Indonesia

Operational Plan Report

FY 2011

Operating Unit Overview

OU Executive Summary

1. **Project Title: Indonesia FY 2011 Country Operational Plan (COP)**

2. **Background**

With over 245 million people (July 2006 estimate) spread out over more than 17,000 islands, Indonesia is the fourth most populous country in the world. According to the 2009 Indonesia Country Report on the Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS), the HIV epidemic in Indonesia is now among the fastest growing in Asia. HIV prevalence among adults is 0.2%, with a higher prevalence among men (0.3%) than women (0.1%). By the end of 2009, there were an estimated 333,200 people living with HIV (PLHIV) in Indonesia. The Indonesian Ministry of Health (MoH) projected that without an increased effort in prevention, 541,700 people will be HIV positive by 2014. (CDC MOH, 2008)

The epidemic is concentrated in four most-at-risk populations (MARPs): 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), transgendered populations, male sex workers and their clients. However, while most of Indonesia is experiencing a concentrated epidemic, there is a growing generalized epidemic in the Papua and West Papua provinces with HIV prevalence of 2.4% among 15-49 year olds. (UNGASS Report 2009)

The highest disease burden is currently among IDUs, with a reported HIV prevalence rate between 43-56% and an estimated population size of 219,200. (National 2006, 2007 Integrated Biological and Behavioral Surveillance). Behavioral data from the 2007 IBBS found that 47% of IDUs had multiple sexual partners and 32% reported having had transactional sex; only 32% of IDUs reported consistent condom use with sex workers. IDUs thus represent a potential bridge for HIV transmission to FSWs.

The Government of Indonesia (GOI) recognizes that the primary driver of the epidemic has shifted from IDUs to sexual transmission in recent years. FSWs now have the highest HIV incidence rate among MARPs (MOH 2010). Indonesia has an active and extensive sex industry and among FSWs, the epidemic is fueled by a combination of the increased mobility of sex workers and their clients, low condom use, and a high number of sexual partners. Accessibility to essential HIV prevention services (e.g. treatment of sexually transmitted infections (STI), HIV testing and counseling and condoms) is limited, in part due to stigma. In 2007, there were an estimated 221,190 direct FSW in Indonesia, with a reported HIV prevalence rate of between 6% and 16%.

HIV prevalence among MSM was reported to be between 2% to 8% in 2007, up from 0-2.5% in 2002. (IBBS, 2007). HIV prevalence among *waria*, the Indonesian language term for transgendered persons, is higher, ranging from 14% to 34%. The number of sexual partners is reported to be high among MSM and condom use is reported to be low. MSM face a similar situation to that faced by FSWs, with limited access to essential HIV prevention services and lack of appropriate care.

While Indonesia's epidemic is mostly concentrated among MARPs, the provinces of Papua and West Papua, know as Tanah Papua, are experiencing a generalized epidemic. Cumulative AIDS cases reported in Papua through the end of July 2010 were the fourth highest in the country, after Jakarta, West Java and East Java. However, the HIV case rate in Tanah Papua is the highest in Indonesia, at 135.44 per 100,000 compared to the national average of 9.44 per 100,000 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. Moreover, limited access to essential services due to inadequate health systems and infrastructure in this region has a negative impact on the effectiveness of the response.

The Office of Defense Cooperation (ODC) in partnership with the Indonesia Armed Forces Surgeon General Office (TNI PUSKES) will focus efforts on prevention and testing. Since the beginning of the FY10 they have supported peer to peer training to strengthen medical infrastructure. The prevention and testing program will assist the Indonesian Armed Forces (TNI) to prevent HIV infections and monitor and evaluate their activities. Training is expected to improve both quality of services and counseling and testing linkages. Using pipeline funding, ODC will support an IBBS among military personnel. Based on this information in 2012, the Indonesia country team will revisit the division of HIV resources in Indonesia and use programmatic needs to inform funding allocations.

3. Sustainability and Country Ownership

The FY 2011 COP emphasizes development of and support for country-level ownership by working with the GOI and civil society to expand both organizational and technical effectiveness and capacity. The USG program, along with other international and bilateral institutions and donors, contributes to the GOI's National HIV/AIDS Strategy and Action Plan 2010-2014, which is being rolled out under the leadership of the National AIDS Commission (NAC). The national strategy is focused on preventing and reducing the risk of HIV transmission, improving the quality of life of PLHIV, and reducing the social and economic impact of HIV/AIDS. The strategy targets prevention services for MARPs and scaling up prevention, access to care, support and treatment, including Anti-retroviral Treatment (ART) for PLHIV. It also addresses provision of services to OVC as a part of impact mitigation, and improving monitoring and evaluation (M&E) efforts. The USG works closely with the NAC to ensure that USG program objectives, interventions, and benchmarks align with the National Strategy. The USG's comparative advantage as a bilateral donor is in providing strategic and targeted technical assistance to GOI and civil society organizations (CSOs), in order to effectively leverage other program activity funds, especially those services funded through the substantial GFATM resources.

In the past, PEPFAR/Indonesia provided direct prevention and clinical services to reduce the incidence of HIV in MARPs through the support of Non Governmental Organizations (NGOs) and civil society, in collaboration with the GOI. In the FY 2007 Mini-COP, the USG began to incorporate 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-COPs, these efforts were further intensified. The FY 2010 COP, by continuing this shift, represented an increased emphasis on the organizational performance and technical assistance necessary for the further development of overall health systems at the provincial and district health departments, and shifted away from direct service delivery and implementation through individual STI/VCT clinics. The USG provided funding to support 60 NGOs and civil society sub-partners in 64 districts, within eight priority provinces, identified by the NAC, where local epidemics are clearly evident and expanding. These included Papua, West Papua, North Sumatra, East Java, DKI Jakarta, Riau, West Java, and Central Java. USG support for direct HIV prevention and care services was an important contribution given the limitations on local government to fund NGOs. The FY2011 COP represents an increased emphasis on the technical and organizational performance assistance necessary to further develop overall health systems at the provincial and district levels.

Sustainability is emphasized through activities focusing on the importance of country ownership, strong civil society, best practices and replicable models**.** The primary implementing mechanisms for the USG program in Indonesia, the USAID managed SUM I and SUM II programs, support sustainability and country ownership by:

1. Providing the targeted technical assistance on HIV prevention to government agencies and CSOs to scale up effective, integrated HIV interventions that will lead to substantial and measurable behavior change among MARPs.
2. Providing targeted assistance to government agencies and CSOs working on strategic information related to the HIV response for MARPs.
3. Providing assistance for increasing organizational capacity among CSOs required for the scale-up of effective, integrated HIV interventions.
4. Providing and monitoring small grants to qualified CSOs with the goal that they become self-sustaining and ensure access to prevention and health care services for MARPs, including HIV services at the Puskesmas (public health centers).
5. Providing assistance to CSOs in organizational development and management skills so that they can access resources from GOI, GFATM and other sources.

In addition to the SUM programs which focus on the civilian population, the USG through ODC also supports targeted interventions for the military, working in partnership with the Indonesia Armed Forces Surgeon General office (TNI PUSKES) for Peer Leaders Training to reinforce HIV and STI prevention and address stigma and discrimination..

To further promote sustainability and country ownership, the USG is developing a 5-year strategic plan to serve as a roadmap for USG investments in the context of the national HIV/AIDS program and the vision of PEPFAR II. The USG team with the Office of the Global AIDS Coordinator (OGAC) Country Support lead held consultations in September 2010 with relevant stakeholders to determine the direction of the 5-year strategy and to identify gaps in current programming where the additional resources might have the greatest impact. Initial discussions were held with the NAC, the MOH, UNAIDS, AusAID and its implementing partners, Indonesian Armed Forces (Tentara National Indonesia /TNI), and USG implementing partners. In support of the NAC's objectives to achieve 80% geographic coverage of MARPs, with a 60% level of program effectiveness, and sustainability of HIV/AIDS services, the USG will focus on improving the effectiveness of interventions and the sustainability of activities by local government and non-governmental partners. Based on initial consultations, the strategy will include the following components:

I. Improving effectiveness of interventions and accelerating use of interventions to prevent sexual transmission.
II. Improving sustainability through capacity building for local government and NGOs and health system strengthening, particularly in strategic information, planning and implementation.
III. Focused health systems strengthening in Tanah Papua (Papua and West Papua) to improve the use of existing resources and accelerate access to services.

The pillars of this strategy will support the PEPFAR II principles of country ownership through technical and financial support to the NAC, the MOH and TNI, as well as civil society. The decentralization of Indonesia's health system has placed increased responsibility on provincial and district governments to manage the HIV/AIDS program; USG efforts will also build management capacity of local government in the provinces with the highest prevalence. Through grants programs and technical assistance, the USG will enable CSOs to advocate for and leverage resources while sustaining the quality of their programs. The strategy will also continue USG efforts to work closely with the GFATM Country Coordinating Mechanism (CCM) and with the Principal Recipients (PRs) to improve the effectiveness of GFATM-financed interventions.

Given the significant governance and developmental challenges and disproportionate burden of HIV in Tanah Papua, the strategy will also focus on prevention and health systems strengthening efforts in Tanah Papua. The USG team will work closely with AusAID and other USG/USAID programming efforts in the areas of Democracy and Governance, Tuberculosis, and Maternal and Child Health to provide a

comprehensive package of developmental assistance.

Based on these initial consultations and to complement the current work that the USG is doing through its current partners, the additional FY10 and FY11 funds will be used to support:

- An increased emphasis on Tanah Papua, specifically focused on an integrated (across health and with other sectors) health systems building effort combined with an accelerated condom promotion effort;
- Integrated Bio-behavioral Survey (IBBS) in FY11 in Tanah Papua and among military personnel, to better understand the drivers of its epidemic;
- The Indonesian Partnership Fund (IPF), under the leadership of the NAC that supports the management of provincial and district AIDS Commissions and provides small grants to civil society organizations;
- Condom social marketing and operations research to improve effectiveness of current prevention efforts;

The USG team will continue discussions with its development partners over the next few months to further develop the objectives of the 5-year strategy and integrate the proposed new activities into the national response.

To address the HIV epidemic in military, the ODC and the Indonesia Armed Forces Surgeon General Office (TNI PUSKES) plan to coordinate and implement training on peer to peer education, training of trainers, TB/HIV and Integrated Management of Adult and Adolescent Illness (IMAI) workshops, VCT and laboratory training, and IBBS among military personnel.

4. GHI Initiative

To promote the principles of the Global Health Initiative (GHI), PEPFAR and its implementing partners will work with the GOI to integrate a woman- and girl-centered approach to PEPFAR programming for HIV/AIDS activities as appropriate. USG efforts in Tanah Papua, where the HIV prevalence rates are more gender-balanced, will focus on the girl- and women centered approach to a greater extent.

The UNGASS 2010 Report stated that in 2006, 21% of the estimated 193,000 PLHIV were women. By 2009, the estimate of PLHIV had risen to 333,200, 25 % of whom were women. USG efforts directed to female sex workers (FSW) will focus on improving the quantity and quality of HIV-related health services available to FSW. In addition to health service interventions, USG efforts will address some of the structural factors that put FSW at elevated risk of HIV transmission, including negative stigmatization of condoms, restrictive local laws that limit women's ability to protect their health, weak bargaining power in condom negotiations with male clients, and limited empowerment to demand services to which they are legally entitled. Complex sexual networks increase the risk of transmission between and among IDU, MSM, FSW, clients of FSW and their sexual partners. Moreover, these sexual networks put a significant number of women at risk of HIV infection although they would be described as "low-risk" because they have sex only with their husbands or long-term partners who may also be MSM or IDU. Program efforts directed to female IDU and women who are partners of IDUs will focus on increased access to information needed to protect their health and increased reach of counseling and support services. The ODC HVOP and HVCT program areas will include technical assistance on gender issues such as male norms and behavior, prevention with positives (PWP) and couples counseling and testing: encouraging military personnel to get their HIV test along with their partners.

In order to optimize engagement with and leverage funding of other partners to increase impact and sustainability, USG will support the development and implementation of a small grants scheme for CSOs in support of scale-up of integrated MARP interventions in identified hot spots, which will be

supplemented by technical assistance available to all CSOs for organizational development and management. The grants will provide incremental working capital for comprehensive MARP-driven interventions and leverage funds from other sources for sustainability beyond the life of the SUM Program. Grants to CSOs will take the form of 1) Leadership Grants designed to support more mature CSOs to enable them to consolidate their base and/or to target specific capacity building needs; and 2) special initiative grants, which may include small rapid response grants to support emerging needs, and start-up grants to foster the development of new civil society groups.

5. Integration Across the USG

PEPFAR/Indonesia is working with several other USG programs to ensure maximal integration of health and other programs, including the use of non-PEPFAR USG funds. The expanded effort in Papua is integrated across health technical areas, as well as with democracy and governance local capacity building. The USG-supported HIV program will continue to work closely with the USG-supported Indonesian National Tuberculosis Program (NTP) program a to expand intensified TB/HIV case finding by national programs and expand access to and integrate treatment of TB and HIV in co-infected individuals. SUM I will assist in development of strategies and tools to support implementation of intensified case finding, assist in facilitating coordination meetings for TB/HIV collaboration, and support discussion with MOH on the use of Isoniazid Preventive Therapy (IPT) by PLHIV, which is currently not part of the Indonesian national TB/HIV policy. The NTP decided to undertake operational research for IPT and has requested that SUM I/FHI assist in developing the IPT operational research (OR) protocol. In the future, findings from this OR will be incorporated into integrated programming undertaken by USG TB and PEPFAR programs in Indonesia. Under the current USG-funded TB program, FHI has been working with the MOH Sub-Directorates for AIDS and TB, which is responsible for prisons within the Ministry of Justice and Human Rights (Dephukham), to introduce universal TB screening of all TB symptomatic and all inmates testing positive for HIV, and to connect inmates to treatment services. This work will continue under the new TB CARE Project.

In FY09, the USG supported the integration of targeted PMTCT into the Continuum of Prevention to Care (CoPC) service models implemented in Papua, Jakarta and Malang. Integrated with USG supported MCH program, Health Service Program (HSP), initial implementation was through Gondang Legi Public Health Center (PHC) in Malang, Gambir PHC and 3 other PHC in Jakarta in collaboration with UNICEF, WHO and AusAID funded HIV/AIDS Control and Prevention in Indonesia (HCPI). Activities included further integration of PMTCT with MNH, malaria, TB and safe water programs in Papua. SUM I and II will continue to collaborate with the new MCH program now in the design stage. Health systems strengthening activities proposed in the new 5-year strategy will also be coordinated and integrated with health and democracy and governance programs in Papua. The ODC is working closely with USAID/Health – HIV section on prevention and testing to ensure the maximal integration toward strengthening and sustaining the health system within the military.

6. Cross Cutting Attributions: Health System Strengthening (HSS) and Human Resources for Health (HRH)

USG has been heavily involved with strengthening leadership and governance of the national response to the HIV epidemic, expanding high quality service provision and referral networks for MARPs, strengthening organizational capacity of civil society, and supporting strategic information systems and management.

To enhance country ownership and sustainability, USG will continue to strengthen CSOs capacity through SUM I and II projects. A major challenge in implementing HIV programs in Indonesia is the lack of an enabling environment for CSOs to effectively deliver high quality interventions and to sustain their own organization and programs. One of the goals in the FY11 COP HSS strategy is to improve the capacity of

CSOs to fully participate in country ownership and enhance their capacity to delivery sustainable services. This will be accomplished through targeted assistance to CSOs and local NGOs on organizational performance, including development of capacity in resource allocation and mobilization, human resource development, financial management and accounting, advocacy and facilitation skills, and effective program M&E. USG will also support efforts to improve basic programmatic reporting systems for CSOs and local government, and to strengthen local CSOs and government skills in the use of data for policy and program decision-making and advocacy. A small grants scheme for qualified CSOs that are playing an active role in the implementation of the comprehensive intervention package will improve organizational performance and the quality of services. In addition, under the country strategy, the expanded effort in Tanah Papua will focus on health systems strengthening. Currently health systems capacity in Papua is so limited that HIV/AIDS prevention, counseling, testing and treatment interventions cannot be made available to the population.

The USG will also work with local government agencies to develop their institutional capacity to leverage funding through collaborations between other local governments and CSOs, develop new public-private partnerships, and improve their efficiency by utilizing existing community resources. Targeted HSS TA will be provided to increase local government capacity in the development of effective, evidence-based strategic action plan, costed annual action plans, and the integration of these plans into the GOI budget planning system.

Increasing the availability of quality data and improving skills in the analysis and use of data are critical in promoting an evidence-based response to the HIV epidemic. Indonesia requires a functional M&E and health information system (HIS) and lacks in-country capacity to conduct behavioral surveys and surveillance. USG will strengthen SI capacity by providing training and technical assistance in the design and implementation of surveys and surveillance for the national and provincial governments. USG-supported activities will include in-service training and TA to district level staff on data management, data use and analysis. In collaboration with GFATM and WHO, SUM I will assist the Indonesian MOH in its national HIS and M&E reform to improve the functionality and interoperability of the national information system.

Data from MOH indicate that the number and distribution of healthcare professionals is insufficient and many healthcare workers have not received adequate training in basic health practices. The USG will use FY11 funding to support in-service training of community health workers and social workers to improve the quality of services, as well as to expand services provided by community health workers through task shifting.

The USG will continue to support laboratory capacity building and expand coverage of quality laboratory support services to improve care and treatment for PLHIV. In FY11, USG will provide TA to laboratory facilities in external quality assurance and proficiency testing (EQA/PT) for HIV diagnostics.

To strengthen the military health system, the ODC will assist TNI in evaluating their laboratory infrastructure and will provide assistance to fill gaps through commodities procurement (e.g., rapid test kits, reagents) and technical assistance in conducting testing in targeting most at-risk personnel. Goals include supporting military laboratories to meet national laboratory standards and providing training to lab technicians.

7. Coordination with Other Donors and Private Sector

The NAC is the national body responsible for donor and overall program coordination. At the request of the NAC, the USG is contributing to the NAC-managed Indonesian Partnership Fund (IPF) and sits on the IPF Steering Committee, which is led by the Coordinating Minister for People's Welfare. The IPF facilitates coordination at national and sub-national levels, responding to emerging HIV/AIDS issues, and

providing financial and technical support to CSOs. Other major development partners working in the HIV/AIDS sector are AusAID, UNAIDS, UNICEF, WHO, the Indonesian Business Coalition (which focuses on workplace interventions) and the World Bank. The private sector has a very limited role in HIV/AIDS in Indonesia at present. To engage the private sector, USG will support CSOs to develop more effective working relationships with private companies that have a vested interest in the well-being of communities nearby or are interested in establishing a national corporate social responsibility profile.

To date, Indonesia has received more than $600 million in funding from the GFATM for all three diseases. Of this total approved amount, roughly $370 million has been obligated through signed agreements. HIV funding amounts to $117 million, with $106 million going to the MOH for public sector services.

The USG is a voting member on the CCM, sits on the CCM Oversight Committee, participates in all three Technical Working Groups (TWG), and provides assistance in writing and submitting grant applications. Through the GMS project, USG supports TA to help strengthen PR M&E and management. For HIV/AIDS, the USG Team works closely with GOI and other partners to leverage funding and maintain alignment of GFAATM grant applications with the National HIV/AIDS Strategy. A Global Fund Liaison position was established in FY09, co-funded with FY10 through OGAC central GFATM TA funding and USAID mission TB funding to strengthen systems and support strategic planning and governance within the CCM and the CCM Secretariat. The other major international Development partner is AusAID. USAID collaborates closely with AusAID to complement technical focus and geographical areas supported with bilateral PEPFAR and TB funding.

In FY08, the USG played a critical role in resolving management issues by providing TA to finalize and introduce the CCM Governance Manual, build CCM capacity for oversight, and establish asset recovery procedures. The USG Team provided TA for Round 8 and Round 9 grant applications and upstream support for implementation activities. In FY11, the USG Team will continue to provide TA on capacity building and strengthening M&E systems as well as TA for a possible Round 11 submission.

8. Programmatic Focus

The USG supports a wide range of HIV/AIDS technical assistance interventions in Indonesia. The most important program areas include: Other Sexual Prevention, Sexual Prevention among Injecting and Non-Injecting Drug Users, Counseling and Testing, Adult Care and Support, Laboratory Infrastructure, HSS, and Strategic Information (SI). USAID launched the Scaling Up for Most at Risk Population Projects (SUM I and SUM II, 2010-2015) to support improvements in the quality of services and institutional capacity required to effectively deliver and sustain high quality interventions. These projects work with the government, civil society, and NGOs to increase their technical capacity, including use of data for strategic decision-making, as well as continued work to enhance the comprehensiveness of interventions for most at-risk populations (MARPs).

Prevention: Given that HIV in Indonesia remains concentrated in MARPs, non-AB prevention efforts directed to such populations are among the highest priorities in the Indonesian national response. USG funds will support the national program via technical assistance to implement a comprehensive intervention package and improve the quality of prevention efforts, as well as increase participation and empowerment of MARPs. Program areas include (1) Services to control STIs; (2) Behavior change communications, (3) Condom use promotion, (4) Structural interventions to create more enabling national and local environments for HIV prevention among MARPs and to de-stigmatize condoms, and (5) Limited lab support for external quality assurance system (EQAS) for STI screening reagents and lab performance, as well as training of lab staff in STI diagnostics. Support will be provided at the national level, at the provincial level in eight priority provinces, including Tanah Papua, and in 10-15 districts/targeted intervention sites. In addition, USG funds will provide TA and small grants to CSOs for

MARP participation, mobilization and community self-reliance activities aimed at prevention of HIV infection from sexual transmission, with a focus on brothel- and street-based FSWs and waria. Their participation at all levels of program planning, implementation, and evaluation is believed to improve their sexual and health-seeking behaviors.

The NAC has requested that USG focus its support primarily on the prevention of sexual transmission of HIV, while AusAID focuses on harm reduction among IDUs. However, as interventions to prevent sexual transmission of HIV directed to IDUs require integration with other components of comprehensive intervention packages and may require adjustment of "harm reduction" interventions in order to be implemented efficiently and effectively, modest USG funds have been allocated for the IDUP program area. Program funds will be used to support integration of HIV sexual transmission messages and services into the national harm reduction model, with an emphasis on secondary prevention in view of the high prevalence of HIV among IDUs. Local structural interventions will focus on advocacy for policy reform, planning and budgeting for the HIV program, community mobilization, raising the prominence of MARP leaders and champions, and reducing stigma and discrimination.

HIV Testing and counseling (HTC) services are a key entry point into the full range of interventions that make up the CoPC and provide an opportunity to reach both HIV+ and HIV- individuals with prevention messages and information. Despite the infusion of substantial resources to make HTC widely available, recent GFATM program data indicate that national program targets are not being met and that program coverage remains far from sufficient. At the targeted intervention site level, USG will support the development and testing of "service models' that minimize "missed opportunities" for MARPs to learn their HIV status and incorporating best practices and innovations into service guidelines.

In addition, USG funds will be used to promote improvements in program performance by means of organization capacity building to CSOs and technical assistance to support both supply- and demand-side interventions. At the national level, USG will continue to promote the formal integration of HTC into STI control services and expanded use of provider-initiated counseling and testing (PITC) for MARPs and will continue to support implementation of EQAS with regard to HIV test kits and reagents. CSOs will be supported to work with MARP indigenous leaders to develop socially and geographically acceptable drop-in centers, including training and mentoring counselors. USG will provide small grants to CSOs for consumable supplies, incentives for additional staff, and staff training to build technical capacity. On the demand side, USG will support TA to the GFATM civil society PRs to strengthen HTC referrals for MARPs via community outreach undertaken by NGOs and Community Based Organizations (CBOs). In addition, USG will support CSOs engaged in increasing demand for HTC among MARPs. USG will continue to support the GOI, as needed, through mentoring programs, quality assurance, and other technical assistance in coordination with the rollout of HTC services under the National HIV/AIDS Strategy and Action Plan and the GFATM work plans.

The ODC portfolio on prevention will focus on peer to peer training (Surabaya, West Java, Central Java, East Java and Denpasar, Bali), prevention training, VCT, IMAI, laboratory training, management of co-infection among PLHIV, and HIV/AIDS workshops for military teachers. The training will reinforce an understanding of HIV, safe sex, other sexually transmitted diseases, drugs and social stigma. An IBBS among military personnel will be conducted during FY11. The data from this IBBS will help target HTC activities specifically for most at risk military personnel, (e.g., make test available to all new recruits, conducted regular testing of active military personnel, and training of healthcare providers and counselors on testing and counseling). The data from IBBS will also be used to redesign IEC material and design activities such as training of trainers and peer educators to target most at risk military personnel that are identified through IBBS (e.g., personnel having unprotected sex, injecting drug users, men who have sex with men, etc.). Prevention with Positives (PWP) technical assistance will also be provided and efforts will be made to increase awareness in correct and consistent use of condoms, promote safer sexual behavior

and counseling and testing. These efforts will focus on high risk prevalence areas, as determined by Indonesian Armed Forces Medical Center.

Care: At the national level, USG funding will support continued expansion of community-based Case Management Services via technical assistance and support to GFATM civil society PR PKBI and policy dialogue with the MOH concerning a longer-term strategy for HBHC. In targeted intervention sites, USG funding will support more intense efforts to develop and implement feasible HBHC models for the Indonesian context in collaboration with the NAC, MOH and other local implementing partners.

Effective and efficient opportunistic infection (OI) management in Indonesia has been an elusive goal for a number of reasons, including rigid specialization among physicians in large hospitals, variable incentive structures for physicians to address different diseases, and supply chain management deficiencies for key OI treatment drugs. Beginning with targeted intervention sites, USG funding will support efforts to promote more holistic treatment of HIV-positive individuals and improvements in OI management, via the conduct of IMAI training and quality assurance/quality improvement (QA/QI) efforts. USG will support CSOs to improve organizational performance of MARP-based care, support and treatment, especially for MSM, *waria* and IDUs. HBHC will include technical assistance and support for management of post-counseling, adherence, psycho-social support, and positive prevention aimed at reducing morbidity and mortality among PLHIV.

Other: In addition to lab support specific for the control of STIs (included under HVOP) and HIV counseling and testing, USG will support general, national-level staff training and implementation of external quality control systems (EQAS). Labs located in targeted intervention sites will receive extra attention on these dimensions of lab strengthening.

With FY11 funds the ODC will continue to support Indonesian National Military Armed Forces (TNI) through the Indonesia Armed Forces Surgeon General Office (TNI PUSKES) in improving and developing laboratory equipment, reinforced by building a better information system through training on related laboratory courses. The procurement of HIV equipment will include but not limited to test kits, CD4 machines, CD4 controls, reagents, laboratory, glass tubes, gloves and other laboratory equipment to support HIV testing. Laboratory training aims to improve technical knowledge on HIV cases and related equipment and produce skilled lab technicians. FY11 funds will also increase surveillance efforts by supporting an IBBS within the Indonesian military.

The USG program focuses on building SI capacity at all levels in collaboration with GOI, MOH, NAC, and other development partners. The emphasis on enhancing SI capacity and sustainable data use will continue in FY 2011, 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. Furthermore, in FY11, USG will support the implementation of a follow-up IBBS from 2006 for the generalized epidemic in Tanah Papua to assess behavioral changes and HIV prevalence in the region. As PEPFAR plans to increase its support in Tanah Papua with the additional funding received in FY10 and 11, it is imperative that targeted interventions in Tanah Papua be evidence-driven and this follow-up IBBS will provide the necessary data USG needs to effectively design future programs.

USG efforts toward strengthening health systems will focus on strategic information systems reform, strengthening public sector-NGO partnerships to expand program coverage, addressing stigma and discrimination toward MARPs and PLHIV among health service providers, improved program technical skills among provincial- and district-level public health officers, and organizational performance and

technical capacity development for local government, other stakeholders, and, in particular, for CSOs to design, plan, and effectively implement HIV comprehensive intervention models for MARPs.

9. **New Procurements: REDACTED**

10. **Program Contact:** PEPFAR Coordinator**:** Irene Koek, ikoek@usaid.gov

11. **Time Frame**: October 2011 to September 2012

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	300,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Adults 15-49 HIV Prevalence Rate	00	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Children 0-14 living with HIV						
Deaths due to HIV/AIDS	8,300	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months	4,386,000	2007	UNICEF State of the World's Children 2009. Used "Annual number of births (thousands) as a			

			proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	2,800	2009	Towards Universal Access. Scaling up priority HIV/AIDS Intervention in the health sector. Progress Report, 2010. This mid-point estimate is calculated based on the range provided in the report.			
Number of people living with HIV/AIDS	310,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)	73,000	2009	Towards Universal Access. Scaling up priority HIV/AIDS Intervention in the health sector. Progress Report, 2010.			
Women 15+ living with HIV	88,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

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			5,000,000	7,750,000	**12,750,000**
Total	**0**	**0**	**5,250,000**	**7,750,000**	**13,000,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency			Total
	DOD	USAID	AllOther	
HBHC		707,257		**707,257**
HLAB	80,000	50,000		**130,000**
HTXS	25,000	75,000		**100,000**
HVCT	47,000	615,805		**662,805**
HVMS	48,000	847,000		**895,000**
HVOP	50,000	4,746,638		**4,796,638**
HVSI		703,628		**703,628**
HVTB		100,000		**100,000**
IDUP		262,177		**262,177**
MTCT		25,000		**25,000**
OHSS		4,617,495		**4,617,495**
	250,000	**12,750,000**	**0**	**13,000,000**

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	707,257	
HTXS	100,000	
Total Technical Area Planned Funding:	**807,257**	**0**

Summary:
(No data provided.)

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
IDUP	262,177	
Total Technical Area Planned Funding:	**262,177**	**0**

Summary:
(No data provided.)

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	662,805	
Total Technical Area Planned Funding:	**662,805**	**0**

Summary:
(No data provided.)

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	4,617,495	
Total Technical Area Planned	**4,617,495**	**0**

Funding:		

Summary:
(No data provided.)

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	130,000	
Total Technical Area Planned Funding:	**130,000**	**0**

Summary:
(No data provided.)

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	895,000	
Total Technical Area Planned Funding:	**895,000**	**0**

Summary:
(No data provided.)

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	25,000	
Total Technical Area Planned Funding:	**25,000**	**0**

Summary:
(No data provided.)

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVOP	4,796,638	
Total Technical Area Planned Funding:	**4,796,638**	**0**

Summary:
(No data provided.)

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	703,628	
Total Technical Area Planned Funding:	**703,628**	**0**

Summary:
(No data provided.)

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	100,000	
Total Technical Area Planned Funding:	**100,000**	**0**

Summary:
(No data provided.)

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)	202,000
12580	Training Resources Group	Private Contractor	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	4,972,565
12670	Family Health International	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	3,380,435
12769	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12866	KINERJA	Implementing Agency	U.S. Agency for International Development	GHCS (State)	1,500,000
13473	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: Grant
Prime Partner Name: US Department of Defense	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 202,000	
Funding Source	**Funding Amount**
GHCS (State)	202,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	36,900

Key Issues

Increasing gender equity in HIV/AIDS activities and services

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	25,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	47,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	50,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	80,000	

Narrative:

None

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12580	Mechanism Name: Scaling Up for Most-At-Risk-Populations (SUM II) - Organizational Performance
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Training Resources Group	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 4,972,565	
Funding Source	**Funding Amount**
GHCS (State)	400,000
GHCS (USAID)	4,572,565

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	164,612
Human Resources for Health	194,612

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**12580**		
Mechanism Name:	**Scaling Up for Most-At-Risk-Populations (SUM II) - Organizational Performance**		
Prime Partner Name:	**Training Resources Group**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	457,257	
Narrative:			
None			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	365,805	
Narrative:			
None			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	228,628	
Narrative:			
None			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	1,717,495	
Narrative:			
None			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	2,066,203	
Narrative:			
None			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	137,177	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12670	**Mechanism Name: Scaling Up for Most-At-Risk-Populations (SUM) I - Technical Assistance**
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: 3,380,435	
Funding Source	**Funding Amount**
GHCS (State)	800,000
GHCS (USAID)	2,580,435

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	130,000
Human Resources for Health	105,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**12670**		
Mechanism Name:	**Scaling Up for Most-At-Risk-Populations (SUM) I - Technical Assistance**		
Prime Partner Name:	**Family Health International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	250,000	
Narrative:			

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	75,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	250,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	475,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	400,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,630,435	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	125,000	

Narrative:

None

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	25,000	

Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HLAB	50,000	
Narrative:			
None			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HVTB	100,000	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12769	**Mechanism Name: Condom Social Marketing**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
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

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12769**
Mechanism Name:	**Condom Social Marketing**
Prime Partner Name:	**TBD**

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

Narrative:
None

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12866	**Mechanism Name: Kinerja**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: KINERJA	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,500,000	
Funding Source	**Funding Amount**
GHCS (State)	1,500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Cross-Cutting Budget Attribution(s)

Human Resources for Health	150,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12866**		
Mechanism Name:	**Kinerja**		
Prime Partner Name:	**KINERJA**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	1,500,000	
Narrative:			
None			

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 13473	**Mechanism Name: Indonesia Partnership Fund**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
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

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	Redacted

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**13473**		
Mechanism Name:	**Indonesia Partnership Fund**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	Redacted	Redacted
Narrative:			
None			

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					20,560	20,560
ICASS					37,150	37,150
Management Meetings/Professional Developement					26,950	26,950
Non-ICASS Administrative Costs					311,615	311,615
Staff Program Travel					31,200	31,200
USG Staff Salaries and Benefits				250,000	169,525	419,525
Total	**0**	**0**	**0**	**250,000**	**597,000**	**847,000**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (USAID)		20,560
ICASS		GHCS (USAID)		37,150
Management Meetings/Professional Developement		GHCS (USAID)		26,950
Non-ICASS Administrative Costs		GHCS (USAID)		311,615

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
Computers/IT Services				85		85
ICASS				9,000		9,000
Non-ICASS Administrative Costs				3,250		3,250
Staff Program Travel				17,726		17,726
USG Staff Salaries and Benefits				17,939		17,939
Total	**0**	**0**	**0**	**48,000**	**0**	**48,000**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (State)		85

ICASS		GHCS (State)		9,000
Non-ICASS Administrative Costs		GHCS (State)		3,250