Indonesia

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

I. Country Context

Throughout most of Indonesia, HIV/AIDS remains a concentrated epidemic, with highest prevalence among high-risk groups of sex workers, intravenous drug users and transgender persons in medium and large cities and major ports in the world's largest archipelago. In the two provinces that make up Papua in the far eastern part of Indonesia, HIV/AIDS is a generalized epidemic, with a 2006 prevalence of 2.4%, although higher among the native Papuan population which accounts for about one half of those living in Papua.

The 2011 integrated bio behavioral survey (IBBS) among high risk behavior groups in Indonesia found HIV prevalence to have declined among people who inject drugs (PWID) – primarily because PWID are increasingly switching to non-intravenous drugs; essentially remained unchanged among sex workers; and increased among trans-genders (waria) and high risk men, who are primarily thought to be clients of sex workers. While the prevalence among high risk men – including mobile men such as sailors, dock workers, and truck drivers – is still relatively low, the increase between the 2007 IBBS and 2011 IBBS is dramatic, rising from 0.1% in 2007 to 0.7 % in 2011.

In 2012 PEPFAR/Indonesia also supported an IBBS among the Indonesian military. While the data is not fully analyzed there are clear indications that knowledge of HIV and of the importance of condoms is low and stigma of HIV/AIDS remains high.

The Government of Indonesia (GOI) has had a progressive and comprehensive strategy and approach to combatting HIV/AIDS for several years. Led by the National AIDS Commission and the Ministry of Health (MOH), there are also presidential decrees supporting the fight against HIV/AIDS and active involvement and engagement of civil society, including from two of the most influential and largest religious NGO organizations in Indonesia (Nahdlatul Ulama (NU) and Muhammidyah). Among the Indonesian military, the Surgeon General's office is a key counterpart for PEPFAR/Indonesia.

As one of a small group of external partners working in HIV/AIDS in Indonesia, PEPFAR/Indonesia works very closely with the GOI and civil society partners as well as with other key organizations involved in HIV including Australian AID (AusAID), the Joint United Nations Programme on HIV and AIDS (UNAIDS), the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the United Nations Office on Drugs and Crime (UNODC) and the Clinton Health Access Initiative (CHAI) (funded by AusAID).

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is a major source of funding, contributing approximately 40% of total resources for HIV/AIDS. At the end of 2012, four principle recipients – including the MOH, National AIDS Commission (NAC), NU and the Indonesian Planned Parenthood Association (IPPA) had signed the Phase II of the 2009 GFATM grant for $100 million. USG staff were extensively involved in the development and finalization of the Phase II grant proposal.

Treatment and care services for HIV/AIDS in Indonesia are fully supported by the GOI and the GFATM. The Ministry of Health has a new prevention of maternal to child transmission (PMTCT) policy and is supporting the roll-out and implementation of this policy. PEPFAR/Indonesia through USAID is supporting technical assistance for a new more aggressive condom promotion strategy targeting key populations (men who have sex with men (MSM)/waria and female sex workers (FSW)) and high-risk men (clients of FSWs), while the costs of implementation and the costs of the condoms are being covered by the GOI and the GFATM grant.

In addition to USAID, the Department of Defense (DOD), through the Office of Defense Cooperation (ODC), is the other USG PEPFAR implementer in Indonesia. ODC focuses on the provision of technical assistance and training for prevention, care and treatment of HIV to the Ministry of Defense and Indonesian Military (TNI).

The small PEPFAR/Indonesia team coordinates and works extensively with GOI – both civilian and military--civil society and external development partners. All of the program activities of PEPFAR/Indonesia are planned and implemented in coordination with these partners, and designed to complement the work supported by AusAID and the GFATM and to accelerate the GOI's implementation of its "National HIV/AIDS Strategy and Action Plan." Coordination takes place through regular formal and informal discussions and meetings.

One of the key contextual factors in Indonesia continues to be decentralization. Set in motion in 2001 as a result of fundamental political reformation, authority to make budget and program decisions was shifted from a highly authoritarian central government to the roughly 500 districts and municipalities. Capacity to make and implement budget and programming decisions at the district and municipality level is highly variable and requires on-going advocacy and capacity building.

II. PEPFAR Focus in FY 2013

In FY 2013, PEPFAR in Indonesia will continue to focus on accelerating prevention interventions, particularly condom promotion among key populations and high-risk men; capacity building focusing on civil society and local government capacity building and enhancing the capacity of key GOI partners in the

area of monitoring and evaluation (M&E); and improving access to key prevention and treatment services in Papua, in coordination with the AusAID and GOI supported efforts there. With the military, training will be conducted in peer education, and testing and counseling, as well as in management of tuberculosis and other opportunistic infections. Technical assistance will also be provided in continuum of care, increased care services to address opportunistic infection at regional and local levels, as well as in strengthening M&E and data collection.
While acceleration of condom promotion will continue to be an important priority in FY 2013, this activity will not require FY 2013 funding. The bulk of the resources required to support the roll-out will come from GFATM grants to the NAC, NU and IPPA and PEPFAR pipeline funding.

The other important change in FY 2013 is expanded emphasis on building the monitoring and evaluation and scientific information capacity among the key GOI partners. In FY 2011 and 2012 COPs, considerable resources were devoted to implementing IBBS surveys in Papua, among high risk groups, and among the military. In FY 2013, activities will build on these investments and provide targeted technical assistance to improve the analytical capacity of our key GOI partners.

The pipeline in Indonesia has been reduced. In early 2012, several long-anticipated activities began implementation, including expanded work in Papua through the health system strengthening program, a number of grants to local NGOs, and the launch of the condom promotion activity. As such, the burn rate increased from $1.6 million per quarter at the beginning of 2012 to $4 million per quarter by the end of the year. This higher burn rate is expected to continue through 2013 and beyond for all of our on-going activities. On average, at the current burn rate, Indonesia has a pipeline of approximately 16 months. However, in the first half of 2013 the Papua IBBS survey will be conducted, increasing the burn-rate substantially for the first part of 2013 and further reduce the pipeline and may reduce the months of available funding to just over 12 months. The Papua IBBS is jointly funded by PEPFAR, AusAID, the World Bank and the GOI and has been delayed several times over the last year because of technical issues associated with the survey questionnaire and planned local elections in Papua. The technical issues have now been fully resolved and the survey is expected to begin in March 2013. If the survey does begin as scheduled and the current quarterly burn rate of $4 million increases for the survey as anticipated, PEPFAR Indonesia will need to request restoration of some of the FY 2012 funds held back for pipeline reduction.

As noted in the COP FY 2013 funding letter, the FY 2013 COP and PEPFAR Indonesia will prioritize reaching key at-risk populations and continuing to expand services in Papua. As a component of this, particular attention will also be given to expanding the capacity of our key GOI counterparts to improve the collection and use of data to make programming and policy decisions in order to better target interventions to key affected populations.

III. Progress and Future

The 2011-2016 PEPFAR strategy in Indonesia is designed to support the Indonesian "National HIV/AIDS Strategy and Action Plan 2010-2014" and complement the efforts of other key donors, notably GFATM and AusAID, and help the Indonesian military put in place an effective HIV/AIDS prevention and treatment program. As such, the PEPFAR strategy for Indonesia has primarily focused on reducing the sexual transmission of HIV/AIDS, while AusAID's strategy focuses on harm reduction and reducing disease transmission among PWID. The PEPFAR strategy is designed to take into account the status of the epidemic and where USG resources can have the greatest impact. The strategy has three interrelated components:

• Acceleration of key prevention strategies, particularly condom promotion among high risk groups.
• Capacity building of local NGOs and local governments to ensure a sustainable response to HIV/AIDS.
• Expanded efforts in Papua, designed to contribute to an improved health system that can effectively deliver services, reach populations most at risk and in need and better use local resources.

There has been substantial progress in the last year around each component of this strategy. USAID developed a condom promotion strategy designed to increase the use of condoms among key populations. The 2011 IBBS data showed that consistent condom use among key populations was much lower than it should be, at only 8% for high risk men and 36% for waria. While limited resources do not allow for PEPFAR to support the full implementation of the condom promotion strategy, the GFATM grantees of the National AIDS Commission, NU and IPPA are using GFATM grant monies to implement the strategy with technical assistance provided by USAID.
Through PEPFAR's support to the Indonesian military, an IBBS was completed in July 2012 among military staff which will help guide the focus of interventions to prevent and respond to HIV among the military. While the analysis and report are still being finalized, preliminary results indicate that knowledge about HIV among Indonesian service men increased somewhat between the 2003 and 2007 surveys. However, knowledge remains low compared to the HIV knowledge found among the key affected populations. Condom use is reported at just 11% at last sexual intercourse, indicating that the Indonesian military needs to strengthen its efforts to increase knowledge and awareness among their personnel.

The survey also indicated that some sub-groups in the military are at higher risk of infection, including: personnel with lower levels of education; enlisted personnel; young personnel; and personnel in selected provinces – i.e, Riau Islands, because of higher levels of risk-taking behaviors and higher levels of HIV prevalence; and Papua, because of the lower mean age of personnel deployed there and relatively high

prevalence of HIV. These groups could be reached through strengthening the prevention program and by utilizing peer training and testing and counseling.
In 2012, a management review of USAID's core implementing programs highlighted the very effective use of local technical assistance providers to build capacity of local civil society organizations for reaching key populations. In addition, in 2012, 25 grants to CSOs were in place reaching over 20,000 key affected populations with prevention services.

In 2012 USAID programs and activities in Papua expanded considerably. The Kinerja program, a partnership with the Democracy and Governance sector designed to improve the local government's delivery of health and HIV/AIDS services, was launched. This program has been strongly embraced by health leadership at the Provincial and District levels and implementation is well underway. In addition, six grants to local CSOs working in Papua were awarded and have begun implementation of prevention services. Finally, substantial effort has been devoted to finalizing the implementation protocol and survey tools for the IBBS among the general population in Papua. This survey is ready to be launched in March 2013.
Country ownership in Indonesia is fundamental to the way that USG operates in Indonesia. PEPFAR activities are fully guided by the "National HIV/AIDS Strategy and Action Plan", and planned and implemented in close collaboration with the National AIDS Commission, the MOH, TNI and local government counterparts and with input from partners and civil society. TNI's HIV program is owned and led by the Indonesian military, and operates within the guidelines and policies of the MOH and National AIDS Commission. Typically, GOI resources support the implementation of programs, while PEPFAR resources support the added technical assistance required to ensure high quality implementation.
FY 2014 will include new programs for USAID, building on the lessons learned from the current programs and focusing on key populations. In addition to significant investments in Papua and West Papua, this will also likely include focused efforts on reaching high risk men and men who have sex with men. Plans will be developed and modified based on the findings of the Papua IBBS and the lessons learned in program implementation.
For the partnership with the Indonesian military, in 2014 the focus will be to further enhance prevention efforts, including : strengthening the lines of reporting and communication among the MOH, Ministry of Defense and TNI; expanding peer counseling and outreach from the national to district level; and improving health care service delivery and health information systems from national to district level. The Indonesian military intends to establish and strengthen the role of the national level in supervising and supporting the district and sub-district levels, in order to improve the continuum of care for prevention, intervention and treatment.

IV. Program Overview

FY 2013 is a transitional year for PEPFAR/Indonesia's core implementation programs. As a small PEPFAR country with very limited resources, much of the implementation is undertaken by only a handful of mechanisms. FY 2013 will be the final year of funding for the two primary implementing mechanisms – Scaling up for Most at Risk Populations (SUM) I and SUM II. A new program design for the future portfolio is currently underway. New procurements would be funded with FY 2014 COP resources.

The FY 2013 COP will focus on reaching key populations through civil society and local government capacity building; improving the scientific information capacity of our key government counterparts; expanding services to at-risk populations in Papua; improving supply chain management; and continued funding for the USG grant to the National AIDS Commission for the Indonesia Partnership Fund – a key partner in prevention and building the national and local response to the epidemic, and continue technical assistance to TNI.

Reaching key populations/building civil society and local government capacity: Through funding for SUM II, we expect to increase the number and capacity of 29 CSOs, including 6 in Papua, and reach 41,000 people with prevention interventions.

Another key intervention area for reaching key populations is the further implementation of the condom promotion strategy. This work will continue during this implementation period, but will be funded with pipeline funding combined with funding supplied by the GFATM in grants to key partners. As a result of this roll out of the condom promotion strategy, condom use among key populations is expected to increase to 60%.

USAID will continue funding the government to government grant to the National AIDS Commission for the Indonesia Partnership Fund (IPF). The IPF is a multi-donor fund which channels funds to the national response to HIV from domestic and international partners, government and the private sector, with the primary goal of supporting the development and strengthening of an effective and sustainable national response to HIV in Indonesia. The IPF serves as a flexible mechanism which reaches key populations through improved capacity at the local level and grants to CSOs – the IPF is currently supporting 13 CSOs and reaching most at risk populations in high priority sites across Indonesia.

DOD, through the ODC, has assisted the Indonesian military to develop a strong prevention program. This program includes: improving and strengthening testing and counseling; increasing the capacity of military doctors; increasing services for sexually transmitted disease in military hospitals; and developing a practical and effective reporting and recording system.
ODC will provide technical assistance in developing the prevention and testing/counseling programs that specifically target most-at-risk personnel within the Indonesian military. The prevention and HIV

counseling and testing program was designed and developed based on the IBBS 2012 preliminary results. These prevention activities will include scaling up of provider initiated testing and counseling as mandated by Ministry of Health. The prevention program will also include messages that focus on reducing gender-based violence and coercive behaviors, and increasing gender equity in access to HIV programs and services.

Strategic information: In the 2013 COP, PEPFAR Indonesia will continue to build on the investments made to date to improve local capacity for use and production of strategic information. For about the next two to three years, long-term advisors will be placed at the National AIDS Commission and Ministry of Health to help further develop each institution's strategic information capacity and mentor local staff, including building skills and capacity in surveillance, data analysis and monitoring and evaluation. Both institutions have a key role to play in collecting, analyzing and reporting data and have requested USG assistance in providing dedicated technical assistance to build their internal capacity.

Supply chain management: Another area of continued investment is supply chain management. Since 2012, HIV funds have been combined with USAID tuberculosis funds to improve the logistics and management of drugs and other commodities, including improved warehousing. This support has allowed full engagement of People that Deliver(PtD) Indonesia, part of a global initiative to improve the demand for and retention of a qualified supply chain workforce, supported by USAID/Indonesia, USAID | DELIVER, TB CARE, the Clinton Health Access Initiative and the Indonesia Office of the World Health Organization.

Reaching key populations in Papua: In the 2013 COP, PEPFAR Indonesia will continue to expand efforts in Papua and West Papua, the region where HIV is a generalized epidemic. We will continue support for the integrated health/democracy and governance Kinerja program, designed to build health system capacity in Papua. This is an integrated health system effort with funding from USAID's PEPFAR, maternal/child health, and tuberculosis programs. Service delivery capacity in Papua is very limited, as is the capacity of local governments to budget, plan and implement services. Kinerja is working with district health authorities to better budget, plan and implement health services focusing on four of districts with the highest prevalence of HIV/AIDS. In addition, under SUM II continued support will be provided to local organizations based in Papua.

V. GHI, Program Integration, Integration with GFATM, Other Key Considerations:

Indonesia developed its GHI strategy in 2011. The strategy has three focus areas: accelerating achievement of the health Millennium Development Goals (MDG); expanding science partnerships and the quality and use of data and evidence for policy and programs; and partnering with Indonesia to

address issues of global importance, such as HIV.

The PEPFAR program is a core component of the GHI strategy in Indonesia, and the priorities for FY 2013 funding are fully in line with the focus areas of the GHI. The emphasis on key populations and Papua is core to reaching the MDG target for HIV; PEPFAR's increased emphasis on strategic information capacity is also a key component of the GHI focus area related to improving the quality and use of data.

The principles of GHI are very much at the heart of the PEPFAR Indonesia program. Country ownership is extremely strong – there is not a separate PEPFAR program outside the priorities of the "National HIV/AIDS Strategy and Action Plan." In the FY 2013 COP, increased attention is being paid to improving the monitoring and evaluation capacity of our key counterparts, building on investments made over the last few years. In Papua in particular, a good deal of attention is focused on health system strengthening and integrated programing. Attention to gender issues is core to how programs are implemented – in Indonesia, this not only means ensuring an effective focus on women and girls but also addressing the needs of waria and accelerating efforts to reach high risk men and men who have sex with men.

A range of social, legal, economic and cultural barriers prevent women and adolescent girls from accessing essential health services, including HIV. Disaggregating data by sex and age in all health service programs is essential to track access and use. Improved access can also be achieved through thoughtful integration of a range of health services that increase efficiency and convenience, and meet the specific needs of women and girls. Addressing these issues and insuring better attention to gender in program information and implementation is integrated into PEPFAR/Indonesia programming.

Stigma and discrimination and gender-related discrimination remain important obstacles to providing quality services for HIV/AIDS and controlling the epidemic. PEPFAR/Indonesia programming promotes the prevention of HIV through ensuring equitable access to gender-appropriate prevention education and services for women, men and transgender individuals. In Papua, USG programs also focus on gender-based violence and intergeneration sex, particularly among young women and high-risk men.

Several components of the PEPFAR program are closely integrated with other components of the USG health program in Indonesia. As noted, the Kinerja health system strengthening program in Papua is an integrated health system and governance effort; and HIV funds are combined with tuberculosis and maternal and child health funds to improve the GOI drug and supply chain capacity. While TB/HIV is not included in the FY 2013 COP specifically, some of the CSO grants in Papua – where there are much higher rates of co-infection – address TB/HIV integrated services, and TB/HIV is a component of USAID's

much larger tuberculosis program.

The GFATM is a critically important partner and important complement to the PEPFAR program. USG staff have been intimately involved in the development of the proposals for the current set of GFATM grants, and as such, have ensured that USG programs complement and are complemented by GFATM grants. The USG supports a GFATM liaison who plays a key role in the smooth functioning of the GFATM Country Coordination Mechanism (CCM), the CCM secretariat, and is a key resource for the Principle Recipients and Technical Working Groups. He also plays a critically important role in ensuring USG programs are coordinated with GFATM grants and in facilitating communication with the Indonesia Fund Portfolio Manager. USAID staff participate as members of the CCM and on each of the technical working groups. This past year, USG staff were intimately involved in the development and review of the GFATM Phase II proposal for HIV/AIDS, and the Transition Funding Mechanism grant for malaria, both of which were successful. At the end of the year, USG staff and programs were working closely with the National Tuberculosis Program in the preparation for and development of the Phase II tuberculosis grant, due at the end of March 2013.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	370,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	00	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	00	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	15,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	00	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults and children	55,000	2011	AIDS Info, UNAIDS, 2013			
Estimated number of	4,372,000	2010	UNICEF State of			

pregnant women in the last 12 months			the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	6,750	2011	WHO			
Number of people living with HIV/AIDS	380,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	13,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	100,356	2011	WHO			
Women 15+ living with HIV	110,000	2011	AIDS Info, UNAIDS, 2013			

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

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

How is the USG providing support for Global Fund grant proposal development?

USG provides support to Global Fund grant proposal development through two specific channels: inputs provided by (1) experts from USG-funded contractors implementing HIV, TB and malaria programs, and

(2) the Global Fund Liaison (GFL) based at the USAID Health Office. Contractor representatives and the GFL played a significant role, for example, in drafting the recently-awarded Phase 2 HIV grant, as well as the new malaria grant awarded through the Transitional Funding Mechanism (TFM). In addition, through membership on the Country Coordination Mechanism (CCM) and CCM Technical Working Groups (TWGs), USG staff were extensively engaged in the discussions, review and CCM approval of the Global Fund proposals.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?
No

Redacted

To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?
No

Public-Private Partnership(s)

(No data provided.)

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Surveillance	2014 Integrated Biological-Behavioral Survey among MARPs in Indonesia	Behavioral Surveillance among MARPS	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men, Other	Planning	06/01/2014

Surveillance	AIDS/HIV Case Reporting	AIDS/HIV Case Surveillance	Other	Implementation	12/01/2012
Surveillance	HIV Sentinel Surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Female Commercial Sex Workers, Other	Implementation	12/01/2013
Surveillance	Integrated Biological and Behavioral Surveillance	Behavioral Surveillance among MARPS	General Population, Uniformed Service Members	Implementation	07/01/2013
Surveillance	Key Populations Size Estimation	Population size estimates	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men, Other	Implementation	09/01/2013
Surveillance	Most At Risk Population Size Estimation	Population size estimates	Female Commercial Sex Workers, Injecting Drug Users, Men who have Sex with Men, Other	Implementation	12/01/2013
Survey	Stigma and Discrimination Survey	Evaluation	Female Commercial Sex Workers, General Population, Injecting Drug Users, Men who have Sex	Implementation	12/01/2013

			with Men, Other		

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		250,000		**250,000**
USAID			7,750,000	**7,750,000**
Total	**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	
CIRC		0		**0**
HBHC	20,000	195,813		**215,813**
HLAB		0		**0**
HTXS	20,000	0		**20,000**
HVCT	20,482	121,071		**141,553**
HVMS	41,556	509,001		**550,557**
HVOP	102,482	2,926,847		**3,029,329**
HVSI	35,000	1,444,106		**1,479,106**
HVTB		0		**0**
IDUP		282,824		**282,824**
MTCT		429,874		**429,874**
OHSS	10,480	1,840,464		**1,850,944**
	250,000	**7,750,000**	**0**	**8,000,000**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Other Policy						
Policy: Integration of CSOs in the provision of services for key populations						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date						
Narrative	• Lack of quality public health sector services• Recent decentralization of health services and finance • Implementation of services vary by region • Untapped potential for civil society	There is a need to engage civil society organization in reaching and providing quality services to key affected population	• Improved quality and comprehensiveness of HIV-related health services • Increase civil society role in identifying and serving beneficiaries • Increase capacity of civil society	National Strategy on levering funding from government institutions to civil society is approved and endorsed by the National AIDS program.	Integration of participation of civil society and increased availability and access to HIV services for key populations within National AIDS program.	N/A
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National Condom Social Marketing Strategy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion			2014	2014	2015	TBD

Date						
Narrative	Consistent condom use for HIV prevention in the general population and among key populations is low. There is a lack of understanding of condom market dynamics and a poor socio-cultural environment for condoms. A national condom social marketing strategy is needed to address the situation.	There is a need to increase demand for condoms among key populations and high risk men. Furthermore, a national strategy for condom social marketing should be developed.	National Condom Social Marketing Strategy developed.	National Condom Social Marketing Strategy approved and endorsed by the National AIDS program.	Integration and scale up of the condom social marketing program within National AIDS program.	Evaluate the behavior change associated with an effective national condom social marketing program (via iBBS results)
Completion Date						
Narrative						

Policy Area: Other Policy						
Policy: National HIV Surveillance Strategy/Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			2014	2015	2015-2016	
Narrative	While a national HIV surveillance strategy is in place, the implementation of surveillance activities at the provincial and district levels is inadequate, and fall short of the WHO recommended second generation surveillance guidelines for concentrated epidemics.	The national HIV surveillance strategy/policy should be reviewed and updated. It also needs to be implemented and scaled up nationally.	National HIV surveillance strategy reviewed and updated.	Updated national HIV surveillance strategy needs to be approved and endorsed by MoH and NAC.	HIV surveillance strategy rolled out nationally.	N/A
Completion Date						
Narrative						


PEPFAR
U.S. President's Emergency Plan for AIDS Relief

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	215,813	0
HVTB	0	0
Total Technical Area Planned Funding:	**215,813**	**0**

Summary:

Major Accomplishments

Strengthening the care, support and treatment services for people living with HIV is one of the four priority actions identified in the National AIDS Commission's National Strategic and Action Plan 2010-2014. Although there is some movement underway at the MOH to decentralize HIV treatment and care from hospitals to Puskesmas and from health facilities to community-based providers of services and support, HIV treatment and care services remain highly concentrated in hospitals, particularly those in large cities. Under the USG-supported programs in the last 5 years strides were made in expanding the reach of case management services for PLWHA from health facilities to communities through partnership arrangements between health facilities and local NGOs. The SUM project builds on this model, and focuses on building the capacity of CSOs to provide access to services for PLWHA. In-service training for palliative, home and community based care initiatives were implemented in Jakarta and Papua focused on creating proactive referral linkages among PLWHA, case managers, clinical service providers and service providers, and home visit teams to provide direct care and adherence support in the community. Limited collaborations have been undertaken with several universities to influence pre-service training, and the USG continues to support HIV/AIDS training for faculty and to advocate for strengthened HIV/AIDS curricula in pre-service training programs.

In FY11 SUM has established grants with 29 CSOs that provide HIV services to MARP groups, including assuring access to clinical services, counseling and testing, adherence support for treatment and management of opportunistic infections, social support and improving the enabling environment.
In addition, SUM has provided key technical assistance to central and national level government partners for gathering strategic information, establishing appropriate policies to target MARPs, as well as provide technical training to CSOs and other implementing partners to assure high quality service delivery.
As a result of PEPFAR investments, the Indonesian military implemented mandatory testing for UN deployment, new recruits, and personnel about to be promoted. HIV positive personnel are treated more humanely and TNI follows best practices such as peer to peer HIV training, and have increased access to testing, counseling and treatment.

Key Priorities & Major Goals for Next Two Years
The USG will support technical assistance to the MOH to develop a medium-term strategy for home-and community-based care of PLWHA. In targeted intervention sites, FY12 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. These models will likely be developed by folding case management functions into the service packages being provided by CSOs providing outreach services to MARPs.
CSOs play a key role in establishing networks to link clients to community-based health facilities and facilitating

referrals to enable MARPs to access care, support and treatment services when they are living with HIV. These organizations also act as in a case management role that complements the clinical service delivery and promotes lifelong health-seeking by MARPs. In their role as case managers, CSO staff and volunteers are playing a mentoring and supporting role for clinical staff and clinical teams in Puskesmas and hospital settings, enabling them to help modify services so they are more appropriately tailored to the needs of MARPs. They created a positive feedback system to health providers to improve the quality and sensitivity of services to MARPs' needs. CSOs track referrals to ensure appropriate follow up is provided and to identify and fill any gaps in service delivery. FY12 USG funding will also be used to improve the technical and organizational capacity of CSOs to deliver MARPs-based care, support and treatment for FSWs, MSM, Waria and PWIDs. This will include TA and support for management of post-counseling, adherence, psycho-social support, and positive prevention aimed at reducing morbidity and mortality among PLWHA. Also in FY12, USG funding will be used to encourage the establishment of up to 15 MARP-based support groups.

Finally, there issues concerning the management of opportunistic infections. A number of issues have rendered effective and efficient OI management in Indonesia an elusive goal, including rigid specialization among physicians in large hospitals, variable incentive structures for physicians to address different diseases, possible resistance issues and supply chain management deficiencies for key drugs for the treatment of OIs. Beginning with targeted intervention sites, FY12 funding will support efforts to promote more holistic care, support and treatment for HIV-positive individuals, and improvements in OI management, specifically via the conduct of Integrated Management for Adult Illnesses (IMAI) training and QA/QI efforts to overcome some of the key barriers to improved program performance.

USG support focuses on efforts directed at MARP populations and enhancing their access to a continuum of prevention, care and treatment services through the development of replicable best-practice models supported through the Packages of Support described below. In addition, USG will prioritize support for an effective continuum of response in Tanah Papua for PLWHA and their families, in addition to MARPs. Presently, at the National level, the MOH does not have a clear policy on care of PLWHA outside of health facilities, in part the result of its limited outreach capacity. The USG will support its partners in engaging the MOH to develop a medium-term strategy for home- and community-based care of PLWHA, including for TB/HIV co-infected persons. The USG approach optimizes quality of care for PLWHA by ensuring that all stakeholders are provided with the best policies, information and training possible of care, support and treatment.

TB/HIV is an important issue in Indonesia and a priority issue for USG Indonesia. Assessments conducted late 2011 found that coordination between national TB and HIV programs remains poorly linked. TB/HIV co-infection is especially high among MARPs and prison populations in Indonesia. During FY12 USG will provide technical assistance to government providers and CSOs funded through SUM and IPF mechanisms to improve the referral of PLWHA for TB testing and provide support for TB treatment and successful cure. In addition, in six of the eight priority provinces, USG will convene meetings among TB and HIV program implementers to develop specific strategies for assuring improved linkages between the two programs and increase the involvement of HIV case managers in assuring successful TB treatment. All activities will be undertaken in close coordination with the National TB Program and the USG-supported TBCARE Indonesia Program.

The USG approach is focused on TA for implementation of a Technical and Operational Performance Package of Support to be provided in 18 targeted intervention districts, working with CSOs and other key stakeholders, both government and non-government, at the provincial and district levels. The TA focuses on providing structural, organizational and technical support for scaling-up a comprehensive package of prevention, care and treatment interventions serving those populations most-at-risk of HIV infection in Indonesia, including FSWs and clients of sex workers, MSM & transgender, and PWIDs. The approach ensures that leaders and champions of MARPs are at the center of USG work and engaged in designing and implementing program activities.

The Package of Support is aligned to: Organizational Performance and Technical Capacity (OPTC) Assessments; Health Sector Assessments; Program Implementation Manuals for FSW, waria, MSM and PWID; and global best

practices for structural interventions.
The Package of Support includes a TA plan and expected outcomes from CSOs and other stakeholders include improvements in the following areas:
• Technical Capacity - Behavior Change Interventions; Injecting Drug User (PWID) Programs; HIV Counseling and Testing (HC&T); STI Control; Care, Support, Treatment; Quality Assurance-Quality Improvement (QA-QI); and Strategic Information
• Organizational Performance - Financial Management; Strategic Planning; Human Resources Management; and Program Planning and Management
• Enabling Environment: Understanding stigma and discrimination
• Advocacy: Importance of involvement and empowerment of MARPs and PLWHA, Using Evidence to Inform Advocacy, and Using the Resource Estimation Tools for Advocacy.
• Monitoring and Evaluation - create a culture of data use and demand at the national, provincial and district levels; improve the referral system between facility-level and community-level programs; systematically track changes in performances of NGOs in organizational management and service provision; and better harmonize national and provincial data collection tools across diseases

In the provision of care, support and treatment, it is well recognized that CSOs play a key role in establishing networks to link clients to community-based health facilities and facilitating referrals to enable MARPs to access care, support and treatment services when they are living with HIV infection. They play an important case management role that complements the clinical service delivery and promotes lifelong health-seeking by MARPs. In their role as case managers, CSO staff and volunteers can provide mentoring and supporting role for clinical staff and clinical teams in Puskesmas and hospital settings, enabling them to help modify services so they are more appropriately tailored to the needs of MARPs. CSOs can also track referrals to ensure appropriate follow up is provided and to identify and fill any gaps in service delivery. These organizations can create a positive feedback system to health providers to improve the quality and sensitivity of services to MARPs' needs.

As part of the USG supported approach for care, support and treatment, CSO staff will develop strategies and program plans for MARP care, support and treatment. They will be provided ongoing TA and coaching to implement the program plan. TA support will ensure an understanding of the technical packages for OI prevention treatment and diagnosis; TB prevention and treatment; ART and clinical care; case management; home-based care; prevention of HIV transmission, and the CSO role in supporting MARP use of these services as needed. Since the technical mentoring and coaching will be on-going, emerging issues related to retention in care of non-ART receiving clinic patients; ART in sero-discordant couples and adherence to medication for those receiving ART can be addressed.

The TA model is not confined to merely intervening on the CSO side. The USG will also support QA/QI initiatives at selected health facilities chosen for more intense support in each targeted intervention site. DHO and targeted health facility staff will be consulted to determine priorities for service improvement. QI initiatives will then be implemented sequentially among the targeted facilities with technical support and facilitation. USG understands that, meaningful implementation of QA/QI processes at health facilities will require the support of higher level health officials, including the DHO and PHO and will engage health officials in targeted intervention sites on the need for continuous quality assurance and improvement and support the incorporation of such processes into the MOH business model.

In addition to the basic package of support outlined above, the enhanced package of support in Tanah Papua will include: expanded condom promotion/demand generation working through the CSOs supported by USG as well as via expanded communications campaigns undertaken in collaboration with the respective provincial AIDS Commissions and HCPI; technical support to condom logistics management efforts to ensure adequate supply throughout Tanah Papua working in collaboration with the NAC, the provincial AIDS Commissions and CHAI; expanded attention to the development of effective provincial health information systems to support more effective planning and program monitoring; increased attention on control of STIs, which are a key risk factor for HIV transmission and on the basis of recent IBBS data in Wamena appear to be a major problem in Tanah Papua; and

increased attention to HIV-positive MARPs who are eligible for ART treated both as means of reducing HIV-associated mortality and slowing the onward transmission of HIV from infected persons to their sexual partners.
The PEPFAR DOD program collaborates with TNI and FHI in developing a training curriculum for continuum of care, prevention with people living with HIV (PLWHA) and psycho-social counseling of HIV-positive TNI personnel and their dependents, and care, support and treatment counseling. Materials and curriculum from MOH will be revised and tailored to the Indonesian military.

Alignment with Government Strategy and Priorities
USG's planned activities are in direct alignment with the Indonesian HIV strategy and action plan, targeting the major at-risk groups and high-priority provinces in the country. Activities are planned and coordinated in consultation with the NAC and the MOH. As a result, USG activities are closely coordinated with other development partners to avoid duplication of effort and create program linkages wherever possible.

Contributions from or Collaboration with Other Development Partners
AUSAID is a major donor and development partner for HIV in Indonesia, supporting harm reduction interventions (HCPI) and supply chain support for treatment (CHAI) in priority provinces, including Papua. In these settings USG works in close collaboration with the respective provincial AIDS Commissions and HCPI; technical support to condom logistics management efforts to ensure adequate supply throughout Tanah Papua working in collaboration with the NAC, the provincial AIDS Commissions and CHAI.
Efforts to Build Evidence-Base – How Evidence Informs Strategy & Priorities
USG actively supports the development of the evidence base in Indonesia by developing tools and approaches that measure the impact of interventions and training and mentoring implementers to use strategic information for designing and modifying approaches.
Currently there is no medical record system that can track the provision of services across facilities and community-based programs at the individual level. The lack of a bidirectional referral tracking system between care and treatment services continues to be a challenge. Furthermore, the lack to capacity to collect high quality data and the demand for data use remain limited.
In FY12, the USG will continue to support the improvement of strategic information under Care and Support by:
• Working with CSOs to improve the referral and monitoring systems among various services by strengthening their monitoring and patient tracking system
• Supporting more streamlined referral mechanisms and tools to improve the follow-up of patients
• Improving data use and quality of data at both the facility and community-levels through on-site training and routine data quality assessments
• Supporting the National M&E system reform effects by assisting provinces and districts in establishing basic M&E databases and capacity to produce routine reports for better programming
• Assisting the national roll out of web-based HIV reporting system to track service provision at the site, district, and provincial levels
• Conducting district ERAs in selected communities to gather basic information for the development of community-based intervention strategies
• Assisting the MoH to improve the integration of HIV program monitoring tools and standardizing national data collection forms across program areas including primary care, TB, MCH, and family planning
• Supporting the NAC in the development and pilot testing of the Data Quality Management (DQM) system for routine data quality improvement

Cross-Cutting Program Elements
Key Vulnerable Populations and Targeted Interventions

TB/HIV
TB/HIV is an important issue in Indonesia and a priority issue for USG Indonesia. TB/HIV activities are undertaken in close coordination with the National TB Program and the USG-supported TBCARE Indonesia Program. Assessments conducted late 2011 found that coordination between national TB and HIV programs remains poorly

linked. TB/HIV co-infection is especially high among MARPs and prison populations in Indonesia. Introduction of new diagnostic technology (Genexpert) in Indonesia by the USG funded TB program during FY12 will facilitate the case identification of TB among HIV + persons, likely increasing the number of diagnosed TB/HIV cases, and close collaboration between programs. In FY12 PEPFAR Indonesia programs will participate in a TB/HIV stakeholder forum (including the SUM project, CHAI, HCPI , MoH and international and local NGOs) working within the HIV community in order to increase awareness about TB-HIV co-infection and the importance of referral and treatment of co-infected persons, and the joint responsibility of TB and HIV programs for assuring treatment of co-infected persons.

Gender
PEPFAR/Indonesia focuses on technical support and capacity building in support of the GOI's strategy to fight HIV/AIDS and does not support direct care services. However, technical assistance is provided to CSOs and government health structures to ensure that targeted care and treatment services and programs are provided to stigmatized and vulnerable populations, e.g., MSM, commercial sex workers, disabled, etc. In addition, technical assistance is provided to ensure MSM-friendly and FSW- friendly HIV/AIDS services encourage the participation marginalized men and women in health care and can facilitate their access to appropriate HIV/AIDS testing, counseling, care and treatment.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	0	0
HVSI	1,479,106	0
OHSS	1,850,944	0
Total Technical Area Planned Funding:	**3,330,050**	**0**

Summary:
Introduction
Though guided by policies adopted at the national level, Indonesia is highly decentralized with decision-making authority and responsibility for action largely at the district level. Much of the work supported by USAID is done through multilateral partners and large US-based implementers; however, Indonesian NGOs and the GOI are increasingly the direct implementing partners for USAID programs. PEPFAR/Indonesia works in close collaboration with the NAC, the MOH, TNI, local non-governmental organizations and civil society, the Global Fund and other donors. NAC is the national body responsible for overall program and donor coordination; NAC oversees the implementation of the National AIDS Action Plan Framework, into which PEPFAR programming is strategically embedded.

Among its partners, PEPFAR/Indonesia has a particularly close and collaborative relationship with AusAID. AusAID has a broad health portfolio including HIV/AIDS and health systems strengthening, with foci on financing and human resources. AusAID provides support for focused harm reduction programs for drug users and inmates in prisons and detention centers in the provinces of Java, Bali and Papua and West Papua, and prevention efforts in Tanah Papua. AusAID also provides funding to the Clinton Health Access Initiative (CHAI) to support development of HIV national policy review and strengthening of the national supply chain management to ensure a reliable supply of ARV and HIV rapid test kits. AusAID and PEPFAR/Indonesia each contribute $1 million annually to the Indonesia Partnership Fund and support the IPF through membership on technical and government committees.

UNAIDS provides technical support for the national M&E system; strengthening the NAC and other key government and civil society partners; and TA for strategic planning for the National AIDS Strategic Plan and proposal development for the Global Fund. UNAIDS also coordinates the effort of the UN agencies' AIDS response in Indonesia, including UNDP, WHO, UNICEF, UNFPA and ILO.

USG is voting member on the Indonesia GFATM CCM, sits on the CCM Oversight Committee, participates in all TWGs, and provides TA for grant applications. USG provides TA to help strengthen the Principal Recipients (PR), M&E and management. USG works closely with GOI and other partners to leverage funding and maintain alignment of GFATM grant applications with the National HIV/AIDS Strategy. A Global Fund Liaison position was established in FY09, co-funded by OGAC, GFATM and USAID/Indonesia TB program funds, to strengthen systems and to support strategic planning and governance within the CCM.

Although Indonesia is making consistent progress within the National AIDS Action Plan Framework, key constraints remain that require collaboration by Indonesia's development partners, these include:

Sustainability: While the allocation of Indonesian domestic resources for HIV have been increasing at around 20% per year since 2003, these are still inadequate to reverse the course of the epidemic. Resources are not yet sufficiently reliable to ensure program sustainability. To sustain the appropriate AIDS response, continued advocacy to increase domestic resource allocation and tap into innovative financing channels is needed.

Decentralization: As a result of decentralization, the role of central government is limited to regulatory, supervisory and partial financial support for program activities, while program implementation, budgetary and planning responsibility is devolved to nearly 500 districts. The local government has the primary role for ensuring that policies are being implemented, and districts have considerable latitude in making choices about resource allocation. There is uneven commitment at the local level to ensure that sufficient resources are devoted to HIV/AIDS activities.

Weak government and community systems: The quality of public health sector services in Indonesia is not yet optimal, with patient demands outweighing available health services and personnel. Health care systems need strengthening to effectively respond to HIV/AIDS -- for prevention, diagnosis, care and treatment, blood safety and full compliance with the practice of universal precautions. Likewise, communities and civil society partners need to increase their capacity for effectively working with key population groups.

Lack of enabling environment: An enabling environment is essential for government and civil society to effectively deliver high quality interventions for successful, sustainable implementation of a comprehensive response, including reducing stigma and discrimination, gender inequalities and violations of basic human rights. There is growing interest in Indonesia for addressing the root causes underlying elevated risk and vulnerability to HIV, as well as making government and society at all levels part of the comprehensive response.

Global Health Initiative
The USG vision for the Global Health Initiative (GHI) in Indonesia is to further strengthen the implementation, reach, and impact of health activities by increasing alignment, coordination and synergies across USG agencies in line with GOI priorities. Current activities and strategies throughout the USG health portfolio strongly reflect the core tenets of GHI – country ownership and whole of government approaches. The GHI goal for Indonesia is "Improved Health Impact through Collaboration", which will be achieved with concentrated efforts in three interrelated focus areas:

- *Catalyze action to accelerate Indonesia's progress toward achievement of Millennium Development Goals (MDG) 4, 5 and 6 (Goal 4: Reduce child mortality; Goal 5: Improve maternal health; Goal 6: Combat HIV/AIDS, malaria and other infectious diseases).*
- *Enhancing the use of quality research and evidence in policy and programming, including introduction and adoption of new technologies and capacity building (including for HIV).*

- *Partnering with the GOI to address regional and global infectious disease threats (including HIV) and strengthen Indonesia's engagement and leadership in regional and global health issues and fora.*

To further enhance Indonesia's ownership of country program efforts, USG is implementing options for direct investment in host country mechanisms, including a direct contribution to a fund for HIV managed by the National AIDS Commission, implementing the Global Fund dashboard to effectively monitor grants, and direct assistance to Indonesian NGOs.

PEPFAR Indonesia strengthens the Indonesian health system by providing technical assistance to the MOH for timely, high quality data collection, analysis and report-writing; operational and technical assistance to implementing partners such as district AIDS Commissions and MOH HIV staff, CSOs and communities to target and improve service delivery to MARPS; providing training and technical assistance to the Indonesian military (TNI) for counseling and testing and prevention services; providing technical assistance to Papua and West Papua for improved health governance and resource allocation for HIV services; and improving the use of data for program management, monitoring and reporting of impact.

Leadership and Governance Capacity Building

PEPFAR/Indonesia has been heavily involved with strengthening leadership and governance of the national response to the HIV epidemic, strengthening organizational capacity of civil society, and supporting strategic information systems and management.

At the national level, the USG continues to support national leadership and country ownership having entered into a closer relationship with the NAC via support to the Indonesian Partnership fund for HIV (IPF). IPF was launched in 2005 as a funding mechanism to receive and channel funds from domestic or international partners, government and the private sector. Its primary goal is to build capacity among stakeholders to support and strengthen an effective, sustainable multisectoral response to the HIV. USG support to the fund has enabled the NAC and its partners at the national, provincial and district levels to provide effective leadership, management, direction and coordination of HIV/AIDS activities; help with resource mobilization from government, private and international donors and development partners; conduct advocacy at all levels to strengthen HIV response; and pursue the development of enabling policies. In addition USG support enables the NAC Secretariat to provide a flexible rapid response fund to address unforeseen problems related to HIV, and to support a grant Program for high quality projects or activities that strengthen CSO capacity building, advocacy and policy, human rights-related initiatives, work with the academic sector and resource mobilization and alignment. IPF facilitates the linkage, acceptance and uptake and replication of the other USG supported TA activities.

Since 2010, the USG has been moving to a TA focused approach, with increased emphasis on improving both technical capacity and organizational performance of CSOs and other stakeholders, and furthering the development of the overall health systems at provincial and district local government institutions. In order to optimize engagement with and leverage funding of other partners, including local governments, to increase impact and sustainability, USG supports 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 provide incremental working capital for comprehensive MARP-driven interventions and leverage funds from other sources for sustainability beyond PEPFAR. Grants to CSOs 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 include small rapid response grants to support emerging needs, and start-up grants to foster the development of new civil society groups.

PEPFAR/Indonesia supports local stakeholders to develop their institutional capacity to leverage funding through collaborations between local government bodies and CSOs, develop new public-private partnerships, and improve their efficiency by utilizing existing community resources to address the needs of MARPs. It also assists these entities in advocating for increased local resource allocation and improving planning capacity. In Papua, targeted HSS TA will support the increase in local government capacity and commitment to develop effective, evidence-based strategic action plans, costed annual action plans, and the integration of these plans into the GOI budget planning

system.

Community organizations and networks have unique abilities to interact with MARPs, PLWHA and affected communities, respond quickly to community needs and issues and engage with affected and vulnerable groups. These organizations provide direct services to the communities and advocate for improved programming and policy environments. As such, support for CSOs and investments in building CSO organizational and management capacity is a significant focus of the PEPFAR/Indonesia strategy which leads to the scaling-up a comprehensive package of interventions serving those populations most-at-risk of HIV infection in Indonesia, including FSWs and clients of sex workers, MSM and waria, and PWIDs. The programs ensure that leaders and champions of MARPs are at the center of USG work and engaged in designing and implementing program activities.

PEPFAR/Indonesia seeks to improve the capacity of CSOs to fully participate in country ownership and enhance their capacity to delivery sustainable services. This organizational performance/capacity building is also necessary to ensure effective support for the building of enabling environments for implementation of the response to HIV/AIDS and for application of the principles of good governance, focusing on transparency and accountability. PEPFAR/Indonesia will ensure that policy gaps are addressed as they are identified and that policies are developed and implemented to support the comprehensive response to AIDS.

This comprehensive approach is particularly important in Papua where the overall health system and infrastructure are serious issues. The USG is supporting mapping of current service activities in priority districts in order to plan activities, determine financial/technical support systems in place, gaps, and factors promoting increase in morbidity and mortality related to HIV/AIDS/STI, and TB. Priority districts, hospitals, health centers and communities will be identified. PEPFAR/Indonesia support will include TA to provincial level and district level governments to plan, manage and implement HIV/AIDS interventions as a core element of improved health system capacity improvement; establish and maintain the quality of services, including TA to service providers to strengthen patient-centered approaches; collaborate with the Provincial and District Health Offices on joint integrated workplans, establish HMIS and M&E systems, support provincial and district health offices on budget planning, map funding sources and gaps, and plan for resource mobilization monitoring; assist local authorities to use and develop appropriate responses to IBBS data, and support IBBS in Papua for the general population; support existing networks of communication in community level; support drug supply chain logistics; and support development of SOPs of minimum requirement of skill-based trainings and mentoring systems to increase capacity and motivation of staff.

A major challenge to successful implementation of 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. CSOs working for the most at risk populations in Indonesia are generally poorly financed, staffed by the MARP communities (thus often lacking high levels of education or formal administrative skills), and working in very limited areas, and relatively unsophisticated organizations, that do not have a strong history of working with the government. USG focuses on building sustainable community organizations and increasing the participation of CSOs in the national HIV strategy, thus increasing the range and quality of services targeting MARPs. USG plays an important role in brokering the relationship between GOI and CSOs, by strengthening the capacity of the CSOs and demonstrating the value added of CSOs to the government's efforts.

To address stigma and discrimination, USG helps CSO and government partners to better understand the bottom-line – that HIV interventions cannot be fully effective in an environment in which those at risk for or living with HIV face stigma and discrimination and other structural barriers that prevent them from protecting their health. In FY12, efforts will include developing CSO leadership to work with local government departments, judges, police, parliament and religious leaders to change policies, build support for HIV programming and help reduce stigma and discrimination. CSO leaders and staff will engage MARP in service design, delivery and evaluation, and district government planning and coordination and CSO leaders will build and strengthen relationships with district and provincial government officials, coordinating closely across sectors engaging in the HIV response, and in particular with district-level political leaders, KPAs and Health Offices to promote the scale-up of services and support systems that reach a high proportion of MARPs at the local level.

DOD, through the Office of Defense Cooperation (ODC), has assisted the Indonesian military to implement HIV/AIDS programming since 2005. The HIV/AIDS program is owned by the Indonesian military within the guidelines and policies of the Indonesian Ministry of Health (MOH) and National AIDS Commission (NAC). With PEPFAR funds, ODC promotes sustainability through trainings, workshops and curriculum development, which are tailored specifically to the TNI. ODC also promotes collaboration between TNI and locally based NGOs with expertise in HIV programming. In FY12 DOD program will support health system strengthening by helping support integrated behavioral and biological surveillances (IBBS) to learn more about the HIV epidemic within the military. DOD also supports dissemination of findings from the IBBS.

Strategic Information
Key Successes and Challenges in FY11
USG has played a significant role in supporting the GOI's national strategy to improve surveillance and monitoring and evaluation through collaborations with the MoH, NAC, provincial and district governments, international partners, and civil society. 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. While progress has been made in recent years in HIV sentinel surveillance, the quality, comparability and usefulness of these data remain suboptimal. In response, USG provided TA to improve the quality of surveillance data in FY11. The USG also provided technical leadership for development of methodological principles and improvements in estimation of MARP population size.

In FY11, USG assisted the GOI in the development and national roll-out of a web-based reporting system for HIV programs. In addition, USG is working closely with other health sectors through active participation in the HIS and M&E TWGs under the National M&E and HIS reform to standardize data collection forms and streamline indicators across diseases in an effort to decrease reporting burden at service delivery sites.

In FY11, USG provided technical support to the national, provincial, district governments and indigenous organizations to improve the quality of routine data through training and supportive supervision. It also supported the NAC to develop and pilot test the Data Quality Management (DQM) system in selected sites to address the need to standardize data quality assessments (DQAs) for program data in the country. In addition, USG conducted 11 district-wide Expanded Readiness Assessments (ERAs) in Jakarta, East Java and Papua to assess the local government's preparedness with regard to knowledge of HIV, the extent of program efforts to address the epidemic, and the availability of financial and human resources in each district. Based on the findings, organizational performance and technical capacity (OP/TC) assessments were conducted for selected CSOs and staff were trained to collect and analyze data collected.

Goals and Strategies for FY12

In FY12, the goals for PEPFAR Indonesia for strategic information are:
1. In collaboration with GOI, to support the collection, analysis, and use of quality strategic information to better monitor trends of the HIV epidemic
2. Increase the use of survey, surveillance, and program-level data for evidence-based programming and to assess the quality and effectiveness of HIV programs
3. Support the MOH to improve the integration and interoperability of the national HIS across HIV and non-HIV health sectors

Know Your Epidemic
HIV sentinel surveillance has been standardized based on the UNAIDS/WHO Guidelines for Second Generation HIV Sentinel Surveillance. Since 2002, GOI has conducted sentinel surveillance including serial IBBS's and size estimations for MARPs with targeted technical support from USG. While this country-led effort is to be commended, the lack of local capacity to design and analyze survey data remains a challenge. In FY12, USG's effort will be devoted to improving the quality and long-term sustainability of epidemiological and behavioral surveillance

systems by building technical capacity of national and provincial staff to conduct and analyze surveillance and surveys.

In FY12, USG will assist the GOI in the planning of medium- and long-term plans for surveillance by MARP groups and provinces in order to maximize the usefulness of surveillance data in tracking epidemiological changes in the country. Technical assistance will be provided by USG in the design and implementation of the next round of MARPs size estimation. While sentinel surveillance from 2010 demonstrated that the provinces of Tanah Papua have the highest HIV prevalence rates in the country, the last IBBS for the general population in this region was conducted in 2006 and risk behavior among this population has not been assessed since. In collaboration with GOI, USG will provide technical support in the design and implementation of IBBS for the general population in Tanah Papua and IBBS for military personnel in FY12. With the focus to increase local capacity and ownership in the area of surveys and surveillance, USG will provide workshops, seminars, and on-the-field training and mentorship for local staff who will be responsible for the IBBS data collection and analysis. We will also assist the MoH in updating the national HIV sentinel surveillance guidelines in FY12.

In collaboration with other donors, including AusAID and GFATM, USG will continue to work closely with the MoH to address the importance of timely surveys and surveillance data dissemination and sustainable data use to inform evidence-based programming for GOI's national response in HIV prevention, care, and treatment in FY12.

Know Your Response
Developing and supporting routine program monitoring and evaluation capacity with an emphasis on data use and improved data quality will be central to USG support in FY12. USG will continue to provide TA in strengthening the M&E system at all levels through on-the-job training, supportive mentorship and workshops for M&E staff, healthcare providers and program managers. Priority attention at the national level will be to continue USG's active engagement in the National M&E system reform efforts to streamline reporting across the health sector and harmonize existing HIV and non-HIV indicators. At the district and local levels, the focus will be to increase the capacity of CSO and district-level staff to better manage, analyze, and use their program data, both at the facility and community settings, for evidence-based decision making and resource allocation. This will be achieved through the provision of customized technical support from USG based on the results of the district-level ERAs and CSO OTPC assessments conducted in FY11.

Existing data flow in Indonesia is often unidirectional with program-level data reported upstream to the provincial and national government without proper feedback downstream to the facilities. USG and its implementing partners will provide support to the national government to improve the frequency and content of data feedback to site-level staff, program implementers, and other stakeholders through regular reporting and dissemination. USG will continue its effort in standardizing DQA tools and providing training to local staff on data quality assurance and improvement at all levels.

USG will continue to closely monitor the effectiveness of USG-funded programs by conducting annual OTPC assessments in PEPFAR-supported CSOs. These assessments are designed to track progress made in strengthening local capacity of CSOs on various organizational and technical strengthening dimensions. Mid-term evaluations of SUM I and II will take place with FY12 funding to assess progress and the effectiveness of their program interventions in the fourth quarter of FY12. ERAs will be conducted in additional community organizations in new districts as PEPFAR expands its local NGO and health systems strengthening project (KINERJA) in Papua.

USG will continue the national roll-out of the HIV web-based reporting system in FY12. As part of USG's HIS technical support, PEPFAR will conduct trainings to local and provincial staff on use of this web-based reporting system and will develop data analysis algorithms and guidelines for basic patient-level analysis. While patient-level data are still paper-based, USG will provide TA to the MoH to standardize the data collection forms for the national VCT, PMTCT, ART, and blood safety programs in FY12.

Service Delivery

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 through activities focusing on the importance of country ownership, strong civil society, best practices and replicable models. Technical and financial support will be given to the NAC, MOH and TNI, and civil society organizations. Given the limited funding in country, USG does not undertake service delivery per se, but prevention, care and treatment services will be delivered as a component of the development of best practice interventions in particular locales among key populations and stakeholders. The goal is to have these best practices adopted at the national and local levels and replicated throughout the country.

Papua has the highest rates of HIV/AIDS in Indonesia, as well among the worst health indicators for malaria, TB, and other infectious diseases. Maternal, infant and child mortality rates in Papua are among the highest. In the remote and rural provinces of Tanah Papua, the vast majority of those with HIV live far from health services, and health facilities are often functioning poorly. Geographic isolation contributes to the high cost of living in Papua and has significant impact on all aspects related to hospital and health center operations. There are only two hospitals in the highlands region of Papua Province, with a catchment area of 1.6 million people. Both are inaccessible to many in the region. Puskesmas often lack appropriate human resources, laboratory capacity, or essential diagnostics and drugs necessary for management of HIV and other communicable diseases. In addition, one third of the puskesmas in the Highlands can only be reached by air or days of walking.

The USG approach is to facilitate implementation of a Combined Technical and Operational Performance Package of Support to be provided in 18 targeted intervention sites is directed at CSOs and other key stakeholders, both government and non-government, at the provincial and district levels. The USG supported AIDS programs focus on scaling-up a comprehensive package of prevention, care and treatment interventions serving those populations most-at-risk of HIV infection in Indonesia, including FSWs and clients of sex workers, MSM & transgender, and PWIDs. The programs ensure that leaders and champions of MARPs are at the center of USG work and engaged in designing and implementing program activities. The knowledge and skills of these representatives, including individuals and NGOs/CSOs, play an important role in the success of the implementing program activities.

The Package of Support focuses on the following areas:

- *Technical Capacity - Behavior Change Interventions; PWID Programs; HIV Counseling and Testing; STI Control; Care, Support, Treatment; Quality Assurance-Quality Improvement (QA-QI); and Strategic Information*
- *Organizational Performance - Financial Management; Strategic Planning; Human Resources Management; and Program Planning and Management*
- *Enabling Environment*
- *Advocacy*
- *Monitoring and Evaluation.*

For instance, Behavior Change activities will focus on TA that assists CSOs with program development or strengthening in: all aspects of the comprehensive community package that includes high quality, evidence-based interventions via community outreach and referral, including (as appropriate): peer-based education; information education communication (IEC) and behavior change communication (BCC) via interpersonal communications, targeted media, and internet-based information and support as appropriate; risk-reduction counseling; case management for HIV-infected MARPs; promotion of, referral for and follow-up of clinic-based HIV-related services, including STI screening and treatment, HIV counseling and testing (HTC), and management of opportunistic infections; and distribution support for HIV prevention commodities, most notably condoms and lubricants.

Per guidance from the National AIDS Commission support for PWID Programs emphasizes prevention of sexual transmission to sex partners among HIV-infected PWID. Because the national program for PWIDs emphasizes the central role of Puskesmas, the role of PWID CSOs as a community partner of Puskesmas and hospital clinical teams

will be emphasized to assure better-tailored and friendlier clinical services for PWIDs. CSOs will also be able to act as lead/participate in PWID Program advocacy campaigns with other district stakeholders directed at district-level police, judges, members of parliament and other local government officials and stakeholders.

For program planning and management USG will support local TA providers to develop a stakeholder analysis to be conducted by the CSO program staff and volunteers. This should enable MARP CSO leadership and staff to understand how programs based on evidence respond better to the needs of those most vulnerable to HIV and its consequences. They will have conducted the consultation (stakeholder analysis) required to understand the existing conditions and situation in their district and the needs of the specific community with which they are working; and the activities and service they are pursuing are based on this consultative process. They will have program plans (aligned with the CSO strategic plan) that outline program goals, objectives, milestones, and indicators of achievement; and more detailed activity and service plans (individual and team) that identify the specific tasks to achieve each milestone and staffing requirements. Before the end of USG support, the CSO should have the skills in preparing realistic and complete program budgets and timelines, in program performance review (managing their programs within the parameters of agreed-to work plans, budget and timeline).

The USG will also support QA/QI initiatives at health facilities chosen for more intense support in each targeted intervention site. DHO and targeted health facility staff will be consulted to determine priorities for service improvement. QI initiatives will then be implemented sequentially among the targeted facilities with technical support and facilitation. The PEPFAR/Indonesia team understands that meaningful implementation of QA/QI processes at health facilities will require the support of higher level health officials, including the DHO and PHO.

In Tanah Papua the package of support will include: expanded condom promotion/demand generation working through the CSOs supported by USG as well as via expanded communications campaigns undertaken in collaboration with the respective provincial AIDS Commissions and AusAID's programs; technical support to condom logistics management efforts to ensure adequate supply throughout Tanah Papua working in collaboration with the NAC, the provincial AIDS Commissions and CHAI; expanded attention to the development of effective provincial health information systems to support planning and program monitoring; increased attention on control of STIs, which are a key risk factor for HIV transmission and on the basis of recent IBBS data in Wamena appear to be a major problem in Tanah Papua; and increased attention to HIV-positive MARPs who are eligible for ART treated both as means of reducing HIV-associated mortality and slowing the onward transmission of HIV from infected persons to their sexual partners.

Human Resources for Health and Health Efficiency and Financing

Indonesia has made impressive gains in expanding the reach of health services over the past 25 years. During this period, the GOI constructed more than 8000 health centers (PUSKESMAS) and 560 hospitals employing in 2005- a total of 415,000 staff (245,000 in health centers and 170,000 in hospitals). The private health sectors grew even faster during the same period, partly as a result of government policy that allows public sector staff to work part-time as private providers.

According to a 2009 World Bank report, "Indonesia's Doctors, Midwives and Nurses - Current Stock, Increasing Needs, Future Challenges and Options," a total of 72,249 doctors, including 15,499 specialists, were registered nationally. The Indonesian Medical Association (IDI) reports a ratio of 23 doctors per 100,000. While these national ratios have been improving since 1996, they remain low by international standards and they fluctuate when comparing different populations; the ratios of doctors to population have shown improvements in rural and remote areas of Indonesia, these ratios have declined in urban areas. The same ratio for specialists is extremely low and has not improved significantly in recent years.

Although the supply of health services has improved significantly, the Indonesian government has only very recently begin to concentrate on improving the quality of health services. Of most importance have been (a) changes in medical education policies, by which the government is trying to increase its oversight, and (b) further clarification

of the local governments in the recruitment and deployment of medical staff and the implications of their responsibilities for the quality of care. At present, however, serious quality concerns remain about the education system itself and the subsequent certification and accreditation of health workers.

Because of this situation in the HRH sector, Indonesia faces many challenges to providing high quality care to its citizens, including many health care workers have not received adequate training on basic health practices; for example, although most health workers are trained in Universal Precautions (UP), few practice UP in the workplace. Differences in the fiscal capacity of local governments to finance public health services, and to hire public health professionals, as well as the low desirability of providers to work in more remote locations (such as Papua) has resulted in an unbalanced distribution of human resources. Prior to decentralization, the GOI deployed newly appointed doctors under contract to remote districts as a mandatory service. Under decentralization it is the policy and authority of local governments to employ medical officers. It is widely believed by PLWHA that health care workers exhibit stigmatizing behaviors, which decreases access to needed services.

USG HSS activities in Papua have served to strengthen health-related human resources through service delivery system development in hospitals and community health services, health workforce capacity building and information system development. The USG has supported in-service training, monitoring and Quality Assurance/Quality Improvement (QA/QI) assistance in order to increase the capacity of prevention and care services, such as in STI/VCT and ART clinics. In addition, the USG works with referral networks for at-risk populations to align with national planning, monitoring and evaluation, coordination, logistics and reporting systems and promote stronger management by local health systems. Technical support to district level MOH and local health services to build systems for basic health services delivering a continuum of care using appropriate public health approaches is undertaken when appropriate.

Key Successes and Challenges in FY 2011

The USG has supported STI and HIV/AIDS related training for clinical service providers in public health centers, private clinics, CSO clinics, government hospitals/clinics and support groups to provide accessible, user friendly services that support risk reduction and behavior change. These providers include medical doctors, nurses, medical social workers and community health workers.

SUM II introduced the Resource Estimation Tool for Advocacy (RETA) and trained 48 representatives of the 15 CSOs, national, provincial, and local AIDS Commissions, and provincial and local health departments in Jakarta, Surabaya and Malang have been trained to use the USAID SUM II Project's Resource Estimation Tool for Advocacy (RETA). RETA estimates the level of finances needed by CSOs and districts to scale-up HIV programming over a 5-year period, based on population size estimates, local costs of HIV prevention, care, treatment and support programs, and service coverage targets. RETA is also a capacity building tool for CSOs to better understand and engage in resource allocation decision making and planning processes. It is a complementary tool to NAC and MOH tools for estimating HIV program resource needs nationally. SUM II has modified RETA for FSWs, waria, and PWIDs from the original version developed for MSM. It has also been adapted to the Indonesian context so it includes the local unit costs derived for each of the core services of the Comprehensive Package of Services, which can then be used with Global Fund applications, and other planning processes which do not have a costing component built in and which rely on external calculations of unit costs of HIV services. RETA is available in Bahasa Indonesia and English.

At the request of UNAIDS and USAID, SUM II provided TA to a GFATM PR, NU, and its SRs by conducting initial evaluations of the SRs. SUM II also assisted the civil society PR, PKBI, in completion of its monitoring and evaluation plan. Through a small grant SUM II has supported financial management of the CCM and plans to continue its support to the CCM with a 1-year grant to develop standard operating procedures for its financial management.

Goals and strategies for the coming year

Deficiencies in health systems affect delivery not only of HIV services, but health services and programs across the board. Addressing underlying system deficiencies is thought to constitute the single most cost-effective intervention for realizing improvements in health service delivery and efficiency for all health services and programs, including those related to HIV. While the number of people needing and seeking HIV/AIDS-related prevention, care, treatment and support services is increasing, health services infrastructure in Indonesia remain at a very basic level throughout Indonesia, especially in Tanah Papua. STI, TB, VCT and CST services are available primarily in the larger cities, and service quality tends to be low. Widespread stigma surrounding HIV/AIDS is another important constraint to access to health services.

USG efforts toward strengthening health systems will support strategic information systems reform, strengthening public sector-NGO partnerships to expand program coverage, addressing stigma and discrimination toward MARPs and PLWHA by 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, CSOs to design, plan, and effectively implement comprehensive HIV intervention models for MARPs.

With limited PEPFAR funding levels, HRH activities will remain unchanged and continue to be a lower priority than technical assistance directly addressing the most pressing aspects of Indonesia's HIV epidemic. However, the USG will continue to support referral networks for MARP and provide technical assistance to MOH and local health services. These activities will be limited in scope.

Gender
Gender inequality remains an important issue that limits women's involvement in economic and social development in Indonesia and, as with many social and health issues in Indonesia, gender, the role of women and girls and gender-based indicators are extraordinarily complex and vary widely across the country and among different regional and ethnic groups. Socio-cultural environments range from the matrilineal societies in West Sumatra, where women are relatively empowered, to other regions and provinces where the rights of women and girls are severely compromised. Some disparities exist between Eastern Indonesia and other parts of Indonesia, stemming from ethnic differences; as such special attention is paid to underserved and disadvantage populations in these areas and Papua. In addition, transgendered individuals, or waria, are widely seen as a third gender and are particularly vulnerable to HIV/AIDS, social stigma and gender-based violence. While Indonesia has established several laws and regulations to ensure equal treatment for men and women in employment, enforcement of these laws remains a challenge. For these policies to be fully implemented law enforcement and improved coordination among government institutions at all level is still required. In addition, recent developments in the status of Indonesian women include a law against pornography. This law, specifically targeting women, provides strict guidelines for clothing, behavior and mobility. It would, for example, declare bus stations off-limits to women at after sundown. Some argue this is a veiled and renewed attempt to oblige the State to enforce conventional Islamic practices.

However, there are positive developments. Indonesia has ratified the UN Gender Conventions, which established political commitment in the form of national plans, guidelines, and reports. Presidential decree No. 9/2000 instructs all government bodies to implement gender mainstreaming for planning, formulation, implementation, monitoring and evaluation of national development policies and programs in accordance with their responsibilities, functions and authorities. This order has been followed by guidance for line ministries on its implementation.

The most recent gender assessment was completed by the World Bank in 2008. In June 2011, a coalition of bilateral and multi-lateral agencies (CIDA, AusAID, World Bank, UKAID, and Asia Foundation) presented the GOI with a set of policy briefs detailing a series of findings and recommendations related to gender and programming within the development context. These policy briefs focused on, among others, gender mainstreaming, gender equity in health, women's voice in decision making, and violence against women. USG programming goals and activities are fully consistent with the recommendations related to maternal health, nutrition and HIV. HIV/AIDS activities are

particularly focused on a woman- and girl-centered approach with a focus on prevention among most at-risk populations – many of whom are at risk because of gender or women's empowerment issues, including female sex workers and waria. 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, and limited empowerment to demand services to which they are legally entitled.

USG will promote an HIV/AIDS enabling policy environment by strengthening gender equity and human rights. Weaknesses in the substance, structure and culture of the law in Indonesia continue to exacerbate the situation among women and children. Legal loopholes and poor enforcement require renewed efforts, especially related to abuse, sexual exploitation, and gender bias in low and protection for women and children in emergencies. The ODC program areas will include technical assistance on gender issues such as male norms and behavior and prevention with positives (PWP). USG activities in Tanah Papua, where the HIV prevalence rates are high and increasing among women, USG funding will focus on a girl- and women-centered approach by targeting interventions toward the general population of women, as well as female MARPs, and emphasizing gender issues in the health systems and governance approach that will be undertaken by Kinerja. PEPFAR Indonesia recognizes that GBV is an important issue in Papua and PEPFAR seeks to expand GBV activities if more funding becomes available in the future.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	550,557	0
Total Technical Area Planned Funding:	**550,557**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	0	0
HVCT	141,553	0
HVOP	3,029,329	0
IDUP	282,824	0
MTCT	429,874	0
Total Technical Area Planned Funding:	**3,883,580**	**0**

Summary:
Overview of the epidemic from the perspective of HIV Prevention

Except in Papua, Indonesia's epidemic is concentrated in four most-at-risk populations: 1) PWID; 2) FSWs; 3)

clients of sex workers/high risk men; and 4) MSM, waria, male sex workers and their clients. The majority of these MARPs are located in urban and peri-urban areas in 11 provinces and the National Capital District (DKI) Jakarta. Since the first reported case of HIV in Indonesia in 1987, the increase of HIV infections has mostly been driven by PWIDs. However, the primary driver of the epidemic has shifted from injection drug use to sexual transmission in recent years. While most of Indonesia has a concentrated epidemic, the two provinces of Papua and West Papua (Tanah Papua) in eastern Indonesia are experiencing a growing generalized epidemic. The HIV prevalence in Tanah Papua is 2.4% among 15-49 year olds. (IBBS Papua 2006).

The MOH, with support from the USG, has conducted Integrated Biological and Behavioral Surveillance Surveys (IBBS) in 2007, 2009 and most recently in 2011. The IBBS contains two components: a behavioral survey and biological testing for HIV, syphilis, gonorrhea, chlamydia. In 2011 the survey was conducted in 12 provinces included in the GFATM Round 8, including 8 priority provinces of USAID HIV activities (Jakarta, Riau Islands, North Sumatra, West, Central and East Java, Papua and West Papua). The sample size was approximately 25,500 MARPs, including FSW, MSM, waria, PWID, high-risk men, prisoners and youth. Given the generalized epidemic in Tanah Papua, the GOI plans to conduct periodic IBBSs among the general public in Tanah Papua. Data collection for the 2012 Papua IBBS is scheduled to begin in August 2012.

The HIV in Indonesia Model (HIM) tool uses data from a variety of sources including, the 2004/5 and 2007 IBBS, the 2008 Probable Village Size Survey, HIV/AIDS sero-surveillance, and population distribution mapping exercises to allow the MOH to calculate population size estimates for MARPs. According to these estimates nationwide in 2010, 234,529 adults were living with HIV - 16,721 of these individuals were newly infected. Among MARPs, male PWIDs make up 28% of the new infections, while MSM, MSWs and waria make up 17%, 5% and 3% of new infections, respectively. FSWs contribute to 8% of new infections while their clients account for 9%. The model projects that women make up about a quarter of new infections, while in Papua women constituted 72% of new infections. Whether the projections for new infections among different groups will change substantially when estimates are calculated using 2011 MARP IBBS and 2012 Papua General Population IBBS data remains to be seen.

TABLE

High Risk Group	*HIV Prevalence 2007*	*HIV Prevalence 2011*	*Est. Population Size 2011*
PWID	*52%*	*42%*	*105,784*
Direct FSW1	*10%*	*9%*	*106,011*
Indirect FSW2	*4%*	*3%*	*108,043*
MSM	*5%*	*12%*	*695,026*
Waria	*24% %*	*23%*	*32,065*
HRM	*0.1%*	*0.7%*	*3,421,244*

Source: 2011 IBBS and Estimation of Adult Populations Vulnerable for HIV infections, 2009, Ministry of Health, Indonesia

While there has been a shift in drug use in Indonesia from opiates to amphetamine-type substances, PWID continue to contribute to the epidemic. Behavioral data from the 2011 IBBS found that of 38% PWIDs did not share needles and syringes in the last week compared to 12 % in 2007. Among PWID in Jakarta, 18,8% had multiple sexual partners and 43.3% of PWIDs reported consistent condom use with sex workers. PWIDs continue to represent a potential bridge for HIV transmission to FSWs.

Among FSWs direct and indirect, the epidemic is fueled by a combination of increased mobility of sex workers and their clients and low levels of condom use. 2011 IBBS indicates that HIV prevalence is 9.3% among direct sex workers and 3.1% among indirect. The prevalence of sexual transmitted infections (STI) which elevates the risk of acquiring and transmitting HIV infection was reported to be very high among brothel- based female sex workers and moderately high among non-brothel based direct and indirect sex workers for Neisseria Gonorrhea from 28.7%

(2007) to 34% (2011) for direct sex workers and 16% (2007) to 20.4% (2011) for indirect sex workers. Chlamydia prevalence for direct and indirect sex workers in 2011 is 34.8% and 37.4%. Condom use among FSWs did not increase substantially according the 2011 IBBS survey. Reported condom use in the last week for among direct and indirect was 32% and 36% in 2011 compared to 31 and 43% in 2007.

MSM continue to engage in unprotected sexual intercourse with only 24% reporting condom use at most recent sexual contact. Some MSM have multiple sex partners, both male and female, and significant numbers of MSM also buy and sell sex. Data from the 2011 IBBS found that 19 % buying sex and 49% of MSM selling sex to male and female clients. Among these, 79% selling sex to male, 4% selling sex to female and 17% selling sex to male and female clients.
The 2011 IBBS focused on 4 groups of HRM – dockworkers, motor-taxi (ojek) drivers, truckers and seafarers, and HIV prevalence among these populations varied by geographic setting. In Papua, 2% 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 detected among dockworkers (0.3%) and motor-taxi drivers in North Sumatra (0.3%) ; HIV prevalence among truckers (1%) and seafarers (0.5%) was higher than in general population males. The majority of seafarers and truckers had multiple partners with 54% and 64% reported sex with FSWs in the last 12 months and reported using condoms with FSWs less than 50% of the time in the 2 weeks prior to the survey. Prevalence among high risk men, representative of the general population, increased from 0.1 to 0.7% from 2007 to 2011. These findings indicate that a significant number of women in the general population are at risk of HIV infection as a result of the participation of their husbands or partners in the sex industry.
Male circumcision is almost universal in Indonesia where most of the population is Muslim. Most boys are circumcised between 6-12 years of age. On the other hand, 5% of ethnic Papuans are circumcised, compared to 70% of non-ethnic Papuans. HIV prevalence among residents of Papua who do not have permanent partners and are circumcised is 1.0 %, while among those who are not circumcised it is much higher, at 5.6 % (Papua IBBS, 2006).

Sex work and transactional sex continue to be major factors in the spread of HIV in Tanah Papua. HIV was higher among men (2.9%) than women (1.9%), although a recent modeling indicates that annual prevalence trajectory for women in Papua will dramatically increase in the coming decade (HIV in Indonesia Model 2011). HIV was also higher among individuals who reported having more than two sexual partners in one year (4.0%); more than 20% of male residents reported more than one sex partner in the past year vs. 8% of female residents. HIV prevalence among those who engaged in sex for payment was 5.1%. HIV prevalence among men in Papua who had a history of STIs was 5.9. Additional important factors driving the epidemic in Papua include: multiple concurrent sexual relationships, frequent intergenerational sex, low condom use, low rates of male circumcision, high rates of alcohol abuse and a highly mobile population. 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 HIV response.

STI prevalence remains an important factor in HIV transmission. The 2011 IBBS reported a decline in syphilis among FSWs and waria, likely due to periodic presumptive treatment (PPT) undertaken in 2011; syphilis rates increased among MSM and PWIDs. Chlamydia declined from 91-11% among FSW in 2007 to 5% in 2011, despite PPT with azithromycin (the new first line drug). This indicates continued low condom use and frequent reinfection.

Indonesia has a history of highly successful condom social marketing in the context of family planning activities, which was supported by USAID. However, the condom social marketing strategy ended several years ago, and currently low condom use and lack of availability of condoms are an important challenge in Indonesia. In the last five years conservative religious and social groups have denounced condoms as contributing to immoral behavior and sexual promiscuity. These pressures have resulted in reluctance by government officials, including those in the MOH and NAC, to actively promote condoms and to speak about the role of condoms in HIV prevention. The result is seen in the low demand and lack of affordable condoms for MARPs. USG is committed to working with the MOH to develop a new condom promotion strategy during FY12, including establishing appropriate policies, distribution systems and social marketing schemes. USAID, in close coordination with NAC and other stakeholders, will prioritize effective mechanisms to ensure that good supply and logistics management for condoms and lubrication

are carried out to enable the most at risk population have reliable access to appropriate and high quality of condoms and lubricants as needed in adequate quantity and delivered in a timely manner.

The GOI National AIDS Strategy and Action Plan 2010-2014 has as its goal: to prevent and reduce the transmission of HIV infection; improve the quality of life for people living with HIV; and reduce the socio-economic impact of the AIDS epidemic on individuals, families, and society, while safeguarding Indonesia's productive and valuable human resources. The Indonesia National Strategy focuses on providing effective HIV prevention efforts to reduce sexual transmission between FSWs and clients, foster harm reduction among PWID and decrease sexual transmission between MSM and PWIDs and their partners; and improving program effectiveness where needed.

While ministerial regulations led to guidelines for comprehensive prevention programming of sexually transmitted HIV in 2008, full implementation of an effective HIV prevention response in recent years has been hindered by a variety of issues, including: (1) lack of consensus among key GOI bodies and conservative groups, particularly in the area of condom promotion; (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.

The NAC's objectives are to achieve 80% geographic coverage of MARPs, with 60% of each of the key populations practicing safe behaviors, and sustainability of HIV/AIDS services. PEPFAR/Indonesia prevention activities are aligned with the goal of the national HIV response as stated in the National Strategy and Action Plan. In the past, PEPFAR/Indonesia directly provided prevention and clinical (STI/VCT) services to reduce the incidence of HIV in MARPs through the support of CSOs, in collaboration with the GOI. With the advent of GFATM support to the GOI and in keeping with PEPFAR's focus on sustainability and country ownership, the USG has lessened its role in the provision of direct service provision.

Over the last several years, the USG has incorporated health systems strengthening and supported activities to increase the capacity of clinics to provide services for MARP with the intention of creating opportunities for replication by the GOI, other donors and the private sector. Given the limited resources available through PEPFAR for Indonesia the USG prevention portfolio investments are now aimed at supporting GOI prevention priorities through a technical assistance and capacity building model. USG prevention activities are focused on improving the effectiveness of interventions and the sustainability of activities by local government and non-governmental partners.

Key priorities include the provision of technical assistance to the GOI and civil society in the development of guidelines for integrated HIV interventions for MARPs, introduction of an accelerated condom promotion strategy, identification of hotspots where integrated interventions will give most impact, implementation of integrated interventions in the identified hotspots, and development of a package of technical support and a sustainable quality assurance processes for partner organizations implementing the interventions. In addition, as part of the efforts to develop technical leadership and administrative and managerial capacity for CSOs, the USG supports development and implementation of a small-grant scheme for qualified civil society organizations that are playing an active role in the scale up of integrated interventions. USG priorities will continue to prioritize increased emphasis on the organizational performance and further development of overall health systems at provincial and district local government institutions, including advocacy for increasing local resource allocation for MARPs (and targeted general population in Papua) and improved planning capacity.

ODC with support from FHI supports the development of prevention and testing/counseling programs that specifically target most-at-risk personnel and regions within the military. These programs, messages and strategies used will be developed based on the results of the IBBS conducted during FY 2012. The results from the IBBS will then be used to review and revise the prevention curriculum, and scale up testing and counseling efforts from voluntary to provider-initiated testing and counseling. In FY2012 ODC will continue to support TNI's prevention and T&C programs, and will assist the Indonesian Armed Forces to monitor and evaluate, control HIV through training, and improved services in counseling and testing. Gender messages focusing on reduction of gender based

violence and coercion, engaging men and boys to address norms and behaviors, and increasing gender equity in HIV programs and services. These prevention activities will also include scaling up of provider initiated testing and counseling as mandated by MOH.

Overarching accomplishments in 2009-2010

Key accomplishments include:

USG provided technical assistance for the design, implementation, analysis and reporting of the 2011 IBBS in eight priority provinces (Papua, West Papua, East Java, Central Java, West Java, Jakarta, Riau Islands, and North Sumatra). The findings of the survey guide national HIV policy, resources allocation, and prevention strategies at the national and local levels.

USG has successfully persuaded the MOH to undertake a new condom strategy, including development of appropriate policies, establishment of supply chain system, increasing production capacity and development of social marketing strategy to increase demand and use of condoms to prevent transmission of HIV.

Twenty-nine Indonesia civil society NGOs have been provided small grants to implement prevention activities that target MARPS, including MSM, waria, FSW and high risk men (with a priority emphasis on truckers, sailors and port workers). A basic package of support has been developed, (peer outreach with IEC materials; condoms, lubricants and safer sex kits; targeted multi-media campaigns; peer support groups; negotiation skills training; individual and group risk assessments; and policy interventions). CSO's are linked with GOI clinic for facility-based services, including STI screening/treatment, HIV counseling and testing, support and treatment.

The CSOs have completed Expanded Readiness Assessments (ERA) and Organizational Performance/Technical Capacity (OPTC) Assessments. In addition, four targeted implementation manuals have been prepared for FSWs and their clients, PWIDs, MSM and waria. Particularly for Papua to cater for general population, one implementation manual will also be developed.

Three local partners have been established as technical assistance partners, thus assuring that USG resources not only strengthen the implementing CSOs, but also establish a cadre of technical expertise in the country to allow for further expansion and sustained capacity in Indonesia.

In addition, USG activities have expanded to Papua. With support from SUM II, the University of Cenderawasih conducted ERAs with seven most-at-risk communities in four geographical areas of Papua – Jayapura city, Jayapura district, Jayawijaya district, and Mimika district. Most-at-risk populations included FSWs, MSM, waria, high-risk men, and adult indigenous men and women. Sixty-six interviews and focus groups were conducted in the seven most-at-risk communities. The results show that all seven communities in the targeted intervention areas are at the initiation stage. This means that a few members of the most-at-risk communities are familiar with the basic HIV and AIDS information and recognize that HIV/AIDS is a problem. Efforts to reduce HIV transmission have been initiated, but in a very limited manner. Six CSOs have been selected as grantees and are undertaking ERA and OP/TC assessments.

In FY11, ODC in collaboration with TNI, conducted a series of training on VCT & Lab, peer leader, and HIV training for military teachers to strengthen case management, and increase the capacity of Indonesian military personnel, increase the level of comprehensive understanding and dissemination of information on HIV/AIDS within the military. These trainings were conducted in high percentage of HIV prevalence areas: Jakarta, Bandung, Malang, Surabaya, Semarang, and Denpasar. TNI provided testing and counseling services to 9438 individuals among UN deployment, new recruitment, rank promotion and other military families.

In support of the prevention program, ODC with Project C.U.R.E. in September 2011 conducted a needs assessment in eight facilities (two TNI hospital and lab facilities each) in Jayapura, Sorong, Bandung and Jakarta. These

facilities were chosen by ODC and TNI specifically because they witness a high volume of military and civilian HIV patients. Based on the needs assessment, six containers of equipment will be delivered to the eight facilities in Jakarta, Bandung, Papua and West Papua.

There are few other development partners working in HIV/AIDS prevention in Indonesia. The Australian government has been a long-time supporter of Indonesia's HIV/AIDS response, and is the other major bilateral donor for HIV/AIDS prevention programs in Indonesia along with the USG. AusAID is developing a comprehensive behavioral communication program in Papua targeting the general population, including youth. In addition, AusAID provides support for focused harm reduction programs for drug users and inmates in prisons and detention centers in the provinces of Java, Bali, Papua and West Papua, in addition to prevention efforts in Tanah Papua. AusAID also provides funding to the Clinton Health Access Initiative (CHAI) to support development of HIV national policy review and strengthening of the national supply chain management to ensure a reliable supply of ARV and HIV rapid test kits. The NAC has requested that the USG focus its support primarily on the prevention of sexual transmission of HIV, while AusAID focus its efforts on harm reduction among PWIDs. However, as interventions to prevent sexual transmission of HIV directed to PWIDs 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 support will be allocated for technical assistance for PWID programming particularly with regard to the prevention of sexual transmission of HIV/AIDS within the PWID population. The USG has worked closely with AusAID to find cost-sharing opportunities for activities avoid duplication and promote synergies. The USG will continue to work with the Australians on prevention priorities in Papua.

With 2012 funding, the USG will conduct a mid-term evaluation of PEPFAR/Indonesia programs in August-September 2013 to assess the effectiveness of the USG program in improving access and quality of services to MARPs in PEPFAR-supported areas. Furthermore, through data comparison from the ERAs and OPTC assessments conducted in FY11, the evaluation will provide insight on whether USG- supported NGOs and district level governments have strengthened their local capacity in organizational management and the delivery of prevention, care and treatment services.

PMTCT

PEPFAR/Indonesia's support for PMTCT is limited to strengthening technical capacity as part of the Package of Support described below. As a result of the technical assistance provided, USG supported CSOs will be able to address PMTCT issues as part of the continuum of services for MARP programming where appropriate.

HTC

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%.

Despite the infusion of substantial resources to make HIV counseling and testing (HTC) widely available in Indonesia, recent GFATM program data indicate that national program targets are not being met and that program coverage remains far from sufficient. USG funds will be used to promote improvements in program performance via technical assistance and support to both supply- and demand-side interventions. At the national level, the USG focus is on the formal integration of HTC into STI control services and, in line with the national strategy, expanded use of provider-initiated counseling and testing (PITC) for MARPs as a means of increasing coverage.

At the targeted intervention site level, USG funds will support the development and testing of "service models' that emphasize minimizing "missed opportunities" for MARPs to learn their HIV status and incorporating best practices

and innovations into service guidelines, ideally among all implementing partners. PEPFAR funds will be used to provide TA to PKBI and NU, the GFATM civil society PRs, to strengthen counseling on and referrals for HTC for all MARPs via community outreach undertaken by NGOs and CBOs. In addition, USG supports the implementation of EQAS with regard to HIV test kits and reagents.

USG funding will be used to assist CSO, DHO and Public Health Center (Puskesmas) staff in developing strategies and program plans that promote better-tailored and friendlier Puskesmas and hospital services, including HTC, directed at most-at-risk populations. CSOs will consult with clinical staff in Puskesmas and hospital settings to increase their knowledge about the unique situations of MARPs and to work with them to modify service design so it is better tailored to the needs of MARPs (including a friendly and supportive environment). TA will be provided to ensure that DHO and Puskesmas staff understand and are able to implement current global best practices in HTC, including provider-initiated testing and counseling (PITC). In addition, the USG will support CSOs to engage in increasing demand for testing and counseling among MARPs. These CSOs will offer pre-counseling and promotion of HIV counseling and testing services and to actively engage MARPs and facilitate their access to HTC services.

Wherever workable, support to CSOs includes counselor training and coaching at drop-in centers conducting pre- and post-counseling. Trained CSOs will support MARP co- or lay-counselors to be local health providers of VCT services. Following review of existing VCT centers at Puskesmas or local hospitals, USG funds will be used to provide small grants to CSOs for consumable supplies, incentives for additional staff, and staff training and coaching to build technical capacity.

Once HIV status is known, CSOs will conduct outreach and support services to facilitate and improve access to treatment services provided by government health facilities for positives.

Condoms

Condom use is low and remains an important obstacle to reducing HIV transmission. The 2011 IBBS found that, except among PWIDs (whose condom use increased from 2007 to 2011), condom use rates are flat among MARPS. To impact on the epidemic the rate of consistent condom use needs to more than double among all MARPs. The various challenges include: unpredictable financial support from the government for condom supplies, inconsistent supply of quality condoms, and inadequate access to affordable condoms by MARPs, little effective promotion of condoms and low demand for condoms by the general population. This situation is largely due to recent conservative religious and social activism that has labeled condoms as leading to immoral behavior and promiscuity. As a result, condom promotion by the MOH has declined dramatically in the last decade. In 2009, the MOH stopped procuring condoms using GOI funding. This led to shortages of free condoms for CSOs working with MARPs. The issue was resolved through the provision of 3.5 million male condoms and 500,000 female condoms from UNFPA and through new funding from GFATM Round 8.

Although increased condom use among MARPs is among the highest priorities in the National HIV Strategic and Action Plan 2010-2014, the national plan lacks a coherent, forward-looking strategy for overcoming the barriers that have to date constrained condom use to levels far below those needed to significantly slow the HIV epidemic among Indonesian MARPs. Access to condoms remains an important obstacle. NAC has distributed free condoms to Provincial and District AIDS Commissions, to be distributed through local condom outlets at their areas. However 2011 IBBS data indicates that 94% of transgendered population, 94% of high risk men, 76% indirect sex workers, and 47% direct sex workers admitted that they have never received free condoms. Condoms are also generally difficult to obtain in Papua. According to the IBBS 2006 General Population in Tanah Papua, only 17% of respondents reported that it was easy to get condoms.

In 2010, UNFPA, the NAC and BKKBN signed an agreement to collaborate on the distribution of female condoms. Distribution of condoms from UNFPA will be managed by NAC in coordination with BKKBN giving priority to 12 provinces with high HIV prevalence including North Sumatra, Riau, West Java, East Java, Central Java, Bali, and Papua. NAC will deliver the condoms to regional AIDS Commissions which will distribute them to condom outlets

close to sex workers.

In 2012 USG will prioritize providing technical support to the NAC to systematically assess the current situation and develop a condom promotion and social marketing strategy. Attention will be focused on acquiring a deeper understanding of the factors constraining condom use among MARPs, identification of strategies for overcoming these key constraints, assuring stakeholder consensus on the strategies to be pursued and commitment for action, as well as work with condom producers to address supply and quality issues that contribute to low condom use.

Positive Health Dignity and Prevention (formerly PWP)

PEPFAR is not directly engaged in support for PHDP in Indonesia except as part of the Technical Capacity built into the Package of Support described below. As a result of the TA provided, USG supported CSOs will be able to address PHDP issues as part of the continuum of services for MARP programming.

MARPs

The HIV epidemic in most of Indonesia remains concentrated among MARPs and prevention efforts directed at these populations are among the highest priorities in the Indonesian national response. The USG supports the national program through technical assistance to implement a comprehensive intervention package and improve the quality of prevention efforts, specifically targeting FSW, MSM, PWIDs, waria and high risk men in priority provinces (Jakarta, Riau Islands, North Sumatra, West, Central and East Java, and Papua). MARPs are among the most difficult groups for governments to access and effectively provide services to. CSOs often offer access to these populations, and can be effective advocates and service providers, providing the outreach and support services to allow MARPs to link up with and gain access to government services. In Indonesia CSOs are relatively new partners to the MOH, but are increasingly recognized as a critical partner in reaching the population most at risk for the HIV epidemic. USG works with the government and civil society to increase the technical and organizational capacity for providing appropriate prevention services for MARPs.

The package of support will be provided in 18 targeted intervention sites to 29 CSO grantees and other provincial and district level stakeholders. The package of support for each site is designed based on OPTC Assessment and Health Sector Assessments. Technical assistance for CSOs will targets strengthening the following key components:

• Technical Capacity - Behavior Change Interventions; PWID Programs; HIV Counseling and Testing (HC&T); STI Control; Care, Support, Treatment; Quality Assurance-Quality Improvement (QA/QI); and Strategic Information
• Organizational Performance - Financial Management; Strategic Planning; Human Resources Management; and Program Planning and Management
• Enabling Environment
• Advocacy
• Monitoring and Evaluation

MARP-specific Program Implementation Manuals based on global best practices have been developed for assuring appropriate approaches and interventions for each of the MARP groups targeted (FSW, waria, MSM and PWID). Manuals provide guidance for CSOs for appropriate education messages (ie, how to negotiate condom use with clients for FSW and other sex workers), strategies for accessing health services at public health clinics(ie, negotiating with health post staff special hours for PWIDs who need MMT, but cannot come during normal clinic hours, or addressing stigma and discrimination issues with health providers dealing with transgender persons), strategies for outreach (ie, condom distribution strategies among MSM in sex "hot spots" and establishing psycho-social support services for PLWHA). Comprehensive guidance is provided for appropriate care-seeking HIV prevention skills building; case management for HIV-infected MARPs; promotion of, referral for and follow-up of clinic-based HIV-related services, including STI screening and treatment (including periodic presumptive

treatment as appropriate), HIV counseling and testing (HC&T), and management of opportunistic infections; and distribution support for HIV prevention commodities, most notably condoms and lubricants.

Training and mentoring will assure that each CSO will be able to effectively incorporate MARP participation into its programs to develop local government prevention messages, programs, and services.

For PWID, Indonesia's comprehensive intervention packages also include addiction counseling, provision of drop-in center services, and referral for methadone services and drug treatment. Per guidance from the National AIDS Commission, USG support for PWID Programs will focus on prevention of onward sexual transmission to sex partners among HIV-infected PWID. Because the national program for PWIDs emphasizes the central role of Puskesmas, the role of PWID CSOs as a community partner of Puskesmas and hospital clinical teams will be emphasized to assure better-tailored and friendlier Puskesmas and hospital services directed to PWIDs. CSOs will also be able to act as lead/participate in PWID Program advocacy campaigns with other district stakeholders directed at district-level police, judges, members of parliament and other local government officials and stakeholders.

At the National level the USG program will work actively with the NAC and MOH to advocate and educate against stigma and discrimination, including through the condom strategy and national level advocacy for human rights and continued commitment to service provision for MARPs.

GENDER

USG programming promotes the prevention of HIV transmission by ensuring equitable access to gender-appropriate prevention education and services for women, men and transgender individuals. In FY 2012, USG effort will continue to address gender-based violence and intergenerational sex, particularly among young women and high risk men in Tanah Papua.

While PWIDs have historically seen the highest disease burden and prevalence rate in Indonesia's concentrated epidemic, preliminary evidence indicates that the primary driver of the epidemic appears to be shifting to sexual transmission. Many women face barriers to HIV prevention, care and treatment services due to their lack of access to and control over resources, child-care responsibilities, restricted mobility and limited decision-making power. Additionally, the current socialization of men may mean that they will not seek HIV services due to a fear of stigma and discrimination, losing their jobs and being perceived as "weak" or "unmanly."

In addition to high HIV prevalence among MARPs, Tanah Papua also has a generalized epidemic. The 2006 general population Tanah Papua IBBS found a HIV prevalence rate of 1.9% among women in Tanah Papua, and 22.2% among ethnic Papuan women. (Another IBBS in Papua to update this information will begin data collection in August 2012, supported by USG.) While entire communities suffer the consequences of conflict in Papua, Papuan women and girls are particularly at risk of certain human rights abuses and other forms of gender-based violence, including sexual violence, discrimination and decision making power and information. Studies indicate that sexual behavior patterns in Tanah Papua are of particular relevance to HIV transmission. In addition to early sexual debut, high risk sexual practices in Papua are also triggered by prevalent extra-marital sex, multiple sexual partners, and "sequential sex" (seks antri), a negotiated, agreed-upon sexual service within which a woman allows several men in a row to have sex with her. USG activities in Tanah Papua in particular, where the HIV prevalence rates among women are believed to be increasing most rapidly, will use a girl- and women centered approach.

The USG supported AIDS programs focus on scaling-up a comprehensive package of interventions serving those populations most-at-risk of HIV infection in Indonesia, including FSWs and clients of sex workers, MSM and transgender persons. In Papua, which also has a generalized epidemic, interventions target both MARPs and the general population. USG supports the provision of technical assistance to relevant stakeholders and CSOs to influence social norms that contribute to HIV vulnerability both by stimulating discussion on gender norms related to masculinity which can encourage men to have more sexual partners and older men to have sexual relations with

much younger women and by addressing the issues of gender-related barriers in access to services that prevent women and men from accessing HIV prevention, treatment and care.

FY 2012 USG programming promotes the prevention of HIV by ensuring equitable access to gender-appropriate prevention education and services for women, men and transgender individuals. Complex sexual networks increase the risk of transmission between and among PWIDs, MSM, FSWs, clients of FSWs and their sexual partners. The USG focuses on increased access to the information needed to protect their health and increased reach of counseling and support services. The ODC program areas will include technical assistance and the updating of peer to peer education and counseling and testing curricula on gender issues such as male norms and behavior and GBV. In FY 2012, USG efforts will continue to address gender-based violence and intergeneration sex, particularly among young women and high risk men in Tanah Papua.

Strategic Information

To increase the effectiveness and sustainability of the USG funded program with limited resources, district and province level decision-makers, individuals and institutions must be able to collect and use timely and accurate data to identify: the right people to receive targeted prevention interventions; the right package of services to address their needs; and the most sustainable and cost-efficient ways to deliver such services. In FY 2012, the USG will help the GOI address data gaps, increase the local capacity in strategic information, and identify prevention priorities by:

• Assisting GOI/MOH to improve the quality of routine sentinel surveillance
• Providing on-going technical support in the planning and design for the next round of IBBS among MARPs
• Supporting implementation of IBBS for general populations in Tanah Papua and the IBBS for military personnel in FY12 to help identify the behavioral and socio-demographic characteristics of these populations for more effective prevention programming
• Supporting the development of protocols and systems to conduct routine size estimations for MARPs
• Conducting follow-up OPTC assessments of PEPFAR-supported NGOs to determine the quality and comprehensiveness of services and the organization capacity to manage and provide services
• Assisting MOH to document promising practices, such as the PITC guidelines, to inform the revision of more effective service delivery protocols
• Providing technical support for timely and accurate HIV case and routine data reporting at the national, provincial, and district levels

HSS/Capacity Building
Since 2010 the USG has been transitioning to a technical assistance approach, with increased emphasis on strengthening the technical and organizational performance of local implementers and service providers in Indonesia. An important part of this approach is further strengthening of the capacity of overall health systems at provincial and district levels, including advocacy to assure that adequate local resources are allocated, and that planning us based on timely and appropriate data. In Papua particularly USG support will use an HSS foundation, helping district governments ensure that staffing is in place and that services are available and delivered.

In support of the NAC's objective 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, developing strong civil society implementing partners, implementation of proven strategies and best practices, and replication of models that have been shown to work in Indonesia.

To strengthen GOI health systems, USG provides technical assistance for improved availability and use of strategic information, including key data collection such as IBBS surveys in Papua, the military and global fund round 9 provinces, redesign of the size estimation of HIV+ population, which serves as the denominator for all service

delivery planning, targeting and resource allocation, update of national HIV epidemiological model, development of a condom logistics management system, modifications to the HIV sentinel surveillance guidelines and systems, and publication of technical reports and articles. In addition, USG provides on-going technical support and mentoring of provincial and district government counterparts in collection and analysis of pertinent data. At the national level USG provides technical support for the Global Fund proposal development, NAC for support to grantees and organizational development, and sits on the GF CCM oversight committee.

USG coordinates closely with AusAID, UNAIDS, WHO and other donors to assure that support to GOI is closely linked and aligned to achieve national strategic goals and that geographic and technical area support is complementary.

A major challenge in implementing HIV programs in Indonesia is a lack of support and recognition of the critical role that CSOs can play in reaching and providing critical services to MARPs, and their potential role as partners in the national strategy. USG will continue to focus on strengthening the technical and operational capacity of CSOs, while working at the national level to create an enabling environment for CSOs. PEPFAR Indonesia seeks to improve the capacity of CSOs to fully participate in the national strategy and to enhance their capacity to complement and extend HIV services to at-risk populations. This is being 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. Stronger CSOs will be better equipped to pressure local governments to employ principles of good governance, transparency and accountability. PEPFAR/Indonesia will also ensure that policies are developed and implemented to support the comprehensive response to AIDS.

Capacity development outcomes include:
• Numbers of CSOs who achieve operational and technical capacity standards
• Number of districts that allocate funding targeting HIV services to MARPS
• Number of CSOs that have received TA from the project and as a result have been able to leverage funding from other sources

Summary

In summary, USG will address HIV prevention efforts through TA and capacity building support for the following priority areas:
• Increase condom use by:
o Improving condom visibility by developing and disseminating consistent and culturally appropriate information to hotspots where most at risk populations gather.
o Improving condom acceptance by disseminating culturally sensitive information on condoms to the general population using mass media campaign.
o Improving access to affordable condoms for most at risk population, both providers and customers of commercial sex, by establishing community-based systems to promote and distribute condom.
o Strengthening condom supply chain management and condom availability.
•Improving services to control STIs including integration of HTC into STI services.
• Developing and testing of the package of support to establish best practices for inclusion in service guidelines.
• 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,
• Providing limited support to labs for external quality assurance system for STI screening reagents and lab performance, as well as training of lab staff in STI diagnostics.
• 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 PWIDs.
• CSOs to increase their capacity to plan and manage HIV/AIDS programs for MARPs.

Data from a military IBBS to be conducted to be carried out in 2012 will help target prevention activities

specifically for most at risk military personnel. These efforts will focus on high risk prevalence areas, as determined by the Indonesian Armed Forces Medical Center. The USG will support:

• Redesign of IEC materials and training materials for training of trainers and peer educators to target most at risk military personnel.
• Developing health communication and prevention strategies and promoting risk reduction.
• Developing protocols to make testing available to all new recruits, conducting regular testing of active military personnel, and training healthcare providers and counselors on testing and counseling.
• Continued support by DOD/ODC to strengthen the M&E component of TNI's HIV program.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXS	20,000	0
Total Technical Area Planned Funding:	**20,000**	**0**

Summary:
Key Successes and Challenges in FY11

The 2010 UNAIDS report estimates that there are 300,000 PLWHA in Indonesia. The annual number of reported AIDS cases has risen from 2,682 cases in 2004 to 21,591 in 2010. As of September 2011, 15,589 new infections had been reported. As of September 2011, the MOH reported 22,843 PLWHA are on ART, including 21,880 adults and 963 children less than 15 years of age from 225 hospitals and 67 satellite clinics. This total is estimated to be less than one third of estimated 92,000 people who are eligible to receive ARV therapy (HIV in Indonesia Model 2011), however represents a significant increase from 2006 when only 5,100 people were receiving ARV treatment. An estimated 60,000 PLWHA who are eligible for treatment are not yet receiving it, making it absolutely critical to accelerate service delivery to reach universal access goals. This situation parallels the huge difference between reported cases and estimated numbers of people living with the virus. In addition to accelerating increased availability of treatment programs, improvement is needed in surveillance, outreach, and case finding systems. Recently there have been debates over the implementation of provider-initiated testing and counseling to strengthen the ability of health care providers to identify and serve people not yet receiving adequate information and/ or treatment.

The 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. However, sufficient resources needed to effectively accomplish universal access have yet to be identified. The PEPFAR/Indonesia 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, USG funding will support efforts to improve HIV treatment in Indonesia through technical assistance to the MOH at the national, provincial and district levels. USG funding will support continued policy dialogue at the national level concerning the issues outlined above and the revision/improvement of service guidelines as appropriate in response to policy changes. A priority will be support for the decentralization of treatment to the Puskesmas level, which is necessary in order to more effectively and efficiently serve MARPs in the Indonesian context.

Universal access to treatment is particularly challenging in Papua, where health services are very limited, ART treatment is located in a very few sites, often at great distance from those needing access to treatment. Strategies to increase access to treatment in Papua will require greater commitment to treatment by provincial government,

efforts to increase knowledge of the disease and reduce stigma, and innovative approaches to improving access. USG will support improved health governance and resource allocation for health priorities, including improved services for HIV, through KINERJA. In addition, USG-funded CSOs will coordinate prevention and community support activities to complement and feed into AusAID programs focused on care and treatment, in sites where both programs are operating.

In FY11 treatment guideline revisions were completed but have not been disseminated or implemented on a large scale, although some hospitals have begun implementing the new guidelines. The timeframe for implementation is uncertain unaddressed logistical issues remain. WHO is the lead external partner on this issue; USG's primary contribution is supporting strengthening the recording and reporting systems.

Health examination fees are often a barrier for FSWs to receive services, and clients of FSWs sometimes refuse to pay brothel managers, especially if they are government officials. FSWs often fail to prioritize their health care and often spend recklessly. SUM project is developing innovative approaches to create a more supportive environment for FSWs, including a health insurance mechanism for the FSWs to be promoted by the Tourism Office and Provincial AIDS Commission, resulting in a surcharge paid by the clients of FSWs for the insurance fund for FSW health services.

In 2011, the SUM project collaborated with the TB CARE program to train parole officers and provincial and district staff affiliated with 10 prisons and scaled up implementation of the new policy to include early screening of all inmates for TB and HIV, as well as involving peer inmates and parole officers in the facilitation of TB and HIV treatment continuation upon release.

As a result of PEPFAR assistance in FY11, the Indonesian military implemented mandatory testing for UN deployment, new recruits, and personnel about to be promoted. HIV positive personnel are treated more humanely and TNI follows best practices such as peer to peer HIV training, and have increased access to testing, counseling and treatment.

Goals and Strategies for FY12
A major focus of the PEPFAR/Indonesia program is performance measurement data used for quality improvement at the site level for both facility- and community-based services. USG funding support technical assistance and organization capacity building to civil society and government based on baseline performance assessment and ongoing quality improvement. Concerning integration, USG focuses on providing technical assistance to government and civil service toward integrating treatment with care services. With regard to TB/HIV services, TB screening and infection control practices are in place in some but not all ART sites. PEPFAR funding also supports MOH efforts to better integrate HIV-related services into service packages at the Puskesmas level. In FY12 USG will promote stronger integration of HIV and TB services in national service guidelines, accelerate the rate of training in clinician awareness, and improved management of HIV-TB co-infection among government health service providers and CSOs, improve linkages (including establishing appropriate sharing of medical records) between TB and HIV clinics and service providers to ensure follow-up on treatment for TB among PLWHA, and improve data collection for TB-HIV co-infection and treatment in priority provinces. USG will also work with hospital facilities to ensure that TB/HIV co-infected patients are not placed in HIV wards.
WHO and the AusAID project, CHAI support a national system of pharmacovigilance and the MOH has a drug resistance surveillance system being supported by WHO; USG funding is used for surveillance sub-system needs.

USG will support the design of implementation research on ART as prevention as part of a multi-country study in Asia (Cambodia, Thailand, Viet Nam and Indonesia). The study will strengthen the evidence base for treatment as prevention, and guide policy decisions and the development of standards for strategic use of anti-retroviral drugs for prevention and treatment, an approach proposed by the NAC to scale up effectively in Papua.
At the targeted intervention site level, USG funds will support CSOs to develop competence with a Package of Support services to support improved services for MARPs. Tailored technical assistance will be provided to CSO staff to assist them in developing strategies and program plans for MARP care, support and treatment. Specifically

CSOs will be trained in OI prevention treatment and diagnosis; TB prevention and treatment; ART and clinical care; case management; home-based care; and the CSO role in supporting MARP use of these services as needed. CSOs will be supported to ensure they have a key role in establishing networks to link clients to community-based health facilities, facilitating referrals to enable MARPs to access care, support and treatment services when they are living with HIV infection, in complementing the clinical service delivery and promoting lifelong health-seeking by MARPs. In their role as case managers, CSO staff and volunteers will mentor and support clinical staff and clinical teams in Puskesmas and hospital settings, enabling them to help modify services to ensure their approaches are appropriately tailored to the needs of MARPs. TA will be provided to train CSOs track referrals to ensure appropriate follow up is provided and to identify and fill any gaps in service delivery.

Gender
PEPFAR/Indonesia focuses on technical support and capacity building in support of the GOI's strategy to fight HIV/AIDS and does not support direct treatment. However, technical assistance is provided to CSOs and government health structures to ensure that targeted care and treatment services and programs are provided to stigmatized and vulnerable populations, e.g., MSM, commercial sex workers, disabled, etc. In addition, technical assistance is provided to ensure MSM-friendly and FSW- friendly HIV/AIDS services encourage marginalized men's and women's participation in health care and ensure their access appropriate HIV/AIDS testing, counseling, care and treatment. Priority target populations are single-gender MARPs for which peer involvement in the response is a critical element and grants are given to CSOs that respond to a single-gender MARP and are staffed by the same, gender equity is principle to the CSOs' constitutions, strategies and policies, and to their participation in the response.

Strategic Information
The lack of a medical record data system to track services across different clinical facilities has hampered the ability of clinicians to closely monitor and manage patients in the continuum of care. The potential for duplicate enrollment of HIV patients also poses a challenge for the country to accurately estimate coverage and loss to follow-up rates for individuals who are on treatment. In FY 2012, the USG will help the local government to strategically respond to these challenges by:
• Assisting the GOI in developing information systems to confidentially track individuals across community and clinical services to assess program performance and accelerate access to antiretroviral medications.
• Supporting the on-going continuous quality Improvement/quality Assurance (QI/QA) program to improve quality of patient management through better tracking and earlier identification of clinical service gaps for ART patients
• Improving the use of data for decision-making at the facility level through supportive supervision and on-site M&E technical assistance
• Supporting M&E system reform efforts by assisting provinces and districts in establishing basic M&E databases and capacity to produce routine reports of required national and key provincial- and district-level indicators
• Building capacity to analyze and act based on routine program data for improved programming and resource allocation
• Supporting the NAC in the development and pilot testing of the Data Quality Management (DQM) system for routine data quality improvement
• Assisting the national roll out of web-based HIV reporting system to track service provision at the site, district, and provincial levels

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
ID.415	Number of USG-funded CSOs with approved grants in the last reporting cycle	53	Redacted
ID.416	Number of CSOs that received technical assistance from USG-funded activities and received non-USG funding from another source to implement the model within the reporting cycle	17	Redacted
ID.417	Number of CSOs that underwent an internal audit by USG-funded partners based on Indonesia audit standardization during the last reporting cycle	4	Redacted
ID.418	Number of CSOs that have strategic and annual plans in place and practiced them for program decision making and implementation during the last reporting	5	Redacted

	cycle.		
ID.419	Number of subsidized and commercial condoms sold or distributed during the last reporting cycle through USG-funded intervention sites	199,000,000	Redacted
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	39,661	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence	n/a	Redacted

	and/or meet the minimum standards required		
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	44,670	
	By MARP Type: CSW	9,034	
	By MARP Type: IDU	3,000	
	By MARP Type: MSM	18,077	
	Other Vulnerable Populations	14,559	
	Sum of MARP types	44,670	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	28,924	Redacted
	By Age/Sex: <15 Male	50	
	By Age/Sex: 15+ Male	22,520	
	By Age/Sex: <15 Female	60	
	By Age/Sex: 15+ Female	6,294	
	By Sex: Female	6,354	
	By Sex: Male	22,570	
	By Age: <15	110	
	By Age: 15+	28,814	

	By Test Result: Negative	28,197	
	By Test Result: Positive	727	
	Sum of age/sex disaggregates	28,924	
	Sum of sex disaggregates	28,924	
	Sum of age disaggregates	28,924	
	Sum of test result disaggregates	28,924	
C1.1.D	Number of adults and children provided with a minimum of one care service	3,341	Redacted
	By Age/Sex: <18 Male	20	
	By Age/Sex: 18+ Male	2,129	
	By Age/Sex: <18 Female	30	
	By Age/Sex: 18+ Female	1,162	
	By Sex: Female	1,192	
	By Sex: Male	2,149	
	By Age: <18	50	
	By Age: 18+	3,291	
	Sum of age/sex disaggregates	3,341	
	Sum of sex disaggregates	3,341	
	Sum of age disaggregates	3,341	
H2.3.D	The number of health care workers who	949	Redacted

	successfully completed an in-service training program		
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7480	U.S. Department of Defense (Defense)	Other USG Agency	U.S. Department of Defense	GHP-State	27,000
13473	National AIDS Commission, Malawi	Parastatal	U.S. Agency for International Development	GHP-USAID	1,000,000
14153	FHI 360	NGO	U.S. Agency for International Development	GHP-USAID	0
14154	Training Resources Group	Private Contractor	U.S. Agency for International Development	GHP-USAID	4,716,613
14157	Research Triangle International	Private Contractor	U.S. Agency for International Development	GHP-USAID	300,000
14355	John Snow, Inc.	Private Contractor	U.S. Agency for International Development	GHP-USAID	200,000
14427	TBD	TBD	Redacted	Redacted	Redacted
17006	Public Health Institute	NGO	U.S. Agency for International Development	GHP-USAID	858,387
17032	FHI 360	NGO	U.S. Department of Defense	GHP-State	150,000

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: U.S. Department of Defense (Defense)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 27,000	
Funding Source	**Funding Amount**
GHP-State	27,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Office of Defense Cooperation in partnership with the Indonesia Armed Forces Surgeon General Office (PUSKES) is committed to focus on prevention and testing. ODC is supporting TNI and FHI in conducting an integrated behavioral and biological surveillance (IBBS). The results from the IBBS will then be used to review and revise the prevention curriculum, and scale up testing and counseling efforts from voluntary to provider-initiated testing and counseling. In FY2012 COP ODC will continue to support TNI's prevention and testing/ counseling programs, and will assist the Indonesian Armed Forces to monitor and evaluate, control the HIV growth number and lower the HIV prevalence through trainings, and improved services in counseling and testing.

TNI, with support from DOD is also partnering with FHI in the process of developing a curriculum for continuum of care, PWP and psycho-social counseling of HIV-positive TNI personnel and their dependents, and care, support and treatment counseling. With this in mind, DOD will support TNI in prevention and testing counseling efforts:

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	10,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7480**		
Mechanism Name:	**DOD**		
Prime Partner Name:	**U.S. Department of Defense (Defense)**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

•Provide TA for continuum of care, PWP and psycho-social counseling of HIV-positive TNI personnel and their dependents, and care, support and treatment counseling
•MOH curriculum and materials will be adapted for military

The TA of continuum of care, PWP and psycho-social counseling of HIV-positive TNI personnel and their dependents, will assist TNI in developing VCT, PITC and CST materials, assist in conducting Neuro-AIDS workshop, and design PLHIV support group. The activities will be conducted in Jakarta and Surabaya which the participants will consist from several of TNI hospitals especially level I and level II.
This program will increase the coverage of HIV testing and counseling and improve care, support and treatment access for military personnel and their dependents, who receive a HIV positive test result, in order to support positive prevention program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

•Providing TA for senior leadership Advocacy workshop for development of continuum of care
There are so many miss understanding within the TNI senior officers. This advocacy workshop will enhance TNI senior officers to have a comprehensive knowledge on HIV continuum of care and in developing HIV program. This advocacy will involves not only health sectors but also will include other sectors such as personnel sector, security sector, religious sector and law sector.
Every two years DHAPP host an International Military HIV/AIDS Conference (IMILHAC). The The DOD program manager and two TNI personnel active in the HIV/AIDS program will attend the IMILHAC to be held during the course of FY 2012. This conference is a means of South-to-South networking, and sharing of information among DHAPP and its partner militaries. By attending the IMILHAC, TNI officers will broaden knowledge, experience and network.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

Implementing partner: DOD
• Total program for HVCT will be $25,000. This full amount will come from pipeline.

DOD through the ODC office will continue to support TNI's HTC through scaling up the provider initiated testing and counseling, as mandated by MOH guidelines and TNI's HIV service delivery and continuum of care.

PITC will be the core of HVCT program due to lack of training and socialization in the past. The target population will cover both military and civilian that have access to TNI hospitals. The approaches that will be use include VCT, and PITC. The service is consisting of static and mobile service. The standard and method of testing is base on MoH standard (3 rapid test). The referral system can be done in TNI hospitals or to general hospitals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	27,000	0

Narrative:

Implementing partner: DOD
• Total program for HVOP will be $40,000
o $27,000 of FY13 COP funds
o $13,000 from pipeline

Support the prevention materials and training curriculum on OI/TB developed by FHI based on the TNI needs. ODC will continue to support peer education training as a key means to strengthen the sharing of peer to peer HIV prevention information. Peer Leader Training reinforces prevention of HIV and sexual transmitted diseases, and

provides information on approach strategies and overcoming societal stigmas. A gender component will also be included targeting male norms and encouraging couples testing and counseling for military personnel and their spouses. *Target Population* *Approx Dollar Amount* *Coverage – number to be reached by each intervention component* *4 PL training each 30 participants (4x30=120) $40,000* *30 X 30 = 900* *Age 25-49, sex male 80% and female 20%* *To promote the quality assurance the PL training will be facilitated by certified trainers and supervised by the core trainer.*

Implementing Mechanism Details

Mechanism ID: 13473	**Mechanism Name: Indonesia Partnership Fund**
Funding Agency: U.S. Agency for International Development	Procurement Type: Grant
Prime Partner Name: National AIDS Commission, Malawi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: USAID

Total Funding: 1,000,000	
Funding Source	**Funding Amount**
GHP-USAID	1,000,000

Sub Partner Name(s)

LSM Graha Mitra	LSM Mata Hati	LSM Pelita Tegal
Organisasi Kembang	PKBI Jabar	PKBI KalSel
Yakkestra	Yayasan Bambu Nusantara	Yayasan Hotline Surabaya
Yayasan Inset	Yayasan OASE	Yayasan Paramitra Jawa Timur
Yayasan Resik	Yayasan SP2S	

Overview Narrative

The Indonesian Partnership fund for HIV (IPF) was launched in 2005 as funding mechanism to receive and channel funds from domestic and international partners, the government, and the private sector. Its primary goal was to support and strengthen an effective and sustainable multi-sectoral response to the HIV epidemic by increasing Indonesia's capacity to halt and begin to reserve the spread of HIV/AIDS infection. The IPF will focus on addressing constraints in national implementation capacity, filling capacity gaps and helping to build national and sub national capacities in the area of prevention and care. PEPFAR's contribution to the IPF is consistent with the goals of USAID Forward for procurement reform, as well as an important example of USG's commitment to country ownership.

The Government of Indonesia sees an urgent need to continue the IPF to further build on the success of the IPF and to consolidate the achievements to date. The IPF mandate has been refocused to address the new challenges in the funding environment and to strengthen the ongoing administrative alignment with the Government programs. IPF resources are used to expand the scope and range of HIV services delivered by local AIDS Commission, and for grant to CSO for HIV prevention, care and treatment.

Monitoring of the IPF is conducted through participation in the IPF Management Committee, of which the PEPFAR Coordinator is a member. USG provides support to IPF and its grantees through the SUM project to strengthen operational performance and technical capacity, including monitoring and evaluation capacity. IN addition, the PEPFAR country team participates in regular site visits where CSOs are operating to monitor implementation performance.

Cross-Cutting Budget Attribution(s)

Gender: GBV	140,000
Gender: Gender Equality	260,000
Human Resources for Health	120,000
Key Populations: FSW	400,000
Key Populations: MSM and TG	160,000

TBD Details

(No data provided.)

Key Issues

Mobile Population

Budget Code Information

Mechanism ID:	13473		
Mechanism Name:	Indonesia Partnership Fund		
Prime Partner Name:	National AIDS Commission, Malawi		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	1,000,000	0

Narrative:

To address new challenges in the funding environment and to align more fully with government programs and systems as guided by the Jakarta Commitment, the IPF will build revise the current operating mechanism for further sustaining management of the IPF. The Indonesian Partnership Fund will develop operating mechanisms with the legal stature and capacity to enter into contracts, adopt mechanisms to generate funds and directly receive and manage funds.

IPF will focus on addressing constraints in implementation capacity, filling capacity gaps and helping to build national, local and sub-regional capacities in its special focus area – prevention and care. This focus will enable IPF to take advantage of opportunities and to complement mandates, capacities and synergies of its partners. It will also permit investment in management policies, tools and people that are necessary to perform at world-class standards of quality, speed and cost-effectiveness. IPF funding will be used to support provincial and district AIDS commissions and provide grants to CSOs to improve access to prevention and care services to MARPs.

Implementing Mechanism Details

Mechanism ID: 14153	**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: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-USAID	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The fundamental objectives of the SUM I project are to 1) Provide targeted assistance in key technical areas required to scale up effective, integrated HIV interventions that lead to substantial and measurable behavior change among MARPs and 2) Provide targeted assistance to government agencies and civil society organizations (CSOs) working on strategic information efforts related to the HIV response for MARPs. These goals are directly linked to the objectives of the Indonesia GHI Strategy, especially to improving the effectiveness of interventions and sustainability of activities by local government and non-governmental partners. SUM I strategically targets MARPs (FSWs, PWIDs, MSM and waria) in districts where HIV prevalence is highest: Jakarta, Surabaya, Malang, Papua and West Papua. In Papua and West Papua, where there is also a generalized epidemic, SUM I provides TA for a response to a generalized epidemic.

In FY12, SUM I will target additional intervention sites with assessments and tailored package of support and will continue to deliver the package of support to the original sites. Planned activities will continue to build the capacity of CSOs to provide technically up to date and appropriate services and will increase the ability of CSOs to leverage funding other than USG funds. Finally, the CSOs will graduate into technical assistance providers for other community organizations. Technical assistance for district governments will also be provided. These activities will lead to efficiency gains and CSOs will be able to independently garner and manage outside funding to sustain their own activities. M&E plans include quarterly and annual progress reports.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14153		
Mechanism Name:	Scaling Up for Most-At-Risk-Populations (SUM) I - Technical Assistance		
Prime Partner Name:	FHI 360		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	0	0

Narrative:

Although there is some movement underway at the MOH to decentralize HIV treatment and care from hospitals to Puskesmas and from health facilities to community-based providers of services and support, HIV treatment and care services remain highly concentrated in hospitals, particularly those in large cities.
SUM I will engage the MOH in dialogue concerning a longer-term strategy for HBHC. In targeted intervention sites, USG funding will support the demonstration of HBHC in the Indonesian context in collaboration with the NAC, MOH and other local implementing partners by including case management functions into the service packages of CSOs providing outreach services to MARPs.

At present, mechanisms in the national program to address client retention and referrals, including the use of outreach and bi-directional referral systems, are limited. Client retention and referral are emphasized for SUM-supported CSOs. As indicated above, SUM is advocating that a similar model be adopted as the national standard and will provide support should the national program move in this direction.

SUM I will provide technical assistance to CSOs and government counterparts to improve: Linkages between program sites with other HIV care, treatment and prevention sites within jurisdiction and linkages and/or referrals between program sites and non-HIV specific services (at a minimum food support, IGA, RH/FP and PLHIV support groups); and Program monitoring and evaluation of the quality of care and support services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Care	HVTB	0	0

Narrative:

Indonesia ranks among the top 5 globally in TB disease burden, and TB co-infection is a major issue among HIV-infected persons in Indonesia, many of whom are members of one MARP or another. In FY11 SUM I assisted the MOH NTP (along with TBCARE and WHO) to develop the National TB-HIV Strategy and Guidelines, and SUM activities are fully aligned with host country national policies and strategic plans for TB and HIV. Revised recording and reporting forms for HIV-TB activities were finalized and socialized, and HIV-TB collaborations were established in priority provinces.

In FY12 USG will promote stronger integration of HIV and TB services in national service guidelines, accelerate the rate of training in clinician awareness, and improved management of HIV-TB co-infection among government health service providers and CSOs, improve linkages (including establishing appropriate sharing of medical records) between TB and HIV clinics and service providers to ensure follow-up on treatment for TB among PLWHA, and improve data collection for TB-HIV co-infection and treatment in priority provinces. SUM I will also work with hospital facilities to ensure that TB/HIV co-infected patients are not placed in HIV wards. TB/HIV activities supported under PEPFAR will also be closely coordinated with related activities supported by USAID/Indonesia's TB program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	0	0

Narrative:

In addition to lab support for the control of STIs (included under HVOP) and HIV counseling and testing (included under HVCT), USG will provide general, national-level support for staff training and implementation of EQAS for labs located in targeted intervention sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

Increasing the availability of quality data and improving skills to use data for policy and program decision-making are crucial to targeting resources for combating HIV. USG will provide technical support to strengthen strategic information systems at all levels through workshops, seminars, on-the-job training and mentoring, and joint data analysis and interpretation, through SUM I. At the national and district levels SUM I will focus on better-informed priority-setting and allocation of resource, and increase capacity to manage, analyze, and use data for decision making.

USG activities supporting M&E system reform will include: participation in ongoing the M&E health information system reform effort at the MOH; assisting provinces and districts to establish basic M&E databases and develop the capacity to produce routine reports of provincial- and district-level indicators; and building the capacity of CSOs to analyze and act based upon routine program data.

SUM I will focus on improving the quality and sustainability of epidemiologic and behavioral surveillance systems, and the use of surveillance data for program planning, monitoring and evaluation. Activities will include technical support for planning the 2013 IBBS among MARPs (GFATM Round 9 provinces); the 2012 IBBS of general population in Papua; and re-establishing regular, high-quality HIV sentinel surveillance.

SUM I and SUM II are jointly responsible for SI activities in targeted districts, while SUM I is responsible for SI support to national stakeholders. At the targeted intervention site level, SUM II is responsible for CSO recording and reporting, while SUM I is responsible for data base management and M&E support for provincial and district health offices and AIDS Commissions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

USG will work with the MOH to support a HSS process at the provincial/district level which brings all stakeholders together to identify priorities and develops plans to undertake HSS. The process entails (1) reaching consensus on a health outcome that would receive priority attention for at least the next 12 months; (2) analyzing the root causes of failure to adequately address the selected health issue; (3) identifying and prioritizing health system changes and/or service quality improvements that would address the problem; (4) choosing a set of priorities that each implementing partner would pursue over the next 12 months; and (5) agreeing to a provincial-level coordination structure to keep the joint efforts moving forward.

The systems/barriers that are addressed will be identified by local stakeholders and may vary from site to site, as may/will the activities supported in response. It is anticipated that linkages will cross functional areas, and the response may well entail leveraging funds from local government health budgets.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	0	0

Narrative:

Unlike most of Indonesia, relatively few Papuan males are circumcised. Establishing male circumcision (MC) as a

HIV prevention intervention is widely discussed in Papua, and some services are available. Recently, a Regent in Sentani District, Papua proposed that circumcision be made mandatory for all males in Papua to reduce HIV transmission, reflecting the limited understanding in Papua of the realities of MC as an HIV prevention intervention and how best to gain wider acceptance, as well as of basic human rights issues.

In response, SUM I will educate policy makers and community stakeholders about the role of MC for HIV prevention and the requirements for effective and safe intervention implementation. The initiative will entail the deployment of (1) a policy brief that places MC in the larger context of HIV prevention in Papua, (2) a technical brief that documents the requirements for MC to be an effective and safe prevention intervention, (3) a seminar for key stakeholders and (4) short "fact sheets" presenting the basic facts in about MC for use by CSOs and front line health staff to educate clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

Despite the gains in coverage of HCT among MARPs reflected by the 2011 IBBS, HCT remains far from sufficient. USG funds will be used by SUM I to improve program performance for both supply and demand for HCT. At the national level, SUM I will promote formal integration of HCT into STI control services and expanded use of provider-initiated counseling and testing (PITC) for MARPs as means of increasing coverage. SUM I will also continue its support to the implementation of EQAS for HIV test kits and reagents. On the demand side, SUM I will provide TA to PKBI and NU, the GFATM civil society PRs, to strengthen referrals for HCT for all MARPs via community outreach, as well as prioritize "knowing one's status" in BCC messages.

To ensure successful referrals and linkages, SUM I will focus on increasing referral and follow-up for HTC among MARPs for CSOs. SUM I supports facility-based case management services to facilitate uptake of care and treatment services by persons testing positive for HIV, but as described above community services are not well linked to facility services. SUM I will also increase emphasis on partner testing in targeted intervention sites.

At present, activities for monitoring linkages from HTC to appropriate services, or systems to evaluate or otherwise measure successful linkages are implemented in the national program on an ad hoc basis. SUM I will test models to accomplishing the above in targeted districts following agreement with MOH. SUM I will also provide training and follow-on mentoring on QA/QI processes and systems to all CSOs, and will assess the extent to which QA/QI systems and processes have been internalized by the MOH.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

Prevention efforts directed to MARPS are among the highest priorities in the Indonesian national AIDS response. Priority MARP populations targeted include FSW, MSM, PWID, high risk men and the sex partners of all MARPs. Support will be provided to national level counterparts (GFATM PRs and SRs), at the provincial level in up to five out of 8 priority provinces and up to 19 targeted districts.

Training and mentoring will be provided to all CSOs provided grants by SUM II. USG-supported CSOs provide MARPs with a standard package of services, including outreach, peer education/promotion, risk reduction counseling, access to prevention commodities (condoms and lubricant) targeted media/internet-based behavior change communications, and referral for clinic-based services (HC&T, STI management, MMT, CST for HIV-positives, management of opportunistic infections, including TB). SUM also provides limited lab support for EQAS for STI screening reagents and lab performance, as well as training of lab staff in STI diagnostics.

SUM interventions also include provincial and/or district level health system strengthening initiatives. Intervention packages were chosen and designed based upon global good practices.

Training for quality assurance/quality improvement (QA/QI) processes and systems are provided to all CSOs. SUM I will also support QA/QI at the MOH and Data Quality Management (DQM) at the NAC. Activities are implemented to supplement national program efforts in/for underserved areas and groups, and are thus fully linked with national program efforts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	0	0

Narrative:

Until recently, the HIV epidemic in Indonesia has been driven primarily by injection drug use although recent data seems to indicate that the types of drug used are shifting away from intravenous drugs. The epidemic appears to have shifted to one that is increasingly driven by sexual transmission, however, sizeable numbers of Indonesian males (and to a lesser extent females) in urban areas continue to inject drugs.

As the NAC has requested that the USG focus its support on the prevention of sexual transmission of HIV, SUM I will focus its TA/capacity building efforts on interventions to prevent sexual transmission of HIV+ PWID. SUM will also provide TA to seven CSOs working with PWIDs in four provinces: Jakarta, East Java, North Sumatra and Riau Islands. The TA package will consist of (1) introduction of an Implementation Manual based upon global and Indonesian good practices, (2) training workshops on activity design and implementation, (3) field mentoring, (4) TA for QA/QI and (5) support to district-level planning, monitoring and evaluation to facilitate integration.

CSOs will undertake quality improvement initiatives on a regular basis with support from the SUM project. Activities are implemented to supplement national program efforts for underserved areas and groups, and are fully linked with the national program.

At the request of the MOH, USG funds will also be used to support an update of national service guidelines for IDUs which will cover, among other things, (1) the integration of HIV sexual transmission prevention interventions into the national harm reduction model and (2) the role of CSOs in providing a comprehensive and accessible package of services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

Because HIV is largely concentrated among MARPs in Indonesia, only limited resources will be allocated to MTCT. USG funding will support: training of national- and provincial-level PMTCT Master Trainers and revision and finalization of service protocols and standard operating procedures (SOPs) (as necessary, following the transition of the program to the Sub-Directorate for AIDS and STIs from the Sub-Directorate for Maternal Health).

High-level discussion is currently underway concerning a major scale-up of PMTCT in Papua. In anticipation that the national program will prioritize scaling up PMTCT in Papua, additional funds were allocated to this program area to support training and mentoring. Details will be finalized in consultation with MOH and Papua provincial counterparts, as well as other development partners (UNICEF, WHO, CHAI) to identify the appropriate inputs by SUM I.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	0	0

Narrative:

In support of the adult treatment area, USG will:

Support continued policy dialogue at the national level regarding on-going challenges to improved treatment, including: concentration of treatment services in hospitals, and the lack of access to treatment that results for PLWHA in remote areas (especially Papua); national service guidelines that restrict patient qualification for treatment. Priority areas for revision of policy and guidelines include: support for the decentralization of treatment to the Puskesmas level, which is necessary in order to more effectively and efficiently serve MARPs in the Indonesian context; and improving treatment adherence in both health facilities and communities.

USG will support in-service training on clinical management of HIV and Integrated Management of Adult Illnesses

(IMAI), and mentoring of clinical staff in targeted intervention sites. SUM-supported CSOs will also be trained and mentored in community-based treatment adherence support strategies and practices.

Implementing Mechanism Details

Mechanism ID: 14154	**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	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,716,613	
Funding Source	**Funding Amount**
GHP-USAID	4,716,613

Sub Partner Name(s)

AIDS Project management Group	Burnet Institute	Research Triangle International

Overview Narrative

SUM II (TRG) Implementing Mechanism Narrative

The SUM II Program, was specifically designed to address the need to build capacity of local government and civil society organizations (CSOs) to deliver services sustainably. The main objectives of the SUM II Project are to: 1) Provide targeted assistance in organizational performance required to scale up effective, integrated HIV interventions that lead to substantial and measurable behavior change among MARPs; and 2) Provide and monitor small grants to qualified CSOs to support the scale-up of integrated interventions in hotspots, where there is a high concentration of one or more MARP and where high-risk behavior is prevalent, including DKI Jakarta, East Java, Papua, Riau islands and North Sumatra.

SUM II will strengthen the capacity of CSOs in the HIV response by providing targeted TA to indigenous CSOs that will eventually become leaders and mentors for other CSOs in their communities. While Year 1 of the project was

spent conducting baseline assessments for the selection of promising NGOs, the primary function of FY12-14 will be to build the capacity of these CSOs to manage their services and programs more effectively, increase their ability to leverage funding other than USG funds, and graduate these organizations into technical assistance providers for other community organizations. At the same time, capacity building on organization performance for district governments will also be provided by SUM II. As a result, efficiency gains, along with proper and sustainable transition of CSOs from SUM II to partner governments or other organizations can then be achieved. Monitoring and Evaluation plans for included activities are reviewed and revised on an annual basis.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	104,797
Education	254,478
Gender: GBV	81,997
Human Resources for Health	1,028,102
Key Populations: FSW	677,014
Key Populations: MSM and TG	544,074

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14154**
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	182,784	0

Narrative:

Similar to HVOP, SUM II will support CSOs to improve organizational performance of MARPs-based care, support and treatment for FSWs, MSM, Waria and PWIDs. HBHC will include TA and support for management of post-counseling, adherence, psycho-social support, and positive prevention aimed at reducing morbidity and mortality among PLHIV. During 2012, SUM II will encourage the establishment of up to 15 MARP-based support groups.

SUM II will support Spiritia's provincial catalyst and local peer support groups for PLHIV that are ensconced in SUM's provinces and districts, including Papua, offering an opportunity for collaboration with SUM in our targeted intervention sites. In addition, SUM II organizational and program TA and grant support to Spiritia will build its capacity to manage its network.

Our activities are implemented to supplement national program efforts in/for underserved areas and groups, and are thus fully linked with national program efforts. However, this is an under-developed program area in the national program, and thus coverage with services that approximate global good practices is low.

SUM II will provide TA that will legalize un-registered CSOs by securing legal entity status according to Indonesian laws and regulations; strengthen organizational governance by re-visiting and developing organizational vision and mission statements, organizational constitutions, organizational management and operational structures and standard operating procedures; promote strategic organizational thinking and longer term planning by developing 3-year strategic plans and annual work plans through one-to-one mentoring and facilitation; develop sound financial management practices and establish organization-wide standard operating procedures; and build CSO capacity in community mobilization through advocacy and community empowerment by applying best practices and evidence based decision making approach. The TA will be provided by local institutions specializing in these technical areas using SUM's Manuals for supporting CSOs to promote consistency and sustainability.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	557,781	0

Narrative:

In 2013, SUM II will continue working to improve monitoring and evaluation of performance indicators for CSOs. In 2012 SUM II expanded its approach to capacity building by partnering with SurveyMETER (October 2012) to support SUM II's responsibility for CSO monitoring and evaluation. In 2012 SUM II assumed complete

responsibility for CSO monitoring and evaluation (M&E), including monthly recordkeeping and reporting, population-based surveys at CSO intervention sites, and qualitative assessments at intervention sites, such as focus group discussions. SUM II's partner SurveyMETER is providing on-the-job training and coaching to CSOs. SUM II is also replacing the proprietary database programmed for CSOs, which is costly to maintain and update, and has hampered CSO staff from learning how to manipulate and analyze data, use it to identify obstacles to service delivery, and present and take appropriate action.

In September 2012, SUM II introduced Epi info 7 and CommCare to two SUM II Principal CSOs in DKI Jakarta to pilot test the integration of the two technologies, and in 2013 this integration will be scaled up to three additional Principle CSO partners in East Java, and eventually to Papua, West Papua, North Sumatra, Riau Islands, and West and Central Java. CSOs are enthusiastic about both technologies and see their potential to improve HIV program results. CommCare Mobile and Epi info 7 will enable "real-time" reporting by field workers and eliminate the data entry task at the CSO office. Together, these technologies will significantly improve CSO outreach, case management and recordkeeping, problem solving, and reporting. CommCare is a mobile phone-based data management tool that SUM II and CommCare customized to Indonesia. Epi info 7 is a series of tools for routine data gathering, database management, and analysis. It was developed by CDC for use by CSOs and community health workers to manage databases for surveillance and other tasks. It is easily used in places with limited network connectivity or limited resources for commercial software and professional IT support. When integrated together, Epi info 7 and CommCare enables CSO field workers to collect and record client data on their phones, which can then be uploaded and synced with the CSO data management system – Epi info 7 – without the need for data re-entry.

SUM II will work with SurveyMETER to provide training and coaching to CSOs in doing regular surveys to measure the outputs and outcomes of provided services. Surveys will be designed on an annual basis, and may be conducted more frequently, e.g., twice a year. CSOs are expected to use the results of the survey for CSO decision making for advocacy and future plans, and disseminate results to stakeholders at district levels were they provide services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	301,751	0

Narrative:

In 2013 SUM II will work with a number of partner CSOs to formulate the concept for model centers of excellence, where the health provider builds a network with CSOs and community organization in MARPs services, and involves them in all levels of planning and implementation. SUM II will identify and engage one local TA provider with expertise in clinical management to assist with formulation of the approach.

SUM II TA provider organizations will continue to provide training and coaching to 28 CSOs in 22 districts in DKI Jakarta, East Java, Central Java, North Sumatera, Riau Islands and Papua. SUM II has identified two CSOs in West Papua that it will partner with in 2013. Seven Principal CSOs will provide technical assistance in project management and community organizations to developing CSOs that work in expansion sites, including MARPs hotspots in the same district/province or neighboring district/province. Yayasan Penabulu, a well-established NGO based in Jakarta is providing financial management training, coaching and system development to SUM II CSO partners in DKI Jakarta, East Java, Central Java, North Sumatera and Riau Islands to improve institutional-based financial management performance and establish sound accounting systems. Likewise, Circle and Satunama, well-known organizations based in Yogyakarta and specializing in organizational development TA will train and coach our CSOs to improve their strategic and annual planning and budgeting, leadership and management performance, human resources, mobilizing MARPs and communities, and advocacy. Yayasan KIPRa, a Papua-specialized community development NGO is receiving mentoring from Penabulu and Satunama for organizational strengthening, in order to more effectively provide SUM II CSO partners in Papua and West Papua with organizational performance TA, including financial management. SurveyMETER will provide technical training in the development of monitoring and evaluation systems, data analysis, and how to use results for decision making and to strengthen networks with health providers and the CSOs non-SUM II partners. OPSI will provide technical capacity to SUM II CSO partners in Papua and West Papua in community organizations to the specific MARPs, e.g., MSM, TG, and CSWs. The goal is to develop CSOs' training and facilitation skills in community empowerment and advocacy. OPSI will accelerate community organization services by working directly with MARPs and simultaneously coaching the CSOs in Papua and West Papua to facilitate FSWs, MSM, TG communities in community organizations.

SUM II will also continue to provide training and coaching to CSOs for advocacy and resource mobilization using the Resource Estimation Tool for Advocacy (RETA). In 2013, SUM II will train SUM II CSO partners in Jakarta and East Java to produce resource gap estimations based on RETA, government budget and response analysis results, with the goal to develop advocacy agendas and instruments, e.g., policy briefs and advocacy plans. SUM II will continue to provide RETA training and coaching to CSOs in 2013 that leads to the CSOs successfully advocating for more resources, and mobilizing communities and leaders. Papua and West Papua will be the top priority in the use of RETA both for MARPs and the general population. Moreover, SUM II staff in Papua, Medan, and Riau Islands regions will be trained on know-how to provide technical assistance to CSOs in the use of RETA for MARPs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	101,778	0

Narrative:

SUM II supports CSOs engaged in increasing demand for testing and counseling among MARPs. CSOs are funded to work with MARP indigenous leaders to develop drop-in centers in communities. The MARP-based centers are socially and geographically acceptable to MARPs and provide education and information related to HIV prevention and care. They also provide pre-counseling services to MARPs if MARP members are already trained as co-counselors or lay-counselors.

Support to CSOs also includes training and coaching to be counselors at the drop-in centers conducting pre- and post-counseling. SUM II CSO partners will participate in the training and coaching provided by TA organizations to improve partnership performance with community health centers (Puskesmas) that provide STI and HCT services. The CSOs are expected to be equal partners of Puskesmas in planning, in reviewing performance of services, and in addressing loss of follow up clients. Wherever workable, the CSOs will second the MARP (co- or lay-counselors) to be local health providers of VCT services.

National HIV prevalence by risk population based on the 2011 IBBS is as follows:

• IDU: 30.0% - 36.4%
• CSW (direct): 3.6% – 25.0%
• CSW (indirect): 2.3% - 2.9%
• MSM: 2.4% - 17.0%
• TG: 14% - 31.0%
• HRM: 0.8%

In 2013, SUM II will make a decision on the feasibility of rapid testing by CSOs and private providers. SUM II is already investigating current legal, policy, regulatory and/or operational barriers that prevent CSOs from providing rapid HIV tests. SUM II will investigate these barriers and determine whether HIV rapid testing is feasible by CSOs. If a rapid testing process is found to be feasible, a pilot rapid testing program will be developed and evaluated in at least two provinces (most likely East Java and Papua). The pilot and associated evaluation will be used to build support for introduction of more accessible HIV testing for MARPs nationally. Where CSOs can provide counseling and HIV rapid testing through outreach or through linking MARPs to testing at "safe spaces" – drop-in centers, CSO offices, etc. – the reach of HCT can be rapidly expanded among MARPs.

If SUM II's investigation determines rapid testing by CSOs is not feasible, it will look at the feasibility of rapid testing by private providers.

SUM II is already identifying private clinics currently providing subsidized HIV and STI services and prepared to expand to underserved hotspots in targeted cities and districts. For example, in January 2013 SUM II provided a small grant to Angsamerah clinic to establish a satellite clinic at a hotspot in South Jakarta in collaboration with

Principal CSO, YKB, and others. SUM II and Angsamerah are co-funding the satellite clinic. Angsamerah is a private clinic specializing in sexual and reproductive health. The satellite clinic will provide free HIV testing, STI screening (syphilis and genital discharge), CD4 count testing and counseling (through collaboration with Provincial Health Office and Provincial AIDS Commission). It is expected that the clinic will become a model that can be replicated in other areas of Jakarta

SUM II will also support CSOs establishing clinics or expanding their clinical services to include HIV and STI testing and counseling services. Some CSOs already provide primary health care services in or near our intervention sites and are prepared to include HIV and STI services with additional support from SUM II.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	2,885,879	0

Narrative:

SUM II provides TA and small grants to CSOs for services to MARPs and PLHIV, and mobilization and community self-reliance activities aimed at prevention of HIV infection from sexual transmission. CSOs provide services to brothel- and non-brothel, including street-based, FSWs, MSM, Waria, (transgender persons), and IDUs. In Papua, CSOs are also providing services to indigenous men and women, and high-risk men. Specifically in Papua, activities aimed at indigenous women and girls include engaging faith-based and women's organizations in HCT and ways to minimize risk of partner violence in Papua. In Riau Islands and North Sumatera, high-risk men are also a target of CSO services. The participation of MARPs, PLHIV, high risk men (and in Papua indigenous men and women) at all levels of program planning, implementation, and evaluation is believed to improve their sexual and health-seeking behaviors.

To respond to the needs of private health services for MARPs, SUM II will provide small grants and TA to private clinics in Jakarta and Papua to improve MARPs access to STI, HCT, and post-exposure prophylaxis. TA to be provided will focus on clinical management, establishing external relationships with stakeholders, and networking with the CSOs and CBOs.

Seven Principal CSOs (five designated in 2012 and two additional CSOs, both in Papua designated in 2013) will receive additional TA and a second cycle of grants to enable them to become local capacity building mentors to developing CSOs and non-SUM II CSOs. Principal CSOs are also expanding coverage of HIV and STI services in multiple ways (through SUM II TA and grants) – to other similar intervention sites; to new geographical areas; by adding new programs that target different most-at-risk populations; to intervention sites formerly covered by other CSOs; by mentoring and providing TA support to small CSOs, CBOs and FBOs that enables expansion of coverage; and by engaging private clinics to provide HIV and STI services.

SUM II Principal CSO partners, as part of the grant agreements, will also build partnerships with other projects that serve MARPs and PLHIV in a district so that HIV programs are mainstreamed in these project activities; they will build linkages with multiple stakeholders and local government to promote mainstreaming of HIV programs and services across departments of local government; and they will start local initiatives for comprehensive HIV programs that include the private sector.

Following a "combination prevention" model, SUM II-supported CSOs provide all groups with a standard package of community-based services, including outreach, community organizations/mobilization for self-help systems to increase access to risk reduction counseling, access to prevention commodities (condoms, lubes, clean needles and syringes), targeted media/internet-based behavior change communications, and referral for clinic-based services (MTCT, HCT, STI management, and CST for PLHIV). SUM II provides TA to establish equal partnership with local health providers for services plan, review coverage and quality, and address loss of follow-up to the services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	IDUP	269,795	0

Narrative:

SUM II's CSO partners in Jakarta, Surabaya, Medan, and Batam provide IDUs with services of intervention aimed at 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. It should be noted that CSOs servicing IDUs are now focusing on harm reduction, in particular needle exchange, MMT, HCT and STI. SUM II will provide training and coaching to CSOs to improve CSO performance in community organization/mobilization to expand their services and increase IDUs' participation at all levels of planning and implementation of harm reduction services. In 2013, SUM II will also promote crossover interventions of injecting drug use and sexual transmission.

SUM II is providing TA to CSOs in DKI Jakarta, East Java, North Sumatera and Riau Islands to develop advocacy plans for March 2013 local government budget discussions. In 2012, a SUM II CSO partner in East Java received IDR 46 million (approximately $4,760) from the national and local narcotic boards.

CSOs serving the IDU communities in East Java and DKI Jakarta participated in SUM II's adaptation of the Resource Estimation Tool for Advocacy (RETA) to create an IDU version. This version is enabling estimates of resource needs to scale up HIV services to IDUs in DKI Jakarta and East Java based on population size estimates, HIV prevalence and projections over the coming 5 years, HIV service targets for the coming 5 years, and mapping of available and anticipated resources for the target HIV programs (to allow estimation of resource gaps). The CSOs participated in the series of RETA use, application, and advocacy planning workshops held in Jakarta and Surabaya with representatives of provincial and district NACs and departments of health.

In 2013, two new technologies will support SUM II CSO partners in program evaluation. CommCare Mobile and Epi info 7 will enable "real-time" reporting by field workers and eliminate the data entry task at the CSO office (see Strategic Information below). Karisma was one of two Principal CSOs selected to pilot test CommCare Mobile in 2012 and they will assist in introducing the new technology to developing CSOs in DKI Jakarta.

In 2013 SUM II will continue to engage in local structural interventions aimed at advocacy for policy reform, planning and budgeting for the HIV program, community mobilization, raising the prominence of MARP and PLHIV leaders and champions, and reducing stigma and discrimination. SUM II's focus on IDUs will be on preventing sexual transmission as requested by the NAC.

SUM II local TA providers will continue to provide CSOs with workplace-based training, coaching and systems development to improve organizational performance and expand coverage of HIV and STI services to IDU communities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	416,845	0

Narrative:

In 2012, SUM II expanded its program of activities to Papua, including TA and small grants for HIV/AIDS prevention programs among indigenous men and women (ages 15 to 49 to be targeted by CSOs) in Jayapura, Mimika, Jayawijaya Districts. These programs in the three districts are integrated into the existing social activities at the community, involving participation of church, tribal, youth, and women leaders.

In 2013, two CSOs working in the three districts will provide education on sexual health, promotion of abstinence/be faithful, pre and post HIV counseling and testing, and education and referral for ante- and post natal care in the context of preventing mother-to-child transmission. Their activities will include protecting the rights of women and girls who tested HIV positive through HCT and PMTCT programs and ensuring adequate support is provided through CSOs for follow-up care, support and treatment services in Papua.

Also in 2013, SUM II will adapt the Resource Estimation Tool for Advocacy (RETA) for Papua by creating a "general population" version. This version will allow inputs of population size estimates for identified sub-populations, such as indigenous women and girls who are being targeted for HIV prevention and care programming, including PMTCT programs in Jayawijaya District. A "general population" version of RETA will function using the same rationale as the original RETA versions: estimating resource needs to scale up HIV services based on population size estimates, HIV prevalence and projections over the coming 5 years, HIV service targets for the coming 5 years, and mapping of available and anticipated resources for the target HIV programs (to

allow estimation of resource gaps). *In 2013, SUM II will expand to Papua two technologies that will support program evaluation, including the PMTCT activities described above. CommCare Mobile and Epi info 7, already introduced in DKI Jakarta and soon-to-be in East Java, will enable "real-time" reporting by field workers and eliminate the data entry task at the CSO office (see Strategic Information below).*

Implementing Mechanism Details

Mechanism ID: 14157	**Mechanism Name: KINERJA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Research Triangle International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 300,000	
Funding Source	**Funding Amount**
GHP-USAID	300,000

Sub Partner Name(s)

New Partner	Social Impact	

Overview Narrative

KINERJA is a project of USAID's Democratic Governance Office, to improve government service programs. Expansion to Papua began in 2012 through modification of the existing CA. In Papua, KINERJA works with local government to improve the quality of health service delivery, including improved resource allocation for priority health issues, including HIV. It addresses the demand, as well as the supply side, of service delivery and intends to strengthen accountability mechanisms, enabling local governments to better respond to citizens' needs. KINERJA will coordinate health systems strengthening and health governance interventions with other USAID-funded projects for TB and MCH. KINERJA objectives in Papua are to develop and ensure the capacity of local governments to deliver effective, safe, quality health services with a minimum waste of resources while promoting (a) an enabling policy environment within the provincial health systems, (b) governance that results in a

relevant, responsive, health system, and (c) the substantive engagement of CSOs.
KINERJA is designed to support the interventions of a range of health priorities, including HIV and TB/HIV interventions. Cost efficiencies will be achieved through close planning, target-setting and collaboration with the other USG implementing partners and programs that will streamline advocacy efforts, reinforce the disease-specific efforts of each program, and create a more efficient approach in Papua.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	51,000
Human Resources for Health	249,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14157**		
Mechanism Name:	**KINERJA**		
Prime Partner Name:	**Research Triangle International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	300,000	0

Narrative:

Papua has the highest per capita prevalence of HIV/AIDS in Indonesia – fifteen times more than the national average. The epidemic is most serious in Papua Province, with unprotected sex the main mode of transmission. In a province-wide, population-based survey in 2006, adult HIV prevalence in Papua was estimated at 2.4%, reaching 3.2% in the remote highlands, and 2.9% in less-accessible lowland areas. Government capacity to make good

choices about how to allocate available funding and deliver the appropriate health services is very limited, with major gaps in service delivery, including absenteeism in health centers, limited access to services and commodities, and failure to fully utilize available local and national government funding for health and HIV services. Papua's poor health indicators are not only a serious humanitarian challenge, but also undermine the overall development of Papua.

The expansion of the Kinerja project to Papua will serve as the foundation for a more comprehensive approach by USG to build local government capacity to plan for and deliver critically needed services, to have a positive impact on health indicators. Kinerja will strengthen health governance and systems in support of the range of health investments by USG, including the SUM project and grantee CSOs, TB, and MCH activities.

Kinerja activities will be directed at the Health System Strengthening (HSS) program element, to improve the provincial and district governments' commitment to providing quality services to communities where there HIV/AIDS is prevalent. The Kinerja Papua funding from PEPFAR is combined with maternal child health and TB funding from USAID for an integrated approach to health system building.

The objectives of the activities will be to develop and ensure the capacity of local governments to deliver effective, safe, quality personal and non-personal health interventions with a minimum waste of resources while promoting (a) an enabling policy environment within the provincial health systems, (b) governance that results in a relevant, responsive, health system, and (c) the substantive engagement of civil society.
• Strengthening capacity of District Health Office and district health facilities' staff in participatory planning, budgeting, professionalism (service excellence)
• Providing/increasing access to information and participation to public
• Establish/Strengthening compliant handling mechanisms in district health facilities' level
• Strengthening accountability of the service units
• Awareness raising in the civic (including reproductive rights, consumers rights) rights so the public can demand for better services
• Improving citizens engagement in the planning and monitoring of public services through multi stake holder forum including media
• Improve access to successful practices in public service delivery.

Implementing Mechanism Details

Mechanism ID: 14355	**Mechanism Name: Supply Chain Management TBD**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement

Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHP-USAID	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TBD will work with local government in Papua and West Papua to develop stronger systems on clinical and laboratory management, and to improve the Supply Chain Management systems and improve ARV management at provincial and site levels as well as other HIV commodities. In particular, the focus of this mechanism is to provide support to the West Papua government for decentralization of ARV management and ensure that a supply chain for ARVs is in place. TBD will work with Provincial and District governments in West Papua to make ARVs more available and to conduct training for accurate ARV recording, reporting, and inventory control, forecasting and management. Provincial decentralization of ARV management has shown to be an effective strategy to decrease stock outs at site levels and to create provincial ownership and accountability to accurate ARV recording, reporting and ordering. TBD will also work with GoI in the decentralization of ARVs to improve timeliness and accuracy of reporting and inventory management at the site level.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14355		
Mechanism Name:	Supply Chain Management TBD		
Prime Partner Name:	John Snow, Inc.		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	200,000	0

Narrative:

The health service situation in Papua is characterized by insufficient public infrastructure, inadequate human resources for health, poor socio-economic development, limited health service facilities and weak supply chain for critical drugs and supplies.

In the remote and rural provinces of Tanah Papua, the vast majority of those with HIV live far from health services, and health facilities are often functioning poorly. Geographic isolation contributes to the high cost of living in Papua and has significant impact on all aspects related to hospital and health center operations. There are only two hospitals in the highlands region of Papua Province, with a catchment area of 1.6 million people. Both are inaccessible to many in the region. Puskesmas (health centers) often lack appropriate human resources, laboratory capacity, or essential diagnostics and drugs necessary for management of HIV and other major communicable and non-communicable diseases. In addition, one third of the puskesmas in the Highlands can only be reached by air or days of walking.

To improve the issue of access to services in these remote and rural provinces, USG will provide funding to TBD in coordination with other USG and AusAID funded activities in Papua and West Papua to work with both hospitals and puskesmas level in Tanah Papua to develop stronger systems for clinical and laboratory management, data collection, quality assurance, and appropriate referral pathways, a strong hub will be established at each hospital to support decentralization of services to the puskesmas. The program will strengthen STI, TB, and ANC services at the puskesmas and poskesdes levels in selected districts in an effort to improve HIV case detection and strengthening the provision of diagnostic and treatment services.

TBD will work with Provincial and District government in West Papua to decentralize ARV management and to conduct training for accurate ARV recording, reporting, and inventory ordering and management. TBD will also partner with GoI in decentralization of ARV to improve timeliness and accuracy of reporting and inventory

management.

Implementing Mechanism Details

Mechanism ID: 14427	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17006	**Mechanism Name: Surveillance/monitoring and evaluation technical assistance**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Public Health Institute	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 858,387	
Funding Source	**Funding Amount**
GHP-USAID	858,387

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Strengthening strategic information in Indonesia is a major focus for PEPFAR/Indonesia. This focus, in support of the National HIV/AIDS Strategy and Action Plan for 2010–2014, will be implemented by providing TA and capacity building to the MOH and the Central Bureau of Statistics in support of an integrated bio-behavioral surveillance on HIV (iBBS) and size estimations among key populations and NAC and by providing support to the NAC for monitoring and reporting on the impact of the HIV/AIDS program.

PEPFAR/Indonesia will support dedicated technical assistance to two of our key GOI partners for strategic information/monitoring and evaluation capacity building.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	171,677

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**17006**
Mechanism Name:	**Surveillance/monitoring and evaluation technical assistance**
Prime Partner Name:	**Public Health Institute**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	858,387	0

Narrative:

A senior surveillance advisor at will be placed at the MOH with to strengthen the national and mentor MOH. A second senior advisor will provide on-going TA to NAC to strengthen the capacity of NAC to effectively manage the performance of grant awardees, to gather and analyze data for decision-making and policy development for HIV/AIDS strategies at the national and sub-national levels, and to provide TA and guidance to implementing partners, including the provincial and district level NAC offices.
Both of these USG-funded positions within GOI institutions will foster the implementation of sustainable, country-led approaches to understand, respond, and monitor the Indonesia HIV epidemic through improved surveillance and M&E. It is expected that these advisors will mentor staff and build capacity in each institution and remain in place for two or three years.

In 2012 USAID/Indonesia signed a limited scope grant to the National AIDS Commission (NAC) for $6

million over five years. The purpose of the grant is to strengthen the capacity of NAC to act as the leader in the planning and implementation of HIV/AIDS prevention activities nationwide, and to ensure that U.S. support for HIV/AIDS prevention in Indonesia is coordinated with activities undertaken by the Government of Indonesia (GOI) and other bilateral donors. To ensure that NAC can provide technical leadership to the GOI for strategic planning and monitoring changes in the epidemiology of the disease, USAID proposes to place a Monitoring and Evaluation (M&E) Fellow at the NAC.

The M&E Fellow will provide on-going technical assistance to the NAC to strengthen the capacity of NAC to effectively manage the performance of grant awardees, to gather and analyze data for decision-making and policy development for HIV/AIDS strategies at the national and sub-national levels, and provide technical assistance and guidance to implementing partners, including the provincial and district level NAC offices.

The M&E Fellow will be located at the NAC offices in Jakarta, provide on-going mentoring of NAC M&E staff, and lead the design of standardized monitoring and reporting tools for NAC to monitor the performance of grants under IPF, and report on program performance and the contribution of approaches to stakeholders and donors, including the Global Fund to Fight AIDS, TB and Malaria (GFATM) and USAID.

Implementing Mechanism Details

Mechanism ID: 17032	**Mechanism Name: FHI 360**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 150,000	
Funding Source	**Funding Amount**
GHP-State	150,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goals in requesting technical assistance from Family Health International (FHI360) for Indonesian National

Armed Forces (Tentara Nasional Indonesia,TNI) are: 1) to strengthen the HIV prevention strategy, 2) to strengthen HIV care services at district and sub-district levels, and 3) to strengthen the Strategic information (SI) system in the Ministry of Defense (MOD) and TNI through recording and reporting. These goals are in line with the objectives of the Indonesia PEPFAR Strategy, especially in improving the effectiveness of interventions and sustainability of activities by local government and non-governmental partners.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	10,000
Human Resources for Health	85,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Military Population

Budget Code Information

Mechanism ID:	**17032**		
Mechanism Name:	**FHI 360**		
Prime Partner Name:	**FHI 360**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	20,000	0
Narrative:			
Activities: • Continue to provide TA for continuum of care and PWP			

Technical assistance focusing on the continuum of care and prevention with positives (PWP) will scale up care services, clinics, and community program for people living with HIV/AIDS (PLHIV) at the district and sub-district levels. Activities under this HBHC funding will increase the coverage of HIV testing and counseling, and improve care, support and treatment access for military personnel and their dependents who have received HIV-positive test results.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	35,000	0

Narrative:

Activities:
• Provide TA from district to province level to TNI structure officers on reporting and recording of data.
• Provide TA to higher raking officers to read, and analyze in using the available data.

With a lack of knowledge and understanding within the TNI senior officers regarding data reporting and recording, this advocacy workshop will give TNI senior officers to a comprehensive understanding of data reporting and recording and the importance of data, provide support to TNI in obtaining accurate data, and to implement strategic data analysis. The workshop will involve both health sectors and commanders. This HVSI funding will strengthen TNI's systems for the reporting and recording of HIV/AIDS data for prevention and health services (HTC and HIV care). The program will focus on 3 provinces in Riau island, East Java and Papua.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	10,000	0

Narrative:

Activities under HVCT will provide technical assistance on Provider-Initiated Testing and Counseling (PITC) in order to strengthen the testing and counseling program of the Indonesian military.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	65,000	0

Narrative:

Activities:
• Develop and executive IEC material specifically for the TNI high ranking troops.

Under HVOP, FHI 360 will focus on strengthening prevention programs in Riau Island, East Java and Papua. The support will include Peer Leader (PL) activities at the battalions' level, implementation of group discussion sessions, and edutainment activities to promote prevention programs and health services in different ways. Each province will receive two sets of Peer Leader edutainment activities, which will take place in two different cities with two different forces.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	20,000	0

Narrative:

Activities:

• Review of current training materials

• Conduct Opportunistic Infections (OI)/tuberculosis (TB) workshops in three focus provinces

Under HTXS, FHI 360 will scale up care services of OI/TB in district and sub-district through OI/TB workshops. The OI/TB workshop will increase the knowledge of health care workers and strengthen the health care service provided by TNI hospitals. The focus area will be in Rau Island.

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services			4,229	4,229
ICASS			65,350	65,350
Management Meetings/Professional Developement			17,910	17,910
Non-ICASS Administrative Costs			280,562	280,562
Staff Program Travel			24,571	24,571
USG Staff Salaries and Benefits			282,378	282,378
Total	**0**	**0**	**675,000**	**675,000**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-USAID		4,229
ICASS		GHP-USAID		65,350
Management Meetings/Professional Developement		GHP-USAID		17,910
Non-ICASS Administrative Costs		GHP-USAID		280,562

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Computers/IT Services		50		50
ICASS		27,000		27,000
Non-ICASS Administrative Costs		4,024		4,024
Staff Program Travel		18,926		18,926
USG Staff Salaries and Benefits		23,000		23,000
Total	**0**	**73,000**	**0**	**73,000**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHP-State		50
ICASS		GHP-State		27,000
Non-ICASS Administrative Costs		GHP-State		4,024