Indonesia

Operational Plan Report

FY 2010

Operating Unit Overview

OU Executive Summary

Funding Sources:
GHCS-USAID: $7,750,000
GHCS-State (DOD): $250,000

Aligning PEPFAR Indonesia with PEPFAR II vision

In alignment with PEPFAR II's vision, the FY 2010 Country Operational Plan (COP) embodies a shifting emphasis to develop and support country-level ownership by working with both the Government of Indonesia (GOI) and civil society to expand organizational and technical efficiency and capacity. The President's Emergency Plan for AIDS Relief **(**PEPFAR) program in Indonesia is strategically targeted and works under the umbrella of the National AIDS Strategic Action Plan in collaboration with the National AIDS Commission (KPA) and the GOI. Given limited resources, our comparative advantage as a bilateral donor is in providing strategic and targeted technical assistance to GOI and civil society alike, in order to effectively leverage other funds, especially the substantial Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) resources which have suffered from a lack of technical assistance. Toward this end, the Office of the U.S. Global AIDS Coordinator (OGAC) has centrally funded a GFATM Liaison whose primary responsibilities are to increase collaboration, transparency and governance within the Country Coordinating Mechanism (CCM) through the development of a strengthened CCM secretariat and Principal Recipients (PR).

Under the direction of the Ambassador and a "Comprehensive Partnership" agenda being pursued by the Embassy, the United States Government (USG) health agencies in Indonesia are currently engaged in the process of negotiating a non-binding Memorandum of Understanding (MOU) that will guide the broad health relationship, including HIV/AIDS. The incorporation of the Partnership Framework (PF) into this broader health MOU allows for a more inclusive process that involves a wider range of stakeholders and for the full alignment of PEPFAR support with national HIV/AIDS strategies and other health programs in Indonesia. A robust Partnership Framework Implementation Plan (PFIP) will be developed in the coming months to guide the implementation and evaluation of the PEPFAR specific engagement under the parameters of the broader MOU.

Key Demographic, Socio-Economic, Health and HIV Statistics

With over 245 million people (July 2006 estimate) spread out over more than 17,000 islands, Indonesia is the fourth most populous country and most populous predominantly Muslim (88%) country in the world. According to Millennium Development Goals (MDG) data, it is estimated that 17.8% of Indonesia's population was living below the poverty line in 2006, an increase from 16% in 2005. Life expectancy at birth is 68 years (World Health Statistics 2008, WHO). The Indonesia Central Bureau of Statistics estimated infant mortality at 34.39 per 1,000 live births in 2006. In 2005, maternal mortality remains the highest in Southeast Asia, at 420 per 100,000 live births (WHO, UNICEF, UNFPA and The World Bank, 2007). Communicable diseases remain a large burden and the prevalence of non-communicable diseases is climbing. In 2007, Indonesia ranked third globally in TB prevalence at 244 per 100,000 and had a TB mortality rate of 39 per 100,000. Health spending per capita was estimated at USD 44 in 2006, representing 5.3% of total government expenditures.

According to the Indonesian Ministry of Health (2007), overall HIV prevalence is 0.16% in Indonesia. HIV prevalence among adults is slightly higher at 0.2%, with a higher prevalence among men (0.3%) than women (0.1%). The number of HIV+ adults and children is estimated at 270,000 (UNGASS, 2007). The AIDS epidemic in Indonesia is concentrated in four most-at-risk populations (MARP): 1) injecting drug users (IDU); 2) female sex workers (FSW); 3) clients of sex workers/high risk men (HRM); and 4) men who have sex with men (MSM), including *waria* (i.e., transgendered populations), male sex workers and their clients. There is also a growing generalized epidemic in Tanah Papua, which includes the two provinces of Papua and West Papua.

The epidemic in Indonesia is most acute among IDU. According to the 2007 Integrated Biologic and Behavioral Surveillance (IBBS) conducted by the Ministry of Health in eight provinces (North Sumatra, Riau Islands, Jakarta, Central Java, East Java and West Java, Bali and Papua), the lowest HIV prevalence among IDU was nearly 43%; the highest was 56%. The study also found that 28% of IDU are married and that 47% have multiple sexual partners. IDU also serve as a potential bridge group to FSW; 32% of IDU reported purchasing sex while consistently using condoms with sex workers only 32% of the time.

HIV is a growing problem among FSW. The 2007 IBBS found rates of infection between 6% and 16% among direct FSW. Indonesia has a very active and extensive sex industry; sex workers have a large number of partners; sex workers and their clients are highly mobile and condom use is low. In addition, the availability of essential services (e.g. treatment of sexually transmitted infections (STI), HIV testing/counseling and condoms) is limited, which has a direct impact on the reach, coverage and quality of the response to HIV.

The epidemic among men who have sex with men continues to grow; rates among the MSM population range from 2% to 8% in 2007, up from 2.5% in 2002. In terms of sexual behavior among all MSM, number of partners tends to be high and condom use is low. Rates of infection among *waria* range from 14% to 34%. Similar to the situation faced by female sex workers, these groups have limited access to essential services and appropriate care.

In 2006, the HIV prevalence rate in Papua and West Papua was estimated at 2.4% among the general population and 3% among 15-24 year olds. Cumulative AIDS cases reported in Papua through the end of March 2007 were the second highest in the country, after Jakarta. However, the HIV case rate in Papua was 60.93 per 100,000 or 15.4 times higher than the national average (3.9). Thus, in proportion to the general population, Papua has the highest AIDS case rate in Indonesia. Sex work is a major factor in the spread of HIV in Tanah Papua, but multiple concurrent sexual relationships, frequent intergenerational sex, low condom use, low levels of male circumcision, high levels of alcohol abuse and a highly mobile population also contribute to the epidemic. Limited access to essential services has a negative impact on the effectiveness of the response.

With limited resources Indonesia faces serious challenges and choices in addressing the epidemic. While the epidemic in Indonesia remains concentrated among marginalized, most-at-risk populations, the continued increase in the rates of infection among these populations and the limited availability of essential services in hotspot areas are worrying trends. When combined with the emerging generalized epidemic in Tanah Papua, it is of utmost importance to quell bridging from the two prongs of Indonesia's epidemic into the broader population. However, depth and effectiveness of coverage must also be considered. Papua's generalized epidemic will be more difficult to battle and will require significant resources; current MARP programming coverage is not sufficiently deep in "hotspot areas" to achieve significant reductions in HIV prevalence. An appropriate balance must be found.

Program Overview

The USG program supports the GOI's National HIV/AIDS Strategy and Action Plan 2010-2014, which is going through the approval process. USG agencies, international and bilateral institutions and other donors contribute to these plans under the coordination of the KPA. The USG commitment supports long-term, sustained efforts to build a comprehensive national response to HIV/AIDS, including effective interventions for prevention of new infections and care and treatment of infected people. Under the 2010-2014 plan, the KPA strategy will include targeting MARP, supporting the Global Fund, providing services to OVC as a part of impact mitigation, and improving monitoring and evaluation efforts. The USG works closely with the KPA to develop program objectives and interventions that are in alignment with the National Strategy. In working together, national polices have been put in place and the KPA, with USG support, will focus on strengthening the National Monitoring and Evaluation System to track progress and impacts.

In the past, the USG HIV Program in Indonesia provided direct prevention and clinical services to reduce the incidence of HIV in MARP through the support of Non Governmental Organizations (NGO) and civil society, in collaboration with the GOI. In the FY 2007 Mini-COP, the USG began to move away from funding direct service provision to incorporate technical assistance for health systems strengthening and increase the capacity of clinics to provide services for MARP with the intention of creating opportunities for replication by GOI, other donors and the private sector. In the FY 2008 and FY 2009 Mini-COP, these efforts were further intensified. The USG provided funding to support 60 NGO and civil society sub-partners in 64 districts, within eight priority provinces, where local epidemics are clearly evident and expanding, including Papua, West Papua, North Sumatra, East Java, DKI Jakarta, Riau, West Java, and Central Java. This has been an important contribution given limitations on local government to fund NGO. The FY 2010 COP continues this shift to increase emphasis on the organizational performance and technical assistance necessary for the further development of overall health systems at the provincial and district health departments. The focus on sustainability will be emphasized through new awards focusing on the importance of strong local NGO, best practices and replicable models, to maximize the impact of limited USG resources throughout a geographically large and populous country.

Program Accomplishments and Future Directions

The USG supports a wide range of HIV/AIDS technical assistance interventions in Indonesia. In FY 2009 and FY 2010, the most important technical areas are Other Sexual Prevention, Counseling and Testing, Adult Care and Treatment, Tuberculosis/HIV (TB/HIV), Laboratory Infrastructure, and Strategic Information.

Prevention
USG efforts focus on MARP: female and male sex workers and their clients and partners, MSM, waria (IDU Harm Reduction technical assistance is provided through AusAID). To address the need to increase coverage, improve quality, and more accurately target interventions to reduce risk behaviors among most-at-risk groups, USG-supported interventions across key MARP include:

- Outreach: including peer outreach, Behavior Change Communication (BCC), and education
- Individual and group level interventions: including counseling, and peer support groups
- Condom promotion and supply
- Referral to HIV services, such as counseling and testing (CT), and STI screening, diagnosis, and management
- Collaboration with other programs conducting risk reduction for IDU (the USG primary implementing partner also receives GFATM Funds)
- Community-level interventions, such as community mobilization, local and central-level advocacy; and other "structural" interventions, such as 100% condom use campaigns and policies designed to reduce HIV and other STI transmission during commercial sex.

Priorities will continue to be promoting risk-reducing behaviors, including partner reduction, condom and

lubricant use with all partners (commercial and non-commercial), STI screening and appropriate treatment, and CT.

Counseling and Testing
Testing and counseling services are a key entry point into the full range of interventions that make up the Continuum of Prevention to Care (CoPC) and provide an opportunity to reach both HIV+ and HIV- individuals with prevention messages and information. USG programs have supported the national roll-out of CT services including the development of national policy and service guidelines, as well as facilitating national training efforts to develop cadres of skilled services providers. A triple rapid test policy and an "opt-out" approach for MARP are standard in all CT sites.

In Tanah Papua, CT services are extremely limited (large hospitals in a few large cities), and USG continues to support the Papua Provincial Health Offices' Health System Strengthening scheme, which entails developing a functioning network of health facilities in Jayapura with capacity to provide comprehensive services, including CT. During FY 2010, technical assistance will continue to be provided to CT services in each of the 10 priority districts in Tanah Papua where at least one Community Health Center will provide comprehensive services (STI, opportunistic infection (OI) management, anti-retroviral therapy (ART)), including quality CT. USG will continue to support the GOI, as needed, through mentoring programs, quality assurance, and other technical assistance in coordination with the rollout of CT services under the National HIV/AIDS Strategy and Action Plan and the GFATM work plans.

Care and Treatment
The USG currently plays a significant role in national palliative care and treatment efforts, supporting 60 NGO to provide community-based "case management" services to individuals testing HIV+, including those on ART. Through the current cooperative agreement, USG supports partner organizations to provide technical assistance and collaborate with the Ministry of Social Welfare and the Ministry of Health on capacity building and developing a cadre of case management trainers and supervisors to coordinate training, mentoring, and supervision from central to district levels.

Moving forward in FY 2010 USG will continue to collaborate with the Minstry of Health (MOH), GFATM, WHO and AusAID, on the development of a national network of ART hospitals which currently involve 235 institutions across the country, with a priority on technical assistance to strengthen OI management, implement Standard Operating Protocols (SOP) and Minimum Standards of Clinical Management, as well as facilitate training and mentoring of doctors, nurses and paramedics. This technical assistance will continue to support the development and implementation of the CoPC network model, which consists of a complete package of services provided by a network of service providers ranging from community-based workers to community health centers up to secondary- or tertiary-level hospitals that serve as the hub of the network.

HIV/TB
The USG program works closely with the National TB Program (NTP) and the Royal Dutch Tuberculosis Foundation (KNCV), using USG Tuberculosis Control Assistance Program TBCAP funding, to support the implementation of national TB/HIV policies, guidelines, and strategic plans developed in prior years with USG-supported technical assistance. Using the national TB/HIV curriculum and training modules previously developed for training for HIV personnel within all priority provinces was completed last year, USG will focus on technical assistance in training on HIV/AIDS to TB personnel from hospitals, community health centers, and local health services within eight priority provinces (Papua, West Papua, East Java, Central Java, West Java, Jakarta, North Sumatra and Riau Islands); provide routine supervision and mentoring on HIV clinical services together with local health services; facilitate the coordination of TB and HIV/AIDS clinical services at selected service sites; and assist with the development of external quality assurance for the laboratory testing of HIV for TB patients. Implementation of integrated services began in Jayapura, and further clinical mentoring was conducted to

strengthen the referral system.

In FY 2010, previously developed national TB/HIV policies, guidelines and strategic plans will be implemented. In collaboration with NTP and KNCV, using TBCAP funding and the national TB/HIV guidelines previously developed by USG partners, PEPFAR funds may provide continued technical assistance in 1) training on HIV/AIDS to TB personnel in hospitals and local health services in the five provinces rolling out CoPC; 2) routine supervision and mentoring for HIV clinical services together with local health services; 3) facilitate the coordination of TB and HIV/AIDS clinical services at selected sites; 4) assist with the development of external quality assurance for the laboratory testing of HIV for TB patients, and 5) other technical assistance in coordination with the rollout of TB/HIV services under the respective National and GFATM work plans.

Strategic Information
The USG program focuses on building SI capacity at all levels in collaboration with GOI, MOH, KPA, and other development partners. Key accomplishments in FY 2009 included further strengthening the health information systems (HIS) at the provincial and community levels, finalization of a national TB/HIV recording and reporting system, and piloting of a nationally standardized data format. USG continued to build M&E capacity via numerous data management trainings, as well as building sustainable data use for program improvement capacity through a series of advanced data analysis workshops for NGO program evaluators. A system for quality assessment and assurance was piloted, and targeted evaluations of specific program components, including the CoPC and PPT model programs and the prevention website for MSM were conducted, with the results directly informing program improvement. This focus on data use and quality improvement was highlighted in a 2009 International Congress on AIDS in Asia and the Pacific (ICAAP) conference session, “Using data to improve programs in Indonesia,” hosted by the KPA and the USG primary implementing partner.

The emphasis on enhancing SI capacity and sustainable data use will continue in FY 2010, with technical assistance and training on M&E and data use, support to the MOH for health information systems development, and further standardizing and harmonizing the national reporting system. Along with other development partners, and in alignment with the AIDS Strategy and National Action Plan, USG will support the collection of data for evidence-informed program planning at the national level. Continued emphasis on data use for program and quality improvement will be a key focus throughout the SI portfolio.

Strengths

The USG program, while comprehensive, supports highly-targeted, evidence-driven approaches addressing the Indonesia’s unique two-pronged epidemic, in alignment with international and bilateral institutions and other donors, under the coordination of the KPA. The KPA Advisory Board, with members from all major donors, is a high functioning group that works together to ensure effective collaboration while not duplicating efforts. For example, because the USG does not fund needle exchange and methadone maintenance therapy for IDU, it is only through the collaborative efforts of KPA, AusAID, and the USG that a comprehensive prevention package is available to IDU.

Over the last several years, the focus has been on creating an enabling environment for effective interventions at the community level and on generating quality surveillance data informing evidence-based programming. Provincial and district level emphasis has been to build local NGO capacity to provide critical outreach and targeted referral networks to disenfranchised MARP; this has included capacity building at the facility level to assure quality clinical services in CoPC models are delivered. In Papua, this focus extended to limited Health Systems Strengthening in 10 districts. The USG bilateral program has achieved a strong impact in targeted technical and geographical areas, but interventions have been constrained by funding and the expense of maintaining activities throughout the archipelago.

In FY 2010, the USG continues to shift focus to technical assistance that will leverage and support the needs of the national HIV/AIDS program. FY 2010 funding will continue to support capacity building of local governments, NGO and networks. Training, mentoring and technical support will assure that appropriate capacity is present at the district clinical level. Supervisory support will be maintained but direct services will not; thus the FY 2010 COP presents with increased emphasis on upstream targets and a decrease in downstream numbers.

Weaknesses and Opportunities

Implementing a comprehensive HIV/AIDS program in Indonesia is challenging due to a variety of factors: vast geographic area (over 17,000 islands) and great diversity among its population, a duality of epidemics, limited human resource capacity in all areas, including laboratory testing and clinical services, and a young, decentralized government. Additionally, work in Tanah Papua is extremely expensive given its remoteness and low level of development. Many of these constraints can be addressed through intensive capacity-building and advocacy within the recently restructured KPA and District AIDS Commissions (KPAD), the MOH and NGO, but strategic choices about coverage are needed in balance with decisions regarding universal access. There is currently insufficient funding to reach the intended coverage needed to effect change.

REDACTED

As the Indonesian government continues its decentralization process there remain challenges in assuring that resources needed for quality service delivery reach the implementers at district level. As it takes time to raise awareness and gain acceptance for AIDS programming, scaling-up requires significant technical, human and financial resources. It is also a challenge to achieve high coverage of prevention and care services due to highly mobile risk populations such as sex workers and IDU, and great distances between population centers within the archipelago.

REDACTED

Important changes since COP FY 2009

In response to the Red Lighted section of the FY 2009 COP, the Department of Defense (DOD) decided to realign the management of their component of the PEPFAR program in Indonesia. These changes were identified in the April FY 2009 reprogramming exercise and focused on building a local management structure. PEPFAR funding will no longer be managed by US Pacific Command's (USPACOM's) Center of Excellence in Disaster Management and Humanitarian Assistance, and will instead move directly from Naval Health Research Center (NHRC) to the Office of Defense Cooperation (ODC), where the PEPFAR program manager will work closely with the ODC Resource Manager in the management and administration of funds. In the midst of these changes, the DOD program work and activity slowed in FY 2009. REDACTED Under this realigned management, DOD will continue to work with Indonesia Defense Force (TNI) and has programmed FY 2010 activities in Adult Treatment, Counseling and Testing, Other Sexual Prevention and Lab Infrastructure.

Given procurement delays, USAID had to extend the current cooperative agreement through March 2010 to avoid a disruption of technical assistance to the National AIDS program. However, two procurements have now been released to replace the expiring cooperative agreement. Generally, these procurements separate assistance in technical areas from assistance in organizational performance. This approach enables a building of expertise and capacity of local civil society organizations and creates opportunities to replicate best practice models with funding from sources such as the Global Fund and District AIDS Commissions to sustainably address the challenges unique to each sector. As such, the majority of the

COP is presented as a To Be Determined (TBD).

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						

Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
2010 Integrated Biological-Behavioral Survey among MARPs in Indonesia	Other	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men, Other	Publishing

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
DOD			250,000		**250,000**
USAID				7,750,000	**7,750,000**
Total	**0**	**0**	**250,000**	**7,750,000**	**8,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency			Total
	DOD	USAID	AllOther	
HBHC		640,000		**640,000**
HLAB	40,000			**40,000**
HTXS	40,000	125,000		**165,000**
HVCT	50,000	302,000		**352,000**
HVMS	34,500	551,089		**585,589**
HVOP	85,500	5,431,911		**5,517,411**
HVSI		150,000		**150,000**
HVTB		155,000		**155,000**
MTCT		35,000		**35,000**
OHSS		360,000		**360,000**
	250,000	**7,750,000**	**0**	**8,000,000**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

REDACTED

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	640,000	
HTXS	165,000	
Total Technical Area Planned Funding:	**805,000**	**0**

Summary:
Background and ContextThe GOI National HIV and AIDS Strategy and Action Plan 2010-2014 calls for universal access to therapy (ART), treatment for opportunistic infections (OI), and care and support for all eligible PLWHA. Sufficient resources needed to effectively accomplish universal access have yet to be identified, although Indonesia was recently awarded a GFATM Round 8 grant and has submitted a Round 9 proposal that, if accepted, may help address some of the resource needs.Ministry of Health (MOH) estimates that there are 193,000 (range: 169,230 – 216,820) people living with HIV in Indonesia. Of these, the number currently eligible for ART in 2009 is estimated to be 40,200. The MOH reported that, as of June 30, 2009, 12,493 people (or 31% of those eligible) were receiving ART at 154 hospitals in 32 (of 33) provinces. The number of people who had ever entered into HIV care was 43,118. Of that number, 28,050 people were medically eligible to receive ART, and 21,653 had ever started ART. The MOH has proposed a more rapid expansion of ART service sites, with a target of 336 facilities providing ART by the end of 2010, and anticipates increasing the number of individuals receiving ART to 15,000 by March 2010.The problem of late entry into HIV care remains a major challenge and is a leading cause of the mortality (20.1%) among those who have ever received ART. VCT is not being adequately accessed by those most at risk for HIV, and the total number of people who know their status is much lower than the total estimated number of people living with HIV.In accordance with WHO guidelines, the following drugs are provided free-of-charge by the MOH: preferred first line: AZT/zidovudine + 3TC/lamivudine (usually FDC, 300mg AZT + 150mg 3TC) + nevirapine, usually locally produced; AZT available alone in 100mg capsule, 3TC available alone in 150mg tablet; alternatives for first line: d4T/stavudine (30mg, usually locally produced), efavirenz (600mg, imported); Second line: tenofovir (imported) + 3TC (local) + Aluvia/lopinavir/ritonovir; alternative for second line: ddI/didanosine (buffered, imported).The MOH policy is that first line drugs should be provided through the national budget, while second line drugs will be paid for by the GFATM, although some first line drugs have been supplied through GFATM. Since Kimia Farma, the State-owned pharmaceutical company, is not WHO pre-qualified, drugs paid for by GFATM must be imported from an approved source, which results in two different procurement systems (see discussion in HSS Technical Area Narrative). There are limited data available on treatment adherence, treatment failure, drug resistance, so assessing the quality of program efforts to date is difficult. MOH is committed to providing ART regardless of the patient's risk group status and other medications the patient is taking, including methadone.While ART and CD4 tests are provided without charge, there is usually a hospital registration charge (usually US$1 or less) and a consultation charge. These charges are supposed to be reduced or waived for indigent patients with the right paperwork. In practice, barriers to free ART and CD4 remain as local providers interpret the policy in different ways (e.g., only for registered residents of the district where they are seeking services, only for the indigent, not for active IDU). All other treatment costs must be borne by patients.This has led to the GOI proposing to increase access (in

the GFATM Round 9 proposal) to prophylaxis and treatment of opportunistic infections be made available for all people requiring care at district level hospitals in twenty-one provinces. This would include inexpensive and readily available cotrimoxazole, drugs and laboratory services for the most important opportunistic infections, and secondary prophylaxis for cryptococcosis. At present, with resources from the Round 4 GFATM grant, 4,583 PLWHA received cotrimoxazole prophylaxis.The Indone sian health system comprises public and private health services and while the MOH is responsible for providing ART for all patients in need, the implementation of AIDS care, support and treatment programs involve mainly the public health system at Sub-District health centers (puskesmas) with participation from private hospitals, the NGO/CBO/FBO sector and private practitioners. The new GOI HIV strategy looks to provide opportunities for the increased involvement of community-based organizations in program implementation, peer education, and community outreach.Training of health care staff has been identified by the MOH as important element of the program success. Training focuses on making timely referrals, quality assured treatment, providing comprehensive information and counselling services. Emphasis is also placed on strategies to promote improved services to patients through hospital case management. The M&E training, expert panels and care provider networks are means to improve knowledge and quality of services and better equip health workers with latest best practice and medical information as well as mechanism to promote staff development and networking skills. Quality assurance of ART programs requires greater participation of peer educators from networks of people living with HIV and improved partnership between the networks and the hospital-based ART services. The MOH supports training for community care providers and others who are involved in providing care for PLWHA to improve equity in access to care and support services in the community and outside the formal health sector to ensure that a continuum of care is provided.Goals and StrategiesThe USG, through ASA, has supported the development of a Continuum of Prevention and Care (COPC) network which links, coordinates and consolidates care, treatment, and support services for PLHIV. COPC services are provided to PLWHA in their homes, in the communities where they live, and in the health facilities that serve them through a partnership between the government (and other) supported hospital,and health centers and civil society (NGO/CBO/FBO). While COPC services are generally provided by a number of different organizations, the system that links and coordinates them is planned and managed by the COPC-Coordination Committee whose members include government officials, service providers, NGO representatives, PLHIV, and other stakeholders operating at the district/municipal level. The USG program prioritizes implementation of the MOH strategic plan to include technical assistance and training to puskesmas as ART sites, starting as satellite sites to hospitals, in order to accelerate universal access to ART. ASA has been a key MOH partner in adapting the IMAAI (Integrated Management of Adult and Adolescence Illnesses) approach for HIV/AIDS case management to provide clear implementation guidelines on initiation and management of ART patients at hospitals and puskesmas, respectively. The USG, through ASA, supports partner organizations to provide technical assistance and collaborate with the Ministry of Social Welfare on capacity building and developing a core of case management trainers and supervisors to coordinate training, mentoring, and supervision from central to district levels.In a major initiative undertaken by the ASA program, FY09 funds were used to provide leadership and technical support to the MOH in shifting care, support and treatment efforts from a limited, facility-based “case management” model to a “community and home-based care” approach. This initiative also continued expansion of coverage and quality improvement of community-based ART adherence counseling and support through ASA’s network of NGO community-based case managers.Case managers function as an integral part of CST teams, providing out-of-hospital/clinic psycho-social support, advocacy, and follow-up, including adherence support. Case management is critical for supporting treatment adherence which cann ot be adequately addressed by hospital/clinic staff. The role of case managers in the COPC is particularly critical with regard to ART and OI drug supplies, which are frequently interrupted due to weaknesses in the supply chain. Case managers have served as a vital link by locating alternative supplies and ensuring that their clients can continue the therapy without interruption.Accomplishments since COP09 and FY10 ActivitiesIn FY09, the USG continued the COPC network model focusing on MARP in 3 sites in Java, West Java and East Java. The COPC network model focuses on 2-3 health centers in each site.A series of workshops for counselors and case managers was organized (some with the KPA) for both ASA-

funded providers, district health staff and other community-based providers in Central Java, West Java, North Sumatra, Riau Island, Jakarta and East Java. Efforts focused on refresher training in adherence monitoring and counseling for NGO and health facility staff, as well as improving linkages between community-based support staff and health facilities that provide ART clinical services through regular case and program review meetings. In addition, USG funds supported testing special palliative care service configurations to meet the needs of IDU.Through USG support, ASA also provided assistance to the MOH and indigenous PLWHA support groups on developing a standard format for medical records and a "health passport" to be carried by patients to assist with referrals and care. ASA also provided home care kits for use by Case Managers.At the CoPC site in Malang, activities focused on strengthening internal services in a referral hospital and linkages to a puskesmas and an ASA NGO partner. Meetings were held with key personnel and the hospital director. In-house training of staff for post-exposure prophylaxis (PEP), provider initiated counseling & testing (PICT), IMAAI, TB-HIV was geared toward building an internal network between the service units in the hospital. A separate CoPC effort was initiated using community work of PLWHA NGO in DKI Jakarta as a foundation. Efforts focused on community-based positive prevention, ARV adherence and, and home -based care with linkages to selected ARV hospitals and community health centers in Jakarta.In FY 07, the USG program began to provide support to a limited number of provincial hospitals in hopes of creating "centers of excellence" in each province to lead the national scale-up effort. Several of these sites now function as referral hospitals for district-level COPC sites that were initiated with FY07 and scaled up with FY08 funds. With FY09 funds, USG supported these clinical staff to continue to serve as front-line trainers for the planned expansion of sites offering ART under the national roll-out plan (for which primary funding comes from the Global Fund).In FY09, following the development and trial of a new, innovative and comprehensive curriculum, a formal training on "positive prevention" was organized for four partner NGO from Java. This will increase the emphasis placed on including "positive prevention" activities in future trainings.Finally, in Papua, care and treatment services are being linked to the expansion and strengthening of the network model. USG is the primary supporter of the ASA Papua Provincial Health Office's Health System Strengthening scheme, which will entail the development of a functioning network of health facilities in Jayapura and one Community Health Center in each of the 29 districts in Tanah Papua. ASA staff played a lead role in assisting the Papua Provincial Health Office in developing the plan and in the early stages of capacity building. These efforts, which leverage GOI and GFATM resources, as well as USG funds, are geared to rapidly expanding the availability of ART and supporting services.In Tanah Papua, the aim has been to strengthen reporting and recording systems to bring these in line with the national system. In FY09, t he focus will be on improving record-keeping systems to manage individual patient care, and monitor the scale-up of ART services and developing referral systems and other mechanisms to enable a functioning network model. Given the physical distances and limited transportation infrastructure in many parts of Papua, it is essential that community health centers are capable of managing non-complicated HIV/AIDS cases as quickly as possible, though it may be necessary for ART to continue to be prescribed at higher-level facilities.With regard to home-based care (HBC), after a series of assessments last year, it was determined that immediate, large-scale implementation of HBC in Tanah Papua is not feasible due to high levels of stigma and discrimination. In remote areas, stigmatization might lead to fatal results. An interim strategy has been adopted that focuses on supporting existing shelters/half-way houses/hospices and will extend coverage through church networks. ASA trained a group of HBC workers in existing self-help groups, NGO, FBO and hospices and will support hospice staff through in-house training in AIDS patient care, TB infection control, positive prevention, and reproductive health for PLWHA. The hospice will be included in the clinical mentoring and program monitoring schedule for Jayapura to provide positive prevention, TB infection control, and reproductive health services for PLWHA. In FY10, in conjunction with MOH and provincial and district health authorities, USG funds will continue to be used to provide technical assistance to support on-going support to MOH in rolling out comprehensive services and scale-up clinic and palliative care aspects of the COPC system.In FY 2009, the DOD component of the PEPFAR program in Indonesia received a "Red Light" from OGAC. In response, the management of the DOD component of the PEPFAR program in Indonesia has been realigned and PEPFAR funding will no longer be managed by US Pacific Command's (USPACOM's) Center of Excellence in Disaster

Management and Humanitarian Assistance. Instead, a local hire PEPFAR program manager at Office of Defense Cooperation (ODC) Jakarta will work closely with ODC Resource Managers in the management and administration of funds. The “Red Light” has been lifted and DOD is recommencing activities.FY 2010 funds for HTXS will be used to coordinate, plan and execute treatment, care and support workshops for military medical officers and other medical staff that work within the military community. This will include training of trainers (TOT) of medical officers, nurses and other ancillary healthcare workers. Training will reinforce the understanding of OI, adherence to ART, working with patients and their families to ensure that they have knowledge of HIV, OI, ART, etc., with the goal of achieving continuity of care.

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	352,000	
Total Technical Area Planned Funding:	**352,000**	**0**

Summary:
Until recently, Indonesians have had limited access to HIV Counseling and Testing (CT) with services being available primarily through Non Government Organizations (NGO). However, in line with the GOI intention to provide universal access to HIV/AIDS-related services, the number of CT sites is being scaled up rapidly by the Ministry of Health (MOH). Through June 2009, the MOH reported that 336,669 visits were made in 135 locations in 19 provinces, up from 83,082 visits in 2006. A total of 266,234 tests were conducted, with 249,763 post test results given. Twenty eight thousand two hundred sixty positive results were given for a sero-positivity rate of 11.3%. The MOH is offering CT services at 215 hospitals that are capable of implementing comprehensive HIV/AIDS services, including CT and ARV. There are currently 575 established VCT units in Indonesia (215 in hospitals; 18 in mental hospitals, and 152 in health centers/puskesmas, 155 in NGO clinics, and 35 in prisons), a substantial increase from the 25 units providing CT in 2004. In addition, CT has been introduced at eight puskesmas in Jakarta and West Java in connection with IDU efforts supported by the respective provincial health offices, the Indonesian Partnership Fund (IPF), and AusAID.The current MOH policy uses triple, serial rapid tests with immediate feedback of results. The MOH minimum standards for HIV diagnostic tests are: (1) registration with the MOH; (2) sensitivity of the first reagent being > 99%; (3) specificity of the second reagent being = 98% and > the first reagent; (4) specificity of the third reagent being = 99% and > the first reagent; (5) that antigen preparation and/or the principle of the test from each reagent should be different; and (6) indeterminate result rates should be < 5%.The first-line combination of HIV tests currently recommended by the MOH consists of SD HIV 1/2 Bioline (Multi) – Determine HIV 1/2 (Abbott) – HIV Tridot. To date, this combination has yielded good results – over 99% joint sensitivity and specificity, with specificity of the second and third reagents being 100%. The primary concern using this combination is maintaining the cold chain during transport, as the HIV Tridot test needs to be kept at 2–8 °C. Some resistance to the use of the triple rapid test without confirmation by ELISA has been reported at the field level. This appears to reflect mistrust of rapid testing in the provinces and possibly vested interests in labs doing ELISA. The MOH is responsible for supply chain management, and with the recent award of GFATM Round 8, funding appears to be sufficient. However, concerns continue to be voiced from the field as to the reliability of supply.Since CT services are a key entry point into the full range of interventions that make up the continuum of prevention and care (COPC) and provide an opportunity to reach both HIV+ and HIV- individuals with prevention messages and information, the USG has supported the national roll-out of CT services through the USG-funded Aksi Stop AIDS (ASA) program, implemented by FHI. Through FY07, support focused on developing national policy, service guidelines and SOPs, as well as facilitating ASA staff participation as national trainers in efforts to develop a cadre of skilled service providers. ASA assisted the MOH with evaluating new HIV test kits for possible adoption by the national program and

quality assurance of HIV testing being undertaken under the national program. Additionally, USG funded the reprinting of national CT service guidelines and SOP manuals to support the ongoing accelerated scale-up of CT services.In 2007, the number of sites supported by ASA with USG funding offering complete CT services was 8. An additional 39 sites were supported through joint funding with the IPF (supported primarily by DfID). With the decrease in IPF funding in 2008 and the availability of funds to support CT in GFATM Rounds 4 and 8, the decision was made to transition USG su pport from direct CT service provision at distinct sites to systemic technical assistance. ASA discontinued financial support to individual public-sector clinics after June 2008 to instead focus on providing technical support and mentoring to all public-sector clinics and hospitals in priority provinces and districts. As the ASA program moved away from funding individual CT sites in 2009 to supporting networks of provincial and district health facilities and strengthening the Continuum of Prevention and Care (COPC) model in specific sites, support for CT services has been transitioned to local and provincial governments. Items such as incentives and the purchase of reagents are being covered by MOH and the local government health budgets with USG funding providing support in the form of mentoring programs, quality assurance, and other technical assistance. In FY09, the USG supported unmet need and filling gaps in CT in the three COPC model sites for MARP on Java. In these sites, CT services continue to be linked with NGO providing outreach, behavior change communication, condoms and lubricants, and the CT referral services focus on MARP (IDU, FSW, MSM, waria, high-risk men (HRM)). GOI clinics, in USG-supported “hot spots” are open extra hours each day in order to increase access by MARP. ASA-supported NGO continue to provide pre- and post-test counseling, but with the exception of three NGO clinics that ASA continues to provide direct financial support, actual HIV testing is performed at clinics that are supported indirectly. Although the official GOI policy for CT is “opt-in,” USG programs are advocating an “opt-out” policy for MARP and have pilot-tested this in those sites. The MOH triple rapid test policy is followed at all USG-supported sites in order to maximize the likelihood of individuals tested receiving their test results. Additionally, USG continued to support capacity building within NGO to improve their outreach skills to increase demand and use of timely CT services among MARP as CT service utilization remains a major challenge to the GOI’s goal of universal access to care, support and treatment. In Tanah Papua, where CT services are extremely limited (large hospitals in a few large cities), USG has been the primary supporter of the Papua Provincial Health Office’s Health System Strengthening scheme, which entails developing a functioning network of health facilities with capacity to provide comprehensive services, including CT. With FY 09 funds, CT services have been expanded so that in each of the 10 USG priority districts in Tanah Papua there is at least one puskesmas providing comprehensive services (OI management, ART), including quality CT. USG supported the Provincial Health Office and other partners to roll-out provider-initiated HIV testing and counseling. A “Could it be HIV” campaign was target at all patients attending public health centers, regardless of the service sought, including those receiving TB treatment. If risk factors are present or HIV is suspected, the patient is offered CT and followed up with case management and CST for positive patients or post-test counseling on prevention, STI screening and treatment for negative patients. A major thrust of USG-supported CT efforts continues to be support for the improvement of the quality of counseling and ensuring confidentiality of CT clients. Lack of privacy and confidentiality remains an issue at GOI facilities. In 2009, QA/QI assessment tools were finalized for use in the counseling and testing and case management components, with implementation expected to begin toward the end of the year. A simple, user-friendly tracking system has also been instituted to help better manage the individual assessments and ensure that appropriate follow-up is provided.In FY10, USG will continue to support the GOI with technical assistance, as needed, through mentoring programs and quality assurance, as well as other technical assistance in coordination with the rollout of CT services under the National HIV/AIDS Strategy and Action Plan and the GFATM work plans. In 2010, DOD will expand and provide support to VCT activities. Funds will be used to procure much needed HIV/AIDS rapid test kits (2-3 brands to satisfy testing algorithms), as well as consumables to augment testing (gloves, needle and waste disposal supplies, etc.). Distribution of supplies will be targeted to facilities designed by the TNI as high prevalence areas or hospitals with critical shortages. Test kits will be those approved for use by the Indonesian Ministry of Health (MOH) so that they may be used both for military personnel and civilians accessing military health facilities. FY2010 funds will also be used to

provide technical assistance in the form of training of staff at VCT centers (including counselors and testers) to support travel, as required.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	360,000	
Total Technical Area Planned Funding:	**360,000**	**0**

Summary:

Overarching Approach to HSSIndonesia has mounted a comprehensive response to the HIV epidemic with the primary goal of slowing new infections. While growing, it is still nascent in comparison to the more mature responses of other Asian countries. The role of the National AIDS Commission (KPA) was revitalized by Presidential Regulation 75/2006 which strengthened the role of the KPA and identified provincial and district leadership as key actors. The draft National HIV and AIDS Strategy and Action Plan 2010-2014 provides a framework for supporting policy environments to assure universal access to prevention, care and treatment and impact mitigation, emphasizing collaboration between the GOI, development partners,(including GFATM) and the private sector, and avoidance of duplication. Operating under the principles of the Three Ones, the KPA has defined targets for the achievement of universal access to HIV prevention, care, support, and treatment as required by the UNGASS HIV/AIDS Declaration. Essential HIV/AIDS policies have been put in place; however, it is necessary for work to continue to assure compliance with updated global technical standards and guidelines. With new leadership over the last 3 years, the KPA is now developing a solid framework for HIV/AIDS programs and providing the national leadership to ensure program success and coordination. A key objective in the draft strategy looks to expand enabling environments to empower civil society to take an active role in the national response. Before 2007, the KPA, the MOH, and other key GOI organizations demonstrated limited institutional interest and capacity to plan, implement and monitor responses to the HIV/AIDS epidemic. A review of the health care system in 2006 identified several weaknesses including the limited capacity of health sector personnel at provincial and district level to implement programmes; weak capacity of civil society organizations and community-based organizations; a difficult policy environment to introduce new strategies and interventions; and poor coordination of AIDS programs among various sectors at district level. A weak community health system is inadequate to cover the health care needs of all community members. The national health system performance varies widely across the 33 provinces and 440 districts. Most of the target populations are poor - they depend on public health care and often do not receive enough support and counselling from health care personnel. Decentralization has further complicated program implementation, as District AIDS Commissions (KPAD) and District Health Offices (DOH) lack trained personnel and systems to manage the response and the KPA and the KPAD are now charged with guiding the HIV/AIDS response in locally appropriate ways. Within the uniformed services, challenges include rivalries among services, suspicion of working with foreigners, and lack of command level commitment. As the Indonesian government continues its decentralisation process there remain challenges in assuring that resources needed for quality service delivery reach the implementers at district level. As it takes time to raise awareness and gain acceptance for certain program interventions for AIDS programs, scaling-up programs require significant technical, human and financial resources. It is also a challenge to achieve high coverage of prevention and care services due to the mobility of people who are at risk of HIV infection such as sex workers and some injecting drug users and the great distances between places and populations in the archipelago. While donor coordination is a KPA priority, donor and financing harmonization is a key issue and one that has not yet received attention. It is an area where targeted and effective technical assistance could yield tremendous impact. The community of development partners is small and cohesive and all recognize the value of synergizing HIV/AIDS work. At

the root of harmonization and poli cy reform, it is important to work closely with GFATM and UNAIDS; AusAID, World Bank and WHO are currently engaged in HSS. Another challenge is the extremely weak performance of the national supply and procurement system. Without a dependable supply and distribution system, the commodities needed for prevention, care and treatment services will not reach service providers and beneficiaries. One of the major causes of patient drop-out and non-adherence to ART is the frequent occurrence of stock-outs of essential medicines. The MOH is responsible for supply chain management of ARV drugs. Although there appears to be sufficient funding from GFATM, concerns continue to be voiced from the field as to the reliability of supplies. This is particularly the case in Tanah Papua where a USAID core-funded situational assessment of the commodities management system was conducted by SCMS in October 2007. The resulting report stated that any strategic design for a supply chain management system must be constructed so that it meets the needs of the local hospital and community health center level. The assessment report serves as a starting point in the development of a master plan to strengthen the supply chain system in parallel with a possible health systems strengthening initiative. While some challenges remain, substantial improvements have been made in 2008-2009, particularly in the area of coordination and partnership at national, provincial and district level.USG Approach and AccomplishmentsWith a limited budget, the USG's approach to HSS has been to leverage other partners and initiatives such as GFATM. Of the six recognized building blocks in the WHO framework, the USG has been most involved with leadership and governance, the delivery of quality services and referral networks (for MARP), and has also had a major role in surveillance and information management. Emphasis has been to build local NGO capacity providing critical outreach and targeted referral networks to disenfranchised MARP at the district level through the Continuum of Prevention-to-Care (CoPC) which consists of a comprehensive package of services provided by a network of service providers ranging from community-based workers to community health centers up to secondary- or tertiary-level hospitals that serve as the hub of the network. Political commitment, joint planning, and structured coordinating mechanisms are key pre-requisite components. The key sustainability strategy is to build capacity and skills in district KPA, MOH and indigenous NGO, including evidence-based program design, proposal writing, strategic assessment, target setting, supervision, quality assurance (QA), monitoring and evaluation (M&E), budgeting and financial tracking and reporting. In FY09 this is implemented through the USG funded ASA Program. In FY10 a new procurement will be let for the continued management of NGO capacity building. In past 5 years, the USG has helped build GOI institutional capacity to plan and implement programs at the national, provincial and district levels, within the national, regional and local prison systems; and in the uniformed services. The USG-supported Health Policy Initiative (HPI) conducted a rapid audit of Indonesia's National HIV/AIDS Strategy and provided TA to the KPA to develop the National HIV/AIDS Strategy for 2007-2010 and the costed action plan. Other system strengthening initiatives have included: supporting the Department of Corrections in the development of National Strategic Plan for introducing HIV/AIDS prevention, care and treatment services in prisons and planning for implementation in prisons located in the 8 priority provinces covered by the USG; undertaking orientation and basic skill training for members of KPADs from all 80 target districts; and providing the technical support to the KPA in the development of a national database and program tracking system. All AIDS commissions in USG priority provinces have strategic plans, activ e secretariats, annual work plans and conduct regular coordination meetings, and all but one province has increased its budget for HIV/AIDS programming versus the prior year's budget. In districts that continue to receive priority USG support (n=64), most had active secretariats , and about 80% had annual work plans, conducted regular coordination meetings, and had increased budgets for HIV/AIDS activities in comparison with the previous year. District-level strategic plans in conjunction with roll-out of GFATM Round 8 activities were updated with ASA support in FY09. Specifically, technical assistance and financial support were provided to various local AIDS commissions to organize routine coordination meetings, including support for a provincial coordination meeting among local AIDS commissions in West Java from which focused on review of progress to date and the development of a strategic plan for the next five years; development of appropriate strategic plans, including support for a workshop to finalize local regulations (PERDA) concerning HIV/AIDS for the City of Surabaya; the development of a new five-year plan for the Provincial AIDS Commission in West Java, and assisting with a new annual work plan

for the Central Java AIDS Commission.Previously, the USG supported the implementation of the Resource Needs Module (RNM) of the Goals Model to cost Indonesia's 2007-2010 Action Plan. Working closely with the University of Indonesia, HPI trained a core team of individuals from the national level on the RNM data collection, and a draft training package was developed for use at the provincial level. In FY09, USG funding was used to support the KPA and KPADs to build capacity for evidence-base decision making and resource allocation, and to provide technical assistance to KPA and involve ministry staff to revise the costed Action Plan using the linked Asian Epidemic and Goals models. The project's assistance helped build the KPA's capacity to help provinces prepare HIV action plans, including cost estimates to ensure that the targets are realistic. HPI also supported the efforts to build the capacity of national and community level leaders to advocate for the implementation of policies by bringing together Muslim leaders to increase awareness of and facilitate implementation of existing policy statements within the faith—which are supportive of HIV prevention programs but have yet to be translated into action at mosque and community levels. The project helped the KPA to address the increasing risk of HIV among MSM by working closely with members of the Gay, Transgender, and Male Sex with Male (MSM&TG) network on strategic programming for MSM and waria; and to build capacity among women PLHIV groups, HPI and Ikatan Perempuan Positif Indonesia (IPPI, Indonesian Positive Women) conducted trainings to further engage positive women in prevention activities.In FY10, in conjunction with needs determined by the KPA, MOH and province and district authorities, USG funds will continue to be used to provide technical assistance to support the scale-up of HSS activities under the new procurements. The USG is in the process of developing a nonbinding broad health MOU to guide the relationship of the two governments. This will incorporate the broad vision for all USG agencies at the broad level intended by the Partnership Framework. This will focus the USG commitment for additional funding on key technical assistance in line with the recently signed AIDS Strategy and National Action Plan 2010-2014, including assistance at national level for donor harmonization and surveillance work, and work specifically with health systems strengthening in Papua with an emphasis on improving service delivery (i.e. access, quality, facilities, referrals, outreach), and increasing the local health workforce through pre- and in-service training, and building capacity within MOH, and diversifying financing and leadership.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	40,000	
Total Technical Area Planned Funding:	**40,000**	**0**

Summary:

Indonesia's Ministry of Health (MOH) estimates that there are 193,000 (range: 169,230 – 216,820) people living with HIV in Indonesia. Of these, an estimated 40,200 are currently eligible for antiretroviral therapy (ART) as of June 2009. The number of people who had ever entered into HIV care was 43,118. Of that number, 28,050 people were medically eligible to receive ART, and 21,653 had ever started ART. The MOH currently reports offering ART services at 154 hospitals and a limited number of Community Health Centers. The MOH has developed laboratory standards and guidelines and conducted national training sessions for lab technicians in each of these health facilities. A recent round of monitoring visits to ART sites, jointly undertaken by the MOH, WHO, and the USG supported Aksi Stop AIDS (ASA) Program, implemented by FHI, suggests, however, that the number of sites actually providing services is much smaller and is largely confined to the original hospitals covered in the national scale-up scheme. The Minister of Health has proposed a more rapid expansion of ART service sites, with a target of 336 facilities providing ART by the end of 2010. The GOI-sponsored quality assurance system for laboratories needs strengthening. While the government financially supports an annual external quality assurance assessment for 124 hospitals that provide ART, 50 blood transfusion units, and 30 health laboratories (26

provincial, 4 central), only a limited number of the total primary health care centers receive annual QA due to lack of supporting funds from the GOI. To date, the Department Of Defense (DOD) -funded portion of the USG program has provided laboratory equipment and supplies to two military referral hospitals in Jakarta and two other military medical laboratories outside of Jakarta. At present, efforts to support laboratory capacity include: AusAID supplies equipment and supplies to perform CD4 tests to one hospital, RS Sulianti Saroso and Global Fund supports CD4 machines and reagents for ART referral Hospitals. Additionally, the Clinton Foundation supports External Quality Assessment (EQA) for CD4 testing, with the ultimate goal of establishing a National External Quality Assessment Service (NEQAS) in Indonesia. The Clinton Foundation is also supporting scaled up treatment of pediatric HIV and will assist in developing a national infant diagnosis system. In FY08, four laboratories with the capacity to perform HIV tests and CD4 tests were supported for the Indonesia Air Force (IAF). Training was provided to 5 lab technicians on the services related to the laboratories. Two members of the IAF attended the Asia-Pacific Regional HIV/AIDS Lab Infrastructure and Capacity Building (Train the Trainer in Lab and Diagnostics) Course in August 2008.In FY 2009, the DOD component of the PEPFAR program in Indonesia received a "Red Light" from OGAC. In response, the Office of Defense Cooperation (ODC), US Embassy Jakarta, in coordination with the Naval Health Research Center (NHRD) and US Pacific Command (USPACOM) have realigned the management of the DOD component of the PEPFAR program in Indonesia. PEPFAR funding will no longer be managed by USPACOM's Center of Excellence in Disaster Management and Humanitarian Assistance, but will be sent directly from NHRC to the ODC, where a local hire PEPFAR program manager will work closely with ODC Resource Managers in the management and administration of funds. The "Red Light" has been lifted and DOD is recommencing activities.In FY2009, DOD supported a workshop to train military laboratory technicians from throughout the country and provide necessary reagents for the three FACSCOUNT® CD4 machines previously procured with PEPFAR support. This activity increased the number of military medical facilities that have trained laboratory staff and ensured a reliable supply of reagents in laboratories providing services to those living with HIV/AIDS and seeking care at military facilities. Add itionally, USG and implementing partner staff have continued to collaborate with the Directorate of Public Health Laboratories, the Department of Clinical Pathology of the University of Indonesia, the HIV National Reference Laboratory at Cipto Mangunkusumo Hospital and the Balai Laboratorium Kesehatan in Surabaya to develop appropriate external quality control systems for laboratory diagnosis of HIV and STIs. FY 2009 funds also supported technical assistance to laboratories.In FY10, the USG program will continue to support laboratory capacity building and expanded coverage of quality laboratory support services to PLWHA through the Indonesia Defense Forces. Funding will go towards the strengthening of laboratory infrastructure at military hospitals that provide HIV testing facilities. In recent years DOD provided the Indonesia Defense Forces/Center for Health Services (TNI/PUSKES) with new CD4 machines for the purpose of HIV testing. FY 2010 funds will support the purchase of reagents for these machines, overall maintenance of equipment and supplies, training of laboratory technicians, etc. DOD will also assist TNI in the procurement and disbursement of equipment, and training of lab personnel.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	585,587	
Total Technical Area Planned Funding:	**585,587**	**0**

Summary:
(No data provided.)

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	35,000	
Total Technical Area Planned Funding:	**35,000**	**0**

Summary:

The relative proportion of total AIDS cases that occur among women in Indonesia has more than doubled in the past decade from 12 % in 1999 to 25 % by end of June 2009 (cumulative HIV/AIDS cases, MOH, July 2009). According to national estimates, there are currently 6,716 women living with HIV/AIDS between the ages of 15-18 years, 10,725 women living with HIV/AIDS between the ages of 19-24 years, and 32,272 women living with HIV/AIDS over the age of 25 years. Though the absolute numbers of women with HIV are still small, HIV prevention programs and intervention services regularly identify women with HIV, almost all of them of reproductive age and sexually active. Most antenatal care in Indonesia occurs at the community level in publicly funded primary care or satellite clinics or through private midwives. Nearly 92% of Indonesian women have had at least one ANC visit (DHS 2007). Over 54% of women give birth in their homes. Among women who deliver in facilities, more than 3 times as many choose private clinics as opposed to public facilities. Approximately 73% of pregnant women deliver with the assistance of a nurse/midwife (DHS 2007). Ensuring that pregnant women who are HIV positive receive ARV prophylaxis is one of the activities prioritized by the GOI in order to reach the targets set out in the Costed National Action Plan HIV and AIDS Response in 2007-2010. According to the National Guidelines for the PMTCT of HIV/AIDS, the Ministry of Health (MOH) is responsible for establishing a sustainable and integrated PMTCT program, which should be implemented within the existing primary health care system, including the family planning infrastructure at the sub-district and community levels, as well as in the 75 referral hospitals supported in GFATM Round 4 to provide HIV/AIDS CST. A working group on PMTCT coordinated by the Directorate of Maternal and Child Health in the MOH has been formed, and the national level guidelines have been adopted in most districts.However, given the current low national prevalence, as well as a lack of funding, the decision was made by GOI experts to limit the current national PMTCT program. No generalized mainstreaming is occurring within national maternal and child health services. Instead, the program has focused on integrating PMTCT activities into services for PLWHA and most at risk populations – FSW, men who pay for sex (HRM), IDU and their partners, and men who have sex with men, including male sex workers (MSW) (most of whom are married) - and more recently on the general population of Papua where the 2006 IBBS found an HIV prevalence rate of 1.9% among women, with a 2.22% rate among ethnic Papuan women. According to the protocol, male members of most at risk populations are encouraged to notify their female partners to access CT linked to targeted intervention programs. Women identified as HIV positive through CT and found to be pregnant are supposed to be offered a PMTCT package of counseling, CT and single dose nevirapine and an oral dose for the new born infant. Pregnant women suspected of being at risk of HIV should be offered testing using a HIV rapid test triple algorithm with opt-in testing approach. Implementation, however, is inconsistent. In some districts, all pregnant women are offered CT with high levels of acceptance. In other districts, CT seems to be selectively offered, and acceptance is much lower (‘Review of the Health Sector Response to HIV-AIDS in Indonesia 2007’). A PMTCT assessment was undertaken in 2005 with GFATM Round 4 funds. Findings suggested a very low knowledge about PMTCT services, even among health providers, and continuing high levels of stigmatization of people living with HIV/AIDS. HIV/AIDS continues to be perceived as an issue for those engaging in deviant and immoral behaviors. Stigma and discrimination makes women reluctant to avail themselves of services for fear that they will be branded as members of an objectionable group. Similarly, the national strategy for PMTCT is not yet widely known. There is a lack of facilities for PMTCT, the provision of basic information on HIV is not yet well understood by health service personnel and sexual health generally is not discussed by health personnel with their clients (‘Indonesian UNGASS Community

Report 2006-2007').Also, since the focus of PMTCT programs is largely on the provision of ART to HIV-positive pregnant women, prevention of unintended pregnancies among women living with HIV has not yet become a prominent feature in counseling, nor is primary prevention of HIV transmission among women generally addressed. Different antiretroviral regimens are used in different places, and infant feeding support varies depending on the existence of external funding. Based on the 2009 Universal Access Report there are 154 hospitals which provide free ART and 150 hospitals where PMTCT programs exist. In addition, there are already 20 referral networks for Integrated Management Adult Illnesses (IMAI). As a result, although PMTCT service coverage remains low, PMTCT is available in 150 large hospitals, 21 community health centers and a handful of NGO sites. At these sites, 5,167 pregnant women were tested and received their results during pregnancy, labor, delivery and post partum period. The number of HIV-positive pregnant women who received prophylaxis was much lower than the estimated number of HIV-positive pregnant women. There are estimated to be 3,400 pregnant women living with HIV. Of that number, 165 have received ART to reduce the risk of MTCT (4.9%) as of June 2009.The GOI's decision to accelerate decentralization of CST services from hospitals to the community health center level will facilitate the scale-up of PMTCT. The speed of the scale-up depends on how quickly and effectively the GOI can utilize GFATM funding.PMTCT has always been a small component of the USG-supported ASA program. The USG response is focused on the integration of targeted PMTCT into a one-stop Continuum of Prevention and Care (CoPC) model featuring comprehensive integrated service packages including STI, CT, TB screening and treatment and case management services. The CoPC service models are designed to provide services to the above-mentioned MARP. The USG-supported models which are being replicated by GOI demonstrate the way in which high quality PMTCT services can be implemented within realistic cost considerations. PMTCT services include information and counseling on the possibility of the client or their partner getting pregnant, the risk of transmitting STI or HIV to a baby, and available prevention measures. Assistance is given for accessing contraceptive measures, if required. USG-supported activities were also designed to help the GOI establish service models that include linkages for care, support and treatment for eligible women and children after delivery.In FY09, the USG supported the integration of targeted PMTCT into the CoPC service models implemented in 3 non-Papua MARP-focused sites. Initial implementation is through Gondang Legi Public Health Center (PHC) another PHC in Malang, Gambir PHC and 3 other PHC in Jakarta in collaboration with UNICEF, WHO and HCPI. Specific activities have included: (1) supporting efforts to implement capacity-building on the use of ART for PMTCT, including training OB/GYNs, pediatricians, general practitioners and midwives; (2) training counselors on pregnancy counseling and couple counseling skills; (3) technical assistance for implementing opt out CT, prevention for positives, access to treatment for mothers and newborns under a revised protocol following the WHO recommendations for safe delivery, infant feeding counseling, neonatal care, and postnatal care; (4) supporting specific training on clinical management of drug addiction as related to PMTCT; and (5) in Papua, further integration of PMTCT with MNH, malaria, TB and safe water programs. As part of these activities in FY09, the ASA program h eld an introductory course on PMTCT for 23 staff from community health centers in Malang, East Java and Jakarta. This was followed by a workshop on PMTCT organized in Malang, Java for ten participants from the local health services and two community health centers as part of efforts to establish a comprehensive continuum of prevention and care.In Papua, PMTCT services are being integrated into the one-stop CoPC service network in the10 districts with technical assistance provided to six public health centers in Jayapura and Sorong and one public health center in each of ten districts, as well as in two hospitals. These services target HIV-positive pregnant women, and provide appropriate ARV treatment, safer delivery, medical follow-up of the newborn, and counseling on breast feeding and informed choice.In FY10, the USG will continue to support technical assistance on PMTCT to the GOI as part of the national rollout of the CoPC model. There are no current plans in FY10 for USG HIV specific funds to be used to strengthen approaches for infant follow-up, OVC and routine MCH beyond the pilot service models. In Papua, aside from TA activities, other donor and USG wrap around funds will be used for the expansion and integration of PMTCT activities into the overall provincial MCH system.

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVOP	5,517,411	
Total Technical Area Planned Funding:	**5,517,411**	**0**

Summary:
Indonesia is comprised of over 220 million people and is at a critical crossroad in the transmission of HIV/AIDS. While national adult HIV prevalence is estimated to be 0.01%, this low rate masks sub-epidemics within Most At Risk Populations (MARP), including Injecting Drug Users (IDU), Female Sex Workers (FSW), clients of sex workers/high risk men (HRM) and men who have sex with men (MSM), including waria (transgender and transsexual males)..In 2006, the National AIDS Program (KPA) with technical assistance from the USG-funded Aksi Stop AIDS program (ASA) conducted size estimations for MARP groups. Median population sizes were 219,200 for IDU, 221,120 for FSW, 766,800 for MSM, 28,130 for waria, and 3,161,920 for HRM/clients of sex workers. In 2007, an Integrated Bio-Behavioral Survey (IBBS) was conducted among selected high risk populations, again with support from ASA.Direct (brothel-based) and indirect (karaoke bar) female sex workers (DFSW and IDFSW) were sampled in 16 sites across the country. In 7 cities, HIV prevalence rates among DFSW were greater than 10% with highest rates occurring in the Papuan cities of Sorong (16.9%) and Jayapura (14.4%). Several cities had rates over 5% among IDFSW (Batam – 8.8% and Sorong – 8.3%). STI rates were also very high among DFSW - active syphilis in North Sumatra (12.9%), gonorrhea in Jakarta (41.2%) and Chlamydia in West Java (55%).While condom use at last sex increased between 2002 and 2007, the percentage of DFSW and IDFSW who reported 100% condom use in the last week remains insufficient (32% and 36%, respectively). However, FSW report when they do propose condom use to their clients, condoms often get used – 77% acceptance by clients of DFSW and 84% by clients of IDFSW. Among FSW who report having multiple contacts with outreach workers, the rate of condom proposal increases to 90%, demonstrating outreach effectiveness. A major challenge is that a large proportion of FSW are infected with HIV within the first six months of initiating sex work, before exposure to interventions. Younger sex workers (< 25 years) are more likely to be HIV+ - 12.8% versus 9.4% for DFSW and 5.8% versus 3.9% for IDFSW. Most waria report selling sex (95.6% in Bandung and 82.4% in Jakarta) and about half report having regular male partners. HIV prevalence among waria is high and continues to rise from 21.7% in 2002 to 34% in 2007 in Jakarta. HIV prevention coverage among waria is high with 80-90% reporting contact with a worker in the past 3 months; STI referrals are also high and significant numbers of waria report receiving HIV test results. Alcohol use is high with over 50% of waria reporting drinking. Consistent condom use in anal sex is insufficient ranging from less than 50% in Bandung to about 10% in Jakarta; despite high STI referral rates, most waria do not follow-up on attendance at STI clinics.Prevalence rates among MSM are comparable to IDFSW – 8.1% in Jakarta, 5.6% in Surabaya, 2.0% in Bandung. Rectal STI rates are high at around one-third of MSM testing positive. The majority of MSM reported not always using condoms for insertive or receptive anal sex in the past month. Ten to twenty percent of MSM reported they had never used a condom, and most MSM have never purchased condoms. MSM are highly knowledgeable about male-to-male transmission and HIV prevention, and several cities report high rates of coverage by outreach workers. However, limited condom use and only modest rates of follow-up (~30%) on HIV testing referrals underscore the continued need to insure coverage and expand effective behavior change interventions among MSM (and waria).The 2007 IBBS focused on 4 groups of HRM – dockworkers, motor-taxi (ojek) drivers, truckers and seafarers, and HIV prevalence differed geographically. In Papua, 3.0% of dockworkers and 1.0% of ojek drivers were HIV+ - in line with the 2.9% prevalence rate among general population men in Papua. In the rest of Indonesia, HIV was not detected among dockworkers and motor-taxi drivers; HIV prevalence among truckers (0.2%) and seafarers (0.5%) was higher than in general population males. The majority of seafarers and truckers had multiple partners and reported sex with FSW in the last 3 months and reported using condoms with FSW less than 50% of

the time in same time frame. Less than 50% of HRM demonstrated adequate knowledge regarding HIV prevention.In Papua, where the epidemic is generalized, the data from the recent general population IBBS (2006) coupled with the 2007 MARP IBBS data for Papua, reveal that the low prevalence, generalized epidemic in Papua is still driven by commercial and transactional sex. HIV was higher among men (2.9%) than women (1.9%); among persons who had more than 2 sexual partners in 1 year (4.0%); and those who engaged in sex for payment (5.1%). HIV prevalence among men who had a history of STI in Papua was 5.9%. More than 20% of male residents reported more than one sex partner in the past year compared to 8% of female residents.The primary focus of the GOI national prevention efforts as outlined in the Indonesian National HIV & AIDS Strategy and Action Plan 2010-2014 is on preventing HIV transmission between FSW and clients, harm reduction among IDU and sexual transmission among MSM and IDU and their partners. AusAID has a comprehensive behavioral communication program in Papua targeting the general population, including youth. In addition, UNICEF will be expanding its efforts to general population youth in Papua. While ministerial regulations led to guidelines for comprehensive prevention programming of sexually transmitted HIV in 2008, full implementation of an effective HIV prevention response has been hindered by a variety of issues, including: (1) lack of consensus among key GOI bodies and conservative groups; (2) regulatory barriers; (3) budgetary constraints related to a general economic downturn; (4) reluctance of GOI to formally acknowledge the magnitude of the commercial sex industry in the country, and 5) lack of a developed comprehensive prevention package for MSM.Condoms are not readily accessible where many FSW work. Only 45% of DFSW can obtain condoms in the brothel area and only 15% of IDFSW can get condoms at their workplace. Last year, the MOH stopped procuring condoms using GOI funding. This led to shortages of free condoms for NGO working with MARP. The issue was resolved through the provision of 3.5 million male condoms and 500K female condoms from USAID and through new funding from GFATM Round 8. USG-supported efforts target 64 districts in 8 priority provinces. These districts were chosen, in consultation with the KPA, as sexual and IDU transmission “hotspots,” because they have sizable MARP populations engaged in high risk behavior, and need additional resources to impact the epidemic. USG support is designed to contribute to the national objective of reaching 80% of MARP in these priority provinces by 2010. The targeted MARP for the USG-supported program are FSW, MSM, and HRM.In FY09, USG supported 66 NGO and CBO to implement the basic prevention intervention package for MARP, consisting of peer outreach with IEC materials; condoms, lubricants and safe sex kits; targeted multi-media campaigns, including innovative internet campaigns for MSM; peer support groups; negotiation skills training; and policy interventions, including 100% condom policies and STI testing for brothel-based FSW. As part of the Continuum of Prevention and Care (COPC), each community-based NGO provides referrals to a GOI or NGO clinic for case management, CT, and STI screening and treatment. USG also supported the KPA’s efforts to make female condoms more accessible throughout Indonesia.In FY 09, the USG-supported ASA program achieved substantial accomplishments in activities directed to FSW, MSM and high risk men. Many of the Life-of-Program targets for FSW, MSM and HRM have been met or exceeded. ASA is on course to meet or exceed remaining targets by the end of the program period.The strategy of the ASA program has been to build replicable COPC models by the national and local government and stakeholders. Based upon initial program success in Malang District, East Java in which local stakeholders were supported to assume ownership of HIV efforts, the Malang model was replicated in three additional districts. The model was extended to include periodic presumptive treatment (PPT) of STIs and introduction of more potent first line STI drugs. Malang District COPC is now funded by national and local government with the exception of NGO supported by ASA. Consistent condom use among FSW hovers around 50%, while never condom use has fallen to near zero. STI prevalence among FSW has fallen to below 15% in 2008 (compared to an average of about 40% among FSW in ten cities in the 2007 IBBS), and prevalence of syphilis has remained below 1% over the last two years.The results at two replication sites indicate a decline in the prevalence of gonorrhea and Chlamydia of 48% over a two-month period. STI prevalence was reassessed this summer to assess whether low prevalence can be maintained via routine screening. Data on condom use indicate consistent use with clients in the previous week has increased by more than 10% over baseline so far. The KPA and MOH have now adopted the pilot intervention package for nationwide implementation and have committed GFATM Round 8 funding.

Program scale up has begun in 14 sites in six provinces with technical support from FHI, HCPI and WHO. ASA staff supported orientation and technical training, and will continue to provide technical assistance and monitoring support.In previous years, USG funds were used to support health clinics to conduct STI services. The emphasis in FY08 shifted from funding specific clinics to helping the provincial and district health services develop systems to serve MARP - including expansion of local STI services and system strengthening (training, mentoring, quality assurance, reporting). In FY09, training in STI Clinical Management was organized for 42 staff from the local health services in East and West Java to assist districts to expand their networks of STI clinics.In FY 09, USG directed ASA to revise its strategy for reaching HRM to focus on men believed to be at the highest risk of HIV infection based upon the results of the 2007 IBBS – truck drivers and seafarers. The revised strategy calls for interventions to be implemented in ports and highways. A targeted media campaign event for HRM was organized in Central Java in collaboration with the local AIDS commission and various partner NGO. Over 4,000 men attended the event featuring local pop stars and motivational messages by local dignitaries; mobile VCT services were available throughout the day.The pace of implementation of outreach activities directed to MSM accelerated during FY09. Coverage for waria in ASA program areas is at or near 100%. Coverage of MSM reached via the “It’s My Life” website expanded significantly. Over 117,489 visits occurred through June 2009, with an average of 8 pages viewed per visit, and an average duration of 11 minutes. In the last quarter, over 73% of hits were new visits. A formal mid-term review of the MSM Website was completed in June 2009. Results showed that a previously underserved segment of MSM was being reached and found a strong relationship between frequency of website use and knowledge, risk perception, and recalling key messages, as well as between recalling key messages and current behaviors including STI check-ups, condom use, and HIV testing.Gender-based violence (GBV) and inter-generational sex continued to be addressed through messages stressing these practices are socially unacceptable, particularly among HRM in Papua. These messages were incorporated into all IEC materials and training curricula provided to individuals in outreach areas.Alcohol issues among groups such as HRM in Papua and waria also need to be addressed as part of behavio r change interventions. USG/Indonesia is interested in strengthening these themes in future interventions and has initiated consultations with the MARP TWG to undertake an assessment/programmatic design visit to explore such programming.DOD activities focus on decreasing new HIV infections in the military through behavior change communication (BCC) with a focus on correct and consistent condom use. While some soldiers practice sexual abstinence and fidelity, factors such as separation from families, mobility, and age increase their HIV risk.In FY 2008, prevention messages reached 10,892 troops and family members of the IAF and 217 peer educators were trained. Condoms and prevention materials were distributed throughout the year to the IAF.In FY 2009, the Department Of Defense (DOD) component of the PEPFAR program in Indonesia received a “Red Light” from OGAC. In response, the management of the PEPFAR’s DOD component in Indonesia has been realigned. PEPFAR funding will no longer be managed by US Pacific Command (USPACOM), but will be sent directly from Naval Health Research Center (NHRC) to the ODC, where a local hire PEPFAR program manager will work closely with ODC Resource Managers and the PEPFAR team in the management and administration of funds. The “Red Light” has been lifted and DOD is recommencing activities.In FY 2010, DOD will continue to assist the Indonesia Defense Forces (TNI) in implementing community-based activities among soldiers, their sexual partners, and surrounding communities to promote safer sexual behaviors. Key strategies include peer education and interpersonal communication sessions, and the promotion of correct and consistent condom use These efforts will focus on the development of strategies to reach individuals who are at higher risk (e.g., pre-deployment to a high prevalence area, STI Clinic patients, etc.). DOD will collaborate with TNI in updating Information, Education and Communication (IEC) materials to reflect best practices in the areas of peer education. In FY 2010, Indonesia Defense Forces/Center for Health Services (TNI/PUSKES) will continue these activities emphasizing correct and consistent condom use, condom access and availability (including minimizing the stigma surrounding condoms), and promoting a counseling and testing campaign (Know Your Status) among higher risk members. Additional IEC materials promoting condom use will be developed.FY 2010 will see a greater number and geographic distribution of peer education activities. These workshops will further provide the opportunity for TNI/PUSKES to develop their own peer

leader workshops and developing and adapting their IEC materials.

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	150,000	
Total Technical Area Planned Funding:	**150,000**	**0**

Summary:
Context and BackgroundAs with other Technical Areas, the USG SI strategy in Indonesia is one of providing appropriate technical assistance to strengthen SI capacity at all levels to effectively use data throughout program development (planning, tracking, reporting, evaluation of results, and program improvement). This strategy, implemented in coordination with other development partners, includes building the capacity of the GOI to take the lead in key SI functional areas (Surveillance, Monitoring and Evaluation, and Health Management Information systems), supporting the development of one national monitoring and evaluation system for HIV/AIDS (the “Third One”), and developing sustainable capacity for data use in program planning and quality improvement across all technical areas. Indonesia continues to serve as a model for effective collaboration and leveraging of resources to implement its HIV/AIDS program, including the SI strategy. Lack of strong leadership from the MOH has slowed implementation of a fully functional national M&E system, however, there is incremental progress. The M&E Technical Working Group was established in 2007 and continues to push the “Third One” (one national M&E system) agenda. National core indicators have been developed and finalized. The National AIDS Commission (KPA) continues to use unified data collection tools and systems to collect national core indicators including information from facility level and community-based systems, based on USG partners’ FHI/ASA program monitoring system. USG has also trained data teams and supported use of standardized reporting systems at the district level in anticipation of a functional national system. Data use for program planning (know your epidemic) and program improvement (know your response) are key areas of emphasis within the USG SI approach, and building capacity in these areas is critical in appropriately responding to the “two-pronged” epidemic in Indonesia (MARPs nationwide and the regionally-generalized epidemic in Tanua Papua). Data from USG-supported surveillance efforts have been used to determine priority prevention populations and craft the targeted MARP prevention efforts and Continuum of Prevention-to-Care (CoPC) and demonstration pilots. In turn, evaluation data from these efforts has been used to further refine, improve quality, and, in the case of the CoPC models, justify the scale-up of these programs, based on results. These efforts are carried out in alignment with the national strategic plan and in conjunction with other international development partners, such as GFATM, The World Bank, WHO, AusAID, DfID, and UNAIDS.Accomplishments since last COPFY09 SI accomplishments include technical assistance targeted at the district and implementing partner level, as well as support to the MOH and collaboration with the National AIDS Commission (KPA). USG and partners continued to build M&E capacity and support the development of one national data system for HIV by conducting data management trainings and mentoring key SI staff within implementing NGOs. A joint data quality management-program quality improvement strategy, involving periodic data quality assessments linked to quality improvement feedback, was put into place at the district level. Standardized software for routine reporting is in use in some districts in anticipation of a fully functional national reporting system. At the national level, USG worked closely with the MOH and KPA to further plan and develop the national reporting system, including developing standardized data formats, modifying and piloting ART reporting software, and implementing a trial of a standardized TB/HIV reporting system (currently underway). USG will continue to support the MOH and encourage action in implementing a single, integrated national M&E system. USG also supported the KPA in the development of a national M&E training module, and conducted national-level training- of-trainers in support of dissemination of this

new curriculum. Support was also provided in the development of the AIDS Strategy and National Action Plan 2010-2014, a key policy document USG SI programming in Indonesia has a particular focus on data use for evidence-informed programming as well as improving quality, coverage, and impact of existing programs; this emphasis is reflected in additional FY09 accomplishments: USG continued to provide support to the MOH and district-level HIV/AIDS planners in the analysis of the 2007 IBBS in support of programmatic decision-making. A series of week-long trainings in advanced data analysis and interpretation were conducted for NGOs in five regions to enhance sustainable capacity in M&E and data use for program improvement. Targeted assessments were conducted to evaluate the PPT and condom use combination prevention pilot programs, demonstrating significant reductions in STI prevalence and supporting expansion of this strategy. A mid-term review of the MSM website, using targeted surveys and qualitative methods, was also completed, with results used for immediate program improvements. The standardized system for assessing program quality cited above illustrates an emphasis on quality assurance and improvement at the implementing partner level—using “their own” data to rapidly improve program quality. Other examples of the data-use emphasis include further disaggregation of some indicators for more locally-useful data interpretation. Along with the KPA, USG partner FHI presented the session "Using data to improve programs in Indonesia at the ICAAP conference held in Bali in August, highlighting the development and application of this data-use strategy. Goals and strategies for the coming year Due to the TBD procurement currently in development in Indonesia, specific SI activities are yet to be announced, however, themes and general directions will reflect a continuation of the current strategy. The technical assistance approach, with a focus of capacity-building and sustainable program development, will be maintained. Similarly, the USG program will continue to support and encourage data use at all programmatic levels, and support efforts to obtain and analyze the data needed to appropriately respond to the epidemic. The next two rounds of the Indonesia IBBS are funded through the Global Fund, but USG will also play a key role in the analysis and interpretation of these data, and advocate for their use in program decision-making. Other illustrative examples of Indonesia SI program priorities in FY10 include:• Continued support and mentoring of key M&E staff within the MOH to further increase national-level SI capacity• Supporting and facilitating movement toward one national, integrated M&E system for HIV monitoring and reporting aligned with the national strategy and “owned” by the GOI/MOH.• Supporting continued development of M&E systems at the district and community levels, in harmonization with the developing national system. • Continued evaluation of model programs and pilots with an eye toward rapid deployment of successful strategies• Further development of data-use for quality assurance and improvement strategies, in support of sustainable program quality• Technical assistance to GOL and MOH in data analysis and interpretation, and in dissemination of findings for program useDuring the FY10COP development process, all technical area summary targets and target justifications were developed by the integrated USG Indonesia Team. Because of the TBD procurement process, the USG Team held general discussions with USAID partners to get current information regarding their programs in order to set direct targets for FY 2010 based on their projected FY 2009 program results. Information was also obtained from KPA, the Global Fund Round 8 application, and UNAIDS to determine national level targets. Management and Operations USG Ind onesia currently does not have dedicated SI staff in country. In FY 2010, the USG team proposes to hire an additional FSN Program Specialist who will work part-time on program management and part-time on SI/M&E related activities, including PEPFAR reporting requirements (see the Management & Operations narrative).

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	155,000	
Total Technical Area Planned Funding:	**155,000**	**0**

Summary:
Indonesia ranks third among countries that contribute 80% of the global TB burden. The 2008 WHO Global TB Report estimates TB incidence in Indonesia at 253/100,000. The estimated number of cases of all forms of TB is approximately 535,000, of which about 240,000 are new smear positive cases. Data on HIV infection among TB cases in Indonesia is limited. The WHO Report estimates that in 2008, 0.6% of all incident TB cases or around 15,100 were HIV positive people. While the overall rate of change in TB incidence in Indonesia has increased by 10% from 2006 to 2008, there has been an 11% increase in TB cases in HIV positive people.The Indonesian HIV/AIDS epidemic is one of the fastest growing in the region with prevalence and epidemic dynamics varying greatly across the country. Seven provinces are the most heavily burdened: Jakarta, West Java, Papua, West Papua, East Java, Bali and West Kalimantan. Based on 2007 IBBS, high HIV prevalence occurs in MARP, including injecting drug users (IDU) (up to 56%), transgender/waria (up to 34%), direct female sex workers (DFSW) (up to 16%), inderect female sex workers (IFSW) (up to 9%), men who have sex with men (MSM) (up to 8.1%), and transvestites (waria) (up to 34%). IDU represent most new HIV cases, with transmission increasing eight-fold since 1998. The HIV epidemic in Papua is generalised with most cases of transmission occurring through heterosexual sex (2.9 per cent male and 1.9 per cent female), but according to 2007 IBBS data, the epidemic continues to be driven by commercial/transactional sex. TB/HIV coinfefction is in prisons is high.The basic Directly Observed Therapy (DOTS) program is achieving 91% treatment and 73% case detection at the puskesmas level. High default rates for TB patients treated in hospitals and irrational use of first-line and second-line TB drugs form major threats for further development of MDR- and XDR-TB. The health system has limited capacity to address MDR-TB due to constraints such as inadequate laboratory capacity and facilities, unavailability of several second line drugs to treat MDR-TB, and insufficient capacity to deliver DOTS-Plus and Hospital DOTS Linkages (HDL). In addition, weak regulations have caused second-line TB drugs to be freely available on the market, and many specialists use these second line TB drugs in first-line TB regimens. The first case of XDR-TB was confirmed by a reference laboratory in 2007; it is widely believed that there are many more undocumented cases of XDR in Indonesia. The extent of the MDR- and XDR-TB problem is still unknown due to the lack of drug resistance surveillance data. According to a small TBCAP Drug Resistance survey completed last year, preliminary data suggest a MDR rate of ± 2 % in new patients and ± 16 % for re-treatment cases. These trends pose a major challenge to the success of TB control in Indonesia. The first treatment program for MDR-TB finally got underway in 2009 with the first patient initiating MDR therapy in August 2009. While the rollout of TB/HIV activities has been planned since 2000, implementation of pilot programs to start TB/HIV activities has been delayed due to a range of constraints, including competing priorities for TB case finding, Directly Observed Treatment (DOTS) expansion and lack of funding. Collaboration between the National TB Program (NTP) and the National AIDS Program (KPA) is improving, but collaboration between key stakeholders at provincial and district levels is generally still weak. A policy document for TB-HIV collaborations was endorsed in 2007, with clear roles and responsibilities for all stakeholders in TB/HIV joint activities. The advent of GFATM resources has enabled the GOI to increase the level of TB/HIV activities. Indonesia has received 3 Global Fund TB grants, two of which include TB/HIV activities. Round 1($68.8 million) supported general expansion of DOTS; Round 5 ($69.2 million) includes support for improved case finding and management of TB/HIV co-infected patient interventions among its objectives; and the recently awarded Round 8 proposal ($93 million) complements some of the under-budgeted interventions supported in Round 5 by supporting activities related to the introduction of infection control in facilities dealing with TB/HIV. The Sub-Directorate for TB in the Ministry of Health and the Sub-Directorate for AIDS in the Ministry of Health (MOH) have committed to intensifying coordination and collaboration to improve TB/HIV prevention, care, support and treatment with specific activities for each sub-directorate clearly designated in the GFATM work plans to achieve an optimal level of integration. Guideline revisions, infection control measures, and the coordination of diagnostic centers are details that will be addressed by the HIV and TB partners throughout the duration of grant implementation under the leadership of the MOH. Strategies specific for TB/HIV include strengthening the collaboration between the NTP and key stakeholders at the district level through the establishment of TB/HIV Collaborative Networks; and scaling-up of TB-HIV sero-prevalence surveys. The results of these surveys

should enable the NTP to define specific interventions for intensified TB case finding in PLWHA, including those on ART; prevention of TB infections in PLWHA; delivery of HIV prevention and counseling and testing (CT) services among newly diagnosed TB patients; and the development of a network of TB/HIV professionals. DOTS is primarily available only at the puskesmas level but using Global Fund TB grant resources, DOTS is being expanded to all sites in which ART is being provided in order to provide coordinated services at a single site. New TB patients found to be HIV positive will be referred to ART service sites for antiretroviral therapy assessment.USG supported TB activities in Indonesia through the TBCAP cooperative mechanism focus on assistance in DOTS expansion, capacity-building, training at the national and district levels, MDR TB treatment availability and TB/HIV. TBCAP and its partners support TB/HIV activities based on the National TB/HIV Strategy. KNCV is the lead organization; FHI, as a sub contractor, is the key USAID implementing agency for HIV through the PEPFAR-funded ASA program, has assumed responsibility for programming in HIV/TB. KNCV plays the leading role in supporting the assessment and establishment of TB DOTS and HIV/AIDS treatment linkages in selected hospitals while the ASA program provides technical assistance to support HIV/AIDS, VCT, treatment, and care linkages in well established DOTS in puskesmas in Tanah Papua (Papua and West Papua) and three Continuum of Prevention and Care (CoPC) model facilities serving MARP. The ASA activities include: national TB/HIV coordination efforts; national training on TB/HIV implementation from curricula, guidelines, SOPs development and training of the national and provincial trainers; training in three CoPC model districts and Tanah Papua; development of a TB/HIV referral system between TB and HIV service sites particularly in district hospitals and puskesmas; and development of national M&E TB/HIV indicators and a M&E system. The ASA program has focused on integrating TB screening and treatment into a one-stop CoPC model, which includes services such as STI, CT, and case management for PLWA. Activities aimed to improve coordination of care in different settings, including intensified TB case finding in PLWA; prevention of TB infection in PLWA through infection control measures; prevention of HIV in TB patients through HIV CT; and Cotrimoxazole Preventive Therapy for patients with dual diseases. Training for clusters of puskesmas, hospitals, and prisons was also conducted.TBCAP funds have enabled structural strengthening to establish services within the prison system. Because of competing program needs and the availability of GFATM and TBCAP funds to work in prisons, very modest ASA funds have been allo cated to keep the prison work moving forward. In FY09, the main activity was the formal linkage of Lowokwaru prison in Malang with Saiful Anwar hospital as part of the emerging CoPC described above. TB-HIV training supported by FHI using TBCAP funds has been completed for Salemba, Pondok Bambu, Cipinang, Lowokwaru, Madiun, Sidoarjo prisons, and future efforts will focus on clinical mentoring. The main activities consisted of (1) strengthening clinic staff capacity through training and clinical mentoring, (2) dissemination of information on the TB control program to prison staff, (3) TB education for prisoners, peer educators and TB drug watchers, and (4) meeting with local stakeholders to develop linkages and a referral system with community health centers, hospitals, and District Health Offices (DHO). HIV funds also supported the CoPC model in two TB clinics, PPTI Jakarta and BP4 Semarang to implement TB/HIV among high risk and marginalized populations. All patients received HIV education; nearly 89% who received pre-test counseling tested for HIV. Of the 2,544 TB patients who were tested for HIV in FY09, 248 persons or 9.5% of all TB patients tested positive. Among all co-infected TB/HIV persons, 113 patients (45.6%) people received ART. Support in FY 2009 covered: opt-out HIV counseling and testing for all new TB patients attending PPTI clinics; technical support and mentoring for clinical management of TB/HIV, including ART; and linkage of TB/HIV care in communities through the IA networks of home-based care (HBC). In FY09, PEPFAR funds supported provincial-level coordination meetings which resulted in the formation of TB-HIV Technical Working Groups (TWGs) in several districts in Papua. Implementation of integrated services began in Jayapura, and further clinical mentoring was conducted to strengthen the referral system. Finalization of the national level TB-HIV recording and reporting system is still in the process of revision. When finished, FHI will take the lead in supporting implementation in Tanah Papua.TB/HIV trainings for HIV medical staff in hospitals and community health centers were completed in Jayapura, Papua and Sorong, West Papua, and was followed with clinical mentoring and program monitoring for TB-HIV in Dok2, Abepura, and Dian Harapan Hospitals, as well as puskesmas in Hamadi and Jayapura Utara. ASA also transitioned formal supervision to the TB/HIV TWG of Jayapura City in

these hospitals and community health centers using supervision tools developed by the NTP, the KPA, and FHI.CoPC activities in West Papua focused on hospitals and puskesmas in Fak-fak, Manokwari, and Sorong for program monitoring and TB/HIV supervision using new supervision tools, and working in collaboration with the Provincial and District Health Offices. ASA staff facilitated the establishment of a TB/HIV technical working group in Sorong, assisted in the development of a TB-HIV quarterly work plan, and provided clinical mentoring to staff of Selebu Solu Hospital, a district hospital and Remu Community Health Center. Planned PEPFAR funded activities in FY10 are based on the National TB Action Plan and a continuing close partnership with NTP and KNCV. Using TBCAP funding to support the implementation of national TB/HIV policies, guidelines and strategic plans developed in prior years with FHI technical assistance. During the ASA extension period and under the two new procurements, USG HIV funding will provide continued technical assistance in training on HIV/AIDS to TB personnel in hospitals, puskesmas and local health services in the five provinces rolling out CoPC; provide routine supervision and mentoring for HIV clinical services together with local health services; facilitate the coordination of TB and HIV/AIDS clinical services at selected sites; assist with the development of external quality assurance for the laboratory testing of HIV for TB patients; and provide other technical assistance in coordination with the rollout of TB/HIV services under the re spective National and GFATM work plans.

Technical Area Summary Indicators and Targets

REDACTED

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7480	US Department of Defense	Own Agency	U.S. Department of Defense	GHCS (State)	215,500
12428	Family Health International	NGO	U.S. Agency for International Development		
12429	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12430	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7480	Mechanism Name: DOD
Funding Agency: U.S. Department of Defense	Procurement Type: Contract
Prime Partner Name: US Department of Defense	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 215,500	
Funding Source	**Funding Amount**
GHCS (State)	215,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The U.S. Department of Defense is committed in its partnership with the Indonesian military (TNI) in their efforts to fight HIV/AIDS in Indonesia. The FY 2010 COP activities for DoD renews this commitment with a focus on prevention and testing efforts within the Indonesian military, and will assist in the strengthening of the TNI medical infrastructure in their efforts to fight the AIDS epidemic. In the TNI, all recruits are screened for HIV prior to induction and HIV positives are not accepted into the military. Although the TNI supports force-wide testing each year, there are not sufficient resources to accomplish this goal, and it may not be a cost effective strategy in a low prevalence epidemic. There is an active peer-to-peer prevention program focused on recruits and other critical high risk groups or situations (e.g., STI clinics, pre-deployment to high prevalence regions, etc.). However, the lack of trained human resources as well as financial constraints have limited the upgrade of necessary laboratory facilities and severely restricted the development of a more robust HIV/AIDS program. These shortages are particularly acute in high prevalence areas such as Papua. It is also important to point out that approximately 75% of the patients seen in military hospitals are civilians. Military HIV treatment hospitals are appointed and certified by the Ministry of Health. Although some HIV-related supplies and equipment are provided by the MOH, significant shortfalls exist in the military. Over the past few years, the DoD PEPFAR program has provided critical laboratory support through the partnership with TNI. As we move forward, the DoD will promote an increased emphasis on prevention among high risk members, increased linkages to counseling and testing, and the development of additional capacity to support counseling and testing as

well as treatment.

The DoD program has faced a number of challenges over the past few years and, in response to the Red Light section of the OGACS notification letter, the Office of Defense Cooperation, US Embassy Jakarta, in coordination with the Naval Health Research Center and USPACOM decided to realign the management of the DoD component of the PEPFAR program in Indonesia in FY 2009. Because of programmatic challenges, the Red Light by OGAC and the resulting realignment, the DoD program was not as active in FY 2009 as it has been in the past. However, the Country Team has approved an ODC request to hire an in-country program manager who duties will include routine interface with the Indonesian military health community, planning and coordination for all PEPFAR funded workshops and training, procurement and disbursement of PEPFAR funded supplies, and development of DoD portions of all Country Team PEPFAR plans and assessments. Additionally, PEPFAR funding will no longer be managed by USPACOM's Center of Excellence in Disaster Management and Humanitarian Assistance, but will be sent directly from NHRC to the ODC, where the PEPFAR program manager will work closely with ODC Resource Managers in the management and administration of funds. Under this realigned management, DoD has programmed FY 2010 activities in Adult Treatment, Counseling and Testing, Other Sexual Prevention and Lab Infrastructure.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors
Military Population

Budget Code Information

Mechanism ID:	**7480**
Mechanism Name:	**DOD**
Prime Partner Name:	**US Department of Defense**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	40,000	

Narrative:

FY 2010 funds for HTXS will be used to coordinate, plan and execute treatment, care and support workshops for military medical officers and other medical staff that work within the military community. This will include training of trainers (TOT) of medical officers, nurses and other ancillary healthcare workers. Training will reinforce the understanding of opportunistic infections (OI), adherence to anti-retroviral therapy (ART), working with patients and their families to ensure that they have knowledge of HIV, OI, ART, etc., with the goal of achieving continuity of care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	50,000	

Narrative:

DoD will expand and provide support to VCT activities. Funds will be used to procure much needed HIV/AIDS rapid test kits (2-3 brands to satisfy testing algorithms), as well as consumables to augment testing (gloves, needle and waste disposal supplies, etc.). Distribution of supplies will be targeted to facilities designed by the TNI as high prevalence areas or hospitals with critical shortages. Test kits will be those approved for use by the Indonesian Ministry of Health (MOH) so that they may be used both for military personnel and civilians accessing military health facilities.

FY 2010 funds will also be used to provide technical assistance in the form of training of staff at VCT centers (including counselors and testers). In addition, funds will support travel as required.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	85,500	

Narrative:

The overall goal of this activity is to decrease new HIV infections in the military through behavior change communication (BCC) with a focus on correct and consistent use of condoms. While some soldiers practice sexual abstinence and fidelity, factors such as separation from families, mobility, and age increase their HIV risk.

In FY 2010, DoD will continue to assist the Indonesian Defense Forces (TNI) in implementing community-based activities among soldiers, their sexual partners, and surrounding communities to promote safer sexual behaviors. Key prevention strategies include peer education and interpersonal communication (IPC) sessions, and the promotion of correct and consistent condom use. Many of these efforts will focus on the development of strategies to reach individuals who are at higher risk (e.g., pre-deployment to a high prevalence area, STI Clinic patients, etc.). DoD will collaborate with TNI in updating information, education and communication (IEC) materials to reflect best practices in the areas of peer education. In

FY 2010, TNI/PUSKES will continue these activities emphasizing correct and consistent condom use, ensuring condom access and availability (including minimizing the stigma surrounding condoms), and promoting a counseling and testing campaign (Know Your Status) among higher risk members. Additional IEC materials promoting condom use will be developed. FY 2010 will see a greater number and geographic distribution of peer education activities. These workshops will further provide the opportunity for TNI/PUSKES to develop their own peer leader workshops and developing and adapting their IEC materials.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	40,000	

Narrative:

FY 2010 funding for HLAB will go towards the strengthening of laboratory infrastructure at military hospitals that provide HIV testing facilities. In recent years DoD provided TNI/PUSKES with new CD4 machines for the purpose of HIV testing. HLAB funds from FY 2010 can be used for the purchase of reagents for these machines, overall maintenance of equipment and supplies, training of laboratory technicians, etc. DoD will also assist TNI in the procurement and disbursement of equipment, and training of lab personnel.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12428	**Mechanism Name: Aksi Stop AIDS (ASA) 2**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Family Health International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

Balai Kesehatan Paru Masyarakat	Centre for Studying Milieu	Community Based Rehabilitation

(BKPM) Semarang	Development (CESMiD)	(CBR)
Fatayat NU Kabupaten Tegal	Gerakan Sehat Masyarakat (GSM)	Gerakan Sosial, Advokasi, dan Hak Asasi Manusia untuk Gay Surakarta (GESSANG)
Himpunan Abiasa	Himpunan Konselor HIV/AIDS	Ikatan Gaya Arema Malang
Institute for Community Development and Social Advocacy	Kelompok Kerja Bina Sehat	Kelompok Kerja Waria Malang Raya Peduli AIDS
Lembaga Graha Mitra	Lembaga KALANDARA	Lembaga Paramitra
Lembaga Peduli AIDS Karya Bhakti	Lembaga Penelitian dan Pengembangan Sumberdaya dan Lingkungan Hidup (LPPSLH) Banyumas	Lembaga Solidaritas Perempuan untuk Kemanusiaan & Hak Asasi Manusia (SPEK-HAM)
LSM Tegar	LSM WARGA SIAGA	Paguyuban Srikandi Pasundan
Perhimpunan Buruh Independen	Perkumpulan Keluarga Berencana Indonesia	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jakarta
Perkumpulan Keluarga Berencana Indonesia (PKBI) Semarang	Perkumpulan Pemberantasan Tubercolosis Indonesia (PPTI) Jakarta	Perkumpulan Terbatas Peduli Sehat (Pt.PS) Manokwari
Persatuan Waria Kotamadya Surabaya (Perwakos)	PMI (Palang Merah Indonesia) Banyuwangi	Pusat Pengkajian dan Pengembangan Masyarakat Nelayan (P3MN)
Puskesmas Putat Jaya Surabaya	Yayasan Bambu Nusantara	Yayasan Bandungwangi
Yayasan Batam Tourism Development Board	Yayasan Bentan Serumpun	Yayasan Gaya Batam
Yayasan Gaya Nusantara	Yayasan Gema Indonesia	Yayasan Genta
Yayasan Gerakan Penanggulangan Narkoba dan HIV-AIDS (YGPNA)	Yayasan Harapan Ibu	Yayasan Insan Hamdani-Bandung Plus Support
Yayasan Inter Medika	Yayasan Karya Peduli Kita (KAPETA)	Yayasan KOMPAK
Yayasan Komunitas Karya Anak Bangsa (KARANG)	Yayasan Kontak	Yayasan Kusuma Buana
Yayasan Media	Yayasan Mitra Sehati	Yayasan Pelayanan Anak dan

		Keluarga
Yayasan Penguatan Rakyat Pedesaan	Yayasan Resik	Yayasan Solidaritas Perempuan Pekerja Seks
Yayasan Sosial Pengembangan Kawasan Timur (YASOBAT)	Yayasan Srikandi Sejati	Yayasan Srimersing
Yayasan Suara Nurani	Yayasan Tegak Tegar	Yayasan Usaha Kesejahteraan Ekonomi Masyarakat Desa Indonesia (Yukemdi)

Overview Narrative

Family Health International (FHI) has been managing the Aksi Stop AIDS (ASA) Program under a USAID Cooperative Agreement No. 497-A-00-05-00045-00 since September 15, 2005. The original CA has been amended twice to extend the program through March 2010. From October 1, 2009 through March 31, 2010, under the current extension of the continuing activity, FHI will continue to implement ASA based on the current program framework, while adjusting program strategies and approaches to address the new vision of PEPFAR, as well as lessons learned, funding realities and PEPFAR and USAID policies. The goal of the program will continue to be to contain the STI/HIV/AIDS epidemic by focusing on target populations in 64 districts, predominantly in Java, Sumatera, Riau, and Papua. Goals for target populations include: 1) reducing the incidence of STI/HIV/AIDS in most-at-risk populations (e.g., injecting drug users, female sex workers, clients of sex workers, men who have sex with men and transgenders); and 2) reducing the incidence of STI/HIV/AIDS within the general population of Papua. Technical assistance and capacity building to organizations working with target populations. The Results Package continues to be:

Result Area 1: Increased intervention coverage and use of risk reduction behaviors, practices and services. This will address the issues related to HIV transmission through MARP and their sexual partners.

Result Area 2: Improving Implementing Associations' (IA) ability to self assess and enhance programs. These activities focus on improving the coverage and quality of all program activities through strengthened monitoring and analysis of field activities and aggregated reporting and evaluation upward through the program management structure.

Result Area 3: Strengthening the Institutional Response. In FY2010 this will include assistance to the local AIDS commissions, Ministry of Health and the health service network, and partner NGOs.

Working in collaboration with all partners, FHI's priorities in FY2010 include continued and increased attention to high performing partners, demonstrating best practice models to leverage alternative funding sources, and increased collaboration with TBCAP on emphasizing TB-HIV integration strategies. FHI's primary intervention activities in FY2010 are reducing STI/HIV transmission in commercial sex, reducing HIV transmission among men who have sex with men (MSM), reducing STI/HIV transmission among

IDUs, HIV prevention among "positives," strengthening National, Provincial and District AIDS Commissions, strengthening STI/HIV/AIDS Clinical Services, and monitoring and evaluation of programs and results.
In regard to HRH, FHI/ASA does not support pre-service training. However, during 2010 FHI/ASA plans to organize in-service training on "Positive Health, Dignity, and Prevention" for selected case managers and other NGO staff responsible for providing support to PLWHA, utilizing a curriculum developed and piloted last year. The estimated cost of this training is US$15,000.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors
TB

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12429	**Mechanism Name: TBD**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**

Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This TBD implementing mechanism has been designed to address the pressing need in Indonesia to scale up the reach and coverage of effective, integrated interventions targeting most-at-risk populations. To meet this need, it is essential to efficiently and cost-effectively increase the number of interventions serving these populations; and local partners must have the technical knowledge and skills needed to effectively implement these interventions. The TBD is designed to leverage past USG programs in Indonesia by formally documenting and disseminating innovative approaches, best practices and lessons learned. This TBD is intended to provide support to the overall scale-up of interventions in Indonesia identified in the National Strategic Action Plan, including Global Fund interventions. In addition, it is designed to provide assistance in technical areas that are critical to the overall success of the HIV/AIDS response in Indonesia.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12429**		
Mechanism Name:	**TBD**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted
Narrative:			
This TBD implementing mechanism has been designed to provide technical assistance to scale up			

effective, integrated Adult Care and Support interventions that lead to substantial and measurable improvement in Adult Care and Support services quality of care and access.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide technical assistance to scale up effective, integrated Adult Treatment interventions that lead to substantial and measurable improvement in Adult Treatment services quality of care, coverage and access.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide technical assistance to scale up effective, integrated Testing and Counseling interventions that lead to substantial and measurable improvement in Testing and Counseling services quality of care, coverage and access.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide targeted assistance to government agencies and civil society organizations working on Strategic Information efforts related to the HIV/AIDS response for most-at-risk populations, including integrated bio-behavioral surveillance (IBBS) and monitoring and evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide technical assistance to scale up effective, integrated Health Systems Strengthening interventions that lead to substantial and measurable improvement quality of care, coverage and accessibility of health care services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide technical assistance to scale up effective, integrated Sexual Prevention interventions that lead to substantial and measurable improvement in behavior change among most at risk populations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide technical assistance to scale up effective, integrated PMTCT interventions that lead to substantial and measurable improvement in PMTCT services quality of care, coverage and access.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide technical assistance to scale up effective, integrated TB-HIV interventions that lead to substantial and measurable improvement in TB-HIV services quality of care, coverage and access.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12430	**Mechanism Name: TBD (Organizational Performance)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted

Funding Source	Funding Amount
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This TBD implementing mechanism has been designed to address the pressing need in Indonesia to scale up the reach and coverage of effective, integrated interventions targeting most-at-risk populations. To meet this need, it is essential to efficiently and cost-effectively increase the number of interventions serving these populations; and local partners must have the organizational capacity and skills needed to effectively implement these interventions. The TBD is designed to leverage past USG programs in Indonesia by formally documenting and disseminating innovative approaches, best practices and lessons learned related to organizational performance. This TBD is intended to provide support to the overall scale-up of interventions in Indonesia identified in the National Strategic Action Plan, including Global Fund interventions. In addition, it is designed to support capacity building of Indonesian agencies and organizations whose services are critical to the overall success of the HIV/AIDS response in Indonesia.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12430**		
Mechanism Name:	**TBD (Organizational Performance)**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted
Narrative:			
This TBD implementing mechanism has been designed to provide the targeted assistance in organizational performance required to provide technical assistance to scale up effective, integrated Adult Care and Support interventions that lead to substantial and measurable improvement in Adult Care			

and Support services quality of care, coverage and access.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide the targeted assistance in organizational performance required to scale up effective, integrated Testing and Counseling interventions that lead to substantial and measurable improvement in Testing and Counseling services quality of care, coverage and access.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to assist participating communities/hotspots monitor and evaluate the quality of the assistance provided by the TBD implementing mechanism as well as its impact on organizational performance.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide the targeted assistance in organizational performance required to scale up effective, integrated Health Systems Strengthening interventions that lead to substantial and measurable improvement quality of care, coverage and accessibility of health care services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

This TBD implementing mechanism has been designed to provide the targeted assistance in organizational performance required to scale up effective, integrated Sexual Prevention interventions that lead to substantial and measurable improvement in behavior change among MARP. It will also provide and monitor small grants to qualified civil society organizations to support the scale up of integrated interventions in "hotspots," where there is a high concentration of one or more most-at-risk populations and high-risk behavior is prevalent.

Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services					9,204	9,204
ICASS					30,500	30,500
Institutional Contractors					4,810	4,810
Non-ICASS Administrative Costs					139,663	139,663
Staff Program Travel					45,022	45,022
USG Staff Salaries and Benefits					321,890	321,890
Total	**0**	**0**	**0**	**0**	**551,089**	**551,089**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount

Computers/IT Services		GHCS (USAID)		9,204
ICASS		GHCS (USAID)		30,500
Non-ICASS Administrative Costs		GHCS (USAID)		139,663

U.S. Department of Defense

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
ICASS				2,500		2,500
Non-ICASS Administrative Costs				1,500		1,500
Staff Program Travel				10,000		10,000
USG Staff Salaries and Benefits				20,500		20,500
Total	**0**	**0**	**0**	**34,500**	**0**	**34,500**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHCS (State)		2,500
Non-ICASS Administrative Costs		GHCS (State)		1,500