For young girls and women vulnerable to HIV

Q2 Score: 2.0

Global AIDS Response Progress Report, 2014

There is no policy or law that specifically prevents key populations from accessing social and legal protection. This means that there are no restrictions for key populations to access social and legal protection. The amended narcotics law (Law 27/2009) guarantees the provision of medical and social rehabilitation for PWID. Ministry of Health Regulation number 21 of 2013 regarding HIV/AIDS Countermeasures provides a strong basis for protection of people living with HIV/AIDS from discrimination, particularly in the health settings. Article 30, paragraph (1) of the Regulation states that "all health service facilities are prohibited in rejecting treatment and care of people living with HIV/AIDS." Link: [http://pppl.depkes.go.id/\\_asset/\\_regulasi/100\\_Permenkes%20No%2021%20Tahun%202013%20P enanggulan%20HIVAIDS.pdf](http://pppl.depkes.go.id/_asset/_regulasi/100_Permenkes%20No%2021%20Tahun%202013%20P enanggulan%20HIVAIDS.pdf)

	<input checked="" type="checkbox"/> For survivors of gender-based violence			
<b>Q3. Civil society sustainability:</b> Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	<input type="radio"/> A. No, there are no special provisions or advantages for CSOs <input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply:  <input type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs <input checked="" type="checkbox"/> Significant tax exemptions for not-for-profit CSOs <input checked="" type="checkbox"/> Open competition among CSOs to provide government-funded services <input checked="" type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 3.0	In country source, name of legislation: Presidential Regulation no. 54, 2010 .	There are government regulations regarding CSOs' ability to provide services using open competition.
<b>Q4. Enabling legislation:</b> Are there policies or legislation that govern HIV/AIDS service delivery?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, there are. Check all below that are included:  <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV  <input type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 3.0	The link is <a href="http://pppl.depkes.go.id/_asset/_regulasi/100_Permenkes%20No%2021%20Tahun%202013%20Penanggulangan%20HIVAIDS.pdf">http://pppl.depkes.go.id/_asset/_regulasi/100_Permenkes%20No%2021%20Tahun%202013%20Penanggulangan%20HIVAIDS.pdf</a>	There is no legislation on the HIV/AIDS Program, Indonesia has a Decree from Ministry of Health
<b>Policies, Laws, and Regulations Score:</b>		<b>14</b>		
<b>15. Planning and Coordination:</b> Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			<b>Source of data</b>	<b>Notes/Comments</b>
<b>Q1. National Strategy:</b> Does the country have a multi-year, costed national strategy to respond to HIV?	<input type="radio"/> A. No, there is no national strategy for HIV/AIDS <input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply:  <input checked="" type="checkbox"/> It is multiyear <input checked="" type="checkbox"/> It is costed <input checked="" type="checkbox"/> Its development was led by the host country government	Q1 Score: 4.0	Draft of Investment Case Analysis and the draft national HIV Strategy plan 2015-2019	

	<input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy			
<b>Q2. Data driven prioritization:</b> Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?	<input type="radio"/> A. No data-driven prioritization approach was used <input type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources <input checked="" type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources	Q2 Score: 4	Draft of National Strategy, Ministry of Health	
<b>Q3. CCM criteria:</b> Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?	<input type="radio"/> A. No or there is no CCM <input type="radio"/> B. Yes, with conditions <input checked="" type="radio"/> C. Yes	Q3 Score: 2	Global Fund Eligibility List 2014	
<b>Q4. Coordination of national response:</b> Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?	<input type="radio"/> A. No, it does not track or map all HIV/AIDS activities <input checked="" type="radio"/> B. the host country government coordinates all HIV/AIDS activities. Check all that apply: <input checked="" type="checkbox"/> Of Civil Society Organizations <input checked="" type="checkbox"/> Of private sector <input checked="" type="checkbox"/> Of donor implementing partners <input checked="" type="checkbox"/> Activities are tracked or mapped <input checked="" type="checkbox"/> Duplications and gaps are addressed <input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies	Q4 Score: 6.0	2013 NASA from National AIDS Commission	
<b>Q5. Civil society engagement:</b> Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply: <input checked="" type="checkbox"/> In advocacy <input checked="" type="checkbox"/> In programmatic decision-making	Q5 Score: 4.0	Global AIDS Response Progress Report, 2014	Based on discussion with National AIDS Commission on February 17, 2015

In technical decision-making

In service delivery

Planning and Coordination Score:

20

**THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN**