UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

USAID

JAKARTA

ACTION MEMORANDUM FOR THE DEPUTY MISSION DIRECTOR

DATE: April 23, 2002

FROM: Molly Gingerich, Director
Office of Health, Population and Nutrition (HPN)

SUBJECT: Assistance Completion Report (ACR)
HIV/AIDS Prevention Project (HAPP)
Project No. 497-0380
Approval for *HAPP* Close Out

TO: Sharon Cromer, Deputy Mission Director

Action Requested:

It is requested that you approve close out of the *HIV/AIDS Prevention Project (HAPP)*, Project No. 497-0380, and approve the change in activity status from "active" to "completed".

Background:

In 1995, USAID/Indonesia assisted the Government of Indonesia (GOI) in launching its National AIDS Prevention Program, through the five-year bilateral *HIV/AIDS Prevention Project (HAPP)*. *HAPP* was a $27 million activity jointly funded by USAID ($21 million) and the GOI ($7 million), originally under a Project Grant Agreement, which later was replaced by a Strategic Objective Agreement between the GOI and USAID/Indonesia for Health and Reduced Fertility. The *HAPP* completion date was 30 September 2000.

The USAID grant funds were channeled through:

- A FHI/AIDSCAP buy-in delivery order (1995 -1997) and a FHI performance based contract with USAID/Indonesia (1997-2000) for technical assistance, training, commodities, operational costs and intervention activities;
- A Participating Agencies Service Agreement (PASA) with CDC/Atlanta to provide short- and long-term technical assistance in preventing and managing Sexually Transmitted Infections (STIs); and

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- Direct funding to the Ministry of Health (MOH) through Project Implementation Letters (PILs) for the development of training modules, training for MOH staff, workshops and supervision activities.

The GOI counterpart contribution funds were used for central and provincial STI/HIV/AIDS prevention activities, including technical assistance, drugs and laboratory services.

The overall goal of *HAPP* was to reduce the rate of HIV transmission in order to promote the general health and economic well being of people in Indonesia. *HAPP's* purpose was to facilitate the development and initial implementation of policies supportive of HIV/AIDS control based upon the documented effectiveness of interventions which reduce HIV transmission in three demonstration areas (North Jakarta, Surabaya and Manado/Bitung). In these three demonstration areas, *HAPP* worked with national and local governments, non-government organizations (NGOs) and universities. *HAPP* was an integrated project comprised of four primary technical components: (1) Policy support and dissemination; (2) Information, education and communication (IEC) for behavior change; (3) Improved management and control of HIV and STIs; and (4) Expanded access to and the promotion of condoms. The *HAPP* interventions focused on high-risk behavior populations, including female sex workers (FSWs) and their clients, and transvestites (waria) through partnerships with NGOs.

Budget:

All the financial responsibilities for both USAID/Indonesia and the GOI were completed under *HAPP*, including residual disbursements, de-commitments, and contract close-outs.

Budget Summary:

Total Obligation (Grant)	$21,000,000
Total Commitment and Expenditures:	$18,863,934
Total funds decommitted/deobligated:	$ 2,136,066
Budget Host Country Contribution (HCC)	$ 7,000,000
HCC reported through September 30, 2000:	$ 8,426,434

Highlights of *HAPP* Achievements:

1. *HAPP*'s IEC/ Behavior Change Communication (BCC) two-pronged strategy promoted health services for STI control and condom use promotion through NGO outreach activities. More than 23,000 units of IEC materials were produced and distributed through outreach activities. Knowledge of acceptable ways to prevent HIV transmission among female sex workers (FSWs) increased from 70% in 1996 to 86% in 2000, and among male respondents increased from 76% in 1996 to 88% in 2000. The percentage of FSWs reporting condom use slightly increased from 36% in 1997 to 41% in 2000, and among high-risk males increased from 14% in 1996 to 22% in 2000.

2. In collaboration with the Futures Group International (TFG), *HAPP* developed a strategy to utilize commercial resources for the social marketing of condoms (SMC). Condom distribution and use was expanded through collaborative activities with the private sector condom consortium (Durex, Simplex, and Artika) to strengthen their promotion of brand name condoms through a variety of mass and print media. Commercial distributors hired sales team to distribute condoms among target groups, and special events for targeted audiences were managed to expand the availability of condoms in the three demonstration areas. Distribution penetration for condoms in red light areas in the three demonstration areas increased from 37% in 1996 to 65% in 2000.

3. Key public hospitals, health centers and family planning clinics were upgraded to provide comprehensive STI services, including STI counseling, and improved STI diagnosis/treatment using syndromic guidelines and simple lab testing. As appropriate, the integration of STIs and family services was encouraged. Beneficiaries (sex workers, sailors, truck drivers) liked these clinics because they were affordable, accessible, and provided quality services. Private practitioners (doctors and midwives) were trained to use STI syndromic guidelines. Central and provincial laboratories were upgraded to support epidemiological and clinical research on STIs and HIV/AIDS. The percentage of patients (high risk) correctly diagnosed and increased for STIs at *HAPP* upgraded facilities increased from 8% in 1996 to 48% in 2000. Universal Precaution guidelines for health centers were strengthened and standardized through a process involving the East Java Department of Health.

4. In collaboration with other donors and partner organizations, HIV serological and behavioral surveillance surveys (BSS) were conducted annually. The results were used to measure behavioral trends overtime, and were utilized by the MOH and World Bank for the 2000 national HIV/AIDS programming review and planning. AusAID adopted the same BSS system to conduct surveys in Makasar and Denpasar. The expanded use of behavior surveillance facilitated the comparison of behavioral data across sites in Indonesia.

5. An important focus of HAPP was to encourage collaboration among national and provincial government offices on the issue of HIV/AIDS prevention and control, as well as to strengthen the capacity of local partners to manage HIV/AIDS interventions. *HAPP* supported and encouraged the Provincial AIDS Commissions (KPAD) in the three demonstration areas to promote a greater interagency and community involvement in HIV/AIDS prevention and advocacy activities. *HAPP* strengthened the role and functioning of the KPAD by assisting the establishment of a working secretariat, hiring full-time staff, and enabling coordination between the KPAD and the *HAPP* partners.

6. In April 2000, *HAPP* established a foundation for future prevention strategies by reporting the changing patterns of HIV transmission and supporting an assessment of HIV risk among injecting drug users (IDU) in collaboration with UNAIDS, WHO and AusAID, in eight cities in Indonesia.

Lessons Learned

1. Experience with the HAPP Performance Based Contract has demonstrated two critical lessons required in the implementation of a challenging public health program such as HIV/AIDS. One is the issue of contract flexibility. An HIV/AIDS activity must react to an evolving epidemiological environment requiring flexibility, opportunities for innovation, and rapid responses. (See Attachment 11, External Assessment of USAID/Indonesia's HIV/HIV Program, page v). A Cooperative Agreement or Grant Agreement contracting mechanism provides increased options for activity changes. Secondly an HIV/AIDS prevention activity, involving major behavior change initiatives can not be implemented in a short time frame, such as a period of three years. Consideration should be given to allow for sufficient activity implementation to allow for sustained and effective behavior change among the beneficiary populations. (See Attachment 9, A Critique of the Performance Base Contract).

2. Quality communication and counseling skills are essential to successful outreach interventions. Focused training and capacity building on the development and utilization of appropriate IEC materials is crucial for effective behavior change interventions. The continued use of mass and print media and peer education approaches with female and male sex workers and their clients, transvestites, men who have sex with men, injecting drug users, and other high-risk population groups is highly encouraged.

3. Effective campaigns must be sensitive to religious and cultural issues while also targeting the myths and stigma attached to AIDS and condoms. The concept of protection is the strongest reason given by clients for purchasing condoms.

4. Although the knowledge of acceptable ways to prevent HIV transmission among FSWs and their clients was quite high, condom use among these vulnerable groups remained low. This was probably a result of several factors, including insufficient emphasis on outreach to male clients, and the difficulties associated with trying to reach highly mobile population groups (both FSWs and mobile men) through outreach education and condom promotion activities.

5. STI syndromic management remains a useful approach for the diagnosis and treatment of STIs in men, however, it is less useful for the screening, diagnosis and treatment of women, due to the fact that women exhibit few STI symptoms. Improved STI management includes the syndromic approach accompanied by a simple testing, counseling and referral system for vulnerable groups.

6. Not only is it important that the GOI's surveillance data are comprehensive, but it is also important that the surveillance process is transparent so that the surveillance data are perceived to be reliable. Resolving these issues and making the necessary changes to the STI/HIV surveillance systems to ensure quality standards are critical areas for USAID support. Programs to improve the monitoring of HIV and STIs should include the integration of serological and behavioral surveillance, as well as the

analysis and use of the data for both local and national policy development and decision-making.

7. Both the national and local-level AIDS commissions serve an important role in HIV/AIDS policy-making and programming across the country. These commissions serve as a "community" forum involving government, political, civil society and religious leaders in making political and budgetary commitments to HIV/AIDS prevention and control. Long-term technical assistance and support to the national and local AIDS commissions are needed from the donor community to ensure organizational development and strengthening.

8. In order to maximize the use of limited local and donor resources for HIV/AIDS, it is critical that local government and civil society organizations manage planning and coordination early on in the implementation process.

Constraints

1. A devastating economic and political crisis has affected Indonesia since July 1997 and has resulted in a health crisis for vulnerable populations across the country. It is believed that Indonesia 's health crisis will accelerate the spread of STIs, including HIV. With an on-going economic crisis, the GOI's ability to provide adequate counterpart funds for HIV/AIDS and STIs is threatened. This, combined with a changing political situation, has affected current and future donor support to the sector. The limited numbers of donors active in the sector have presented plans to cut contributions to the national HIV/AIDS program. This, compounded with the impact of the economic crisis on family income, employment, and purchasing power directly impacts Indonesia's ability to prevent and control STIs and HIV/AIDS.

2. Limited technical skills and human resource capacity may be the greatest barrier to managing HIV/AIDS program interventions working to reduce risk behaviors. Evidence suggests that time and resource-intensive interventions are required to achieve sustainable behavior change.

3. Simple, cost effective solutions to the diagnosis and treatment of STIs are still lacking for women. Many vulnerable women continue to be ineffectively treated, due to poor treatment-seeking behaviors combined with poor quality STI services and the lack of "user friendly" services, for sex workers and other vulnerable women.

Post Project Assistance Completion Actions

Continued support for HIV/AIDS initiatives in Indonesia is critical at this time. In January 2000 the Mission issued an RFA for an expanded response to HIV/AIDS and STIs as part of the Mission's Strategic Objective Grant Agreement (SOAG) "Protecting the Health of the Most Vulnerable Women and Children". In August 2000 FHI was awarded a three-year, US$ 13.9 million Cooperative Agreement to manage and implement USAID/Indonesia's STI/HIV/AIDS Prevention Support Program, known locally as "*Aksi Stop AIDS" (ASA).* The

program works in partnership with the MOH and local government offices, technical assistance partners, non-government organizations and the private sector.

There are no further actions required under HAPP, except that the HPN office will work closely with OFIN and PRO offices to expedite the de-obligation/re-obligation of the remaining budget, and request approval from USAID/Washington to reprogram the remaining funds to the ASA Program. All required final reporting from FHI and CDC/Atlanta have been submitted. The documentation of disposal of all non-expendable commodities have been submitted and approved by USAID/CM.

Authority: Pursuant to ADS 202.3.8, regarding "Activity Completion Reports", approval is required for closing out assistance and changing activity status from "active" to "completed". Mission Order No. 300.8 gives the authority to the Mission Deputy Director to authorize activity close out.

Recommendation: That you approve this request to close *HIV/AIDS Prevention Project (HAPP)* and to change activity status from "active" to completed".

Approved: _____

Sharon Cromer
Deputy Mission Director

Disapproved: _____

Sharon Cromer
Deputy Mission Director

Date: 4/24/02

Attachments:

1. Strategic Objective Grant Agreement, No. 497-0380, dated August 19, 1998, between the Republic of Indonesia and the United States of America for Health and Reduced Fertility
2. HAPP Completion Report, 1997-2000, dated September 29, 2000

3. USAID Performance Evaluation and Award Fee Determination Report for FHI, dated May 21, 2001
4. USAID Final Contract Performance Report for FHI, dated March 6, 2001
5. USAID Contract Close-out Completion Statement for FHI, dated September 27, 2001
6. PASA/CDC Close Out- Completion Statement, dated May 25, 2001
7. Project Implementation Letter No. 9 for de-commitment excess funds, dated April 11, 2001
8. Final Host Country Contribution Report, dated September 20, 2000
9. A FHI critique of the Performance Base Contract, dated February 26, 1999
10. USAID Financial Status Report, dated March 21, 2002
11. External Assessment of USAID/Indonesia's HIV/AIDS Program, dated February 1999
12. Contractor's Release a/o Assignment of Refund, Rebates, Credits, and other amounts, dated April 22, 2002

ATTACHMENT 1

USAID GRANT AGREEMENT NO. 497-0380

AMENDMENT NO. 1 TO
STRATEGIC OBJECTIVE GRANT AGREEMENT
BETWEEN THE
REPUBLIC OF INDONESIA
AND THE
UNITED STATES OF AMERICA
FOR
HEALTH AND REDUCED FERTILITY

Dated: August 19, 1998

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Dated: August 19, 1998

This AMENDMENT NO. 1 TO STRATEGIC OBJECTIVE GRANT AGREEMENT, dated August 26, 1997, (the "Agreement") which was created by amending the Project Grant Agreement for the HIV/AIDS Prevention Project originally dated March 28, 1995, is entered into between the REPUBLIC OF INDONESIA ("Grantee") and the UNITED STATES OF AMERICA, acting through the U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT ("USAID").

WHEREAS, the Grantee and USAID ("Parties") entered into the Strategic Objective Grant Agreement, whereby USAID agreed to grant to the Grantee a total amount not to exceed U.S. $20,000,000;

WHEREAS, at that time, USAID provided an increment of U.S. $5,740,000, bringing the total obligations to date to U.S. $15,770,000;

WHEREAS, the Parties now desire to increase the total amount of the grant to U.S. $21,000,000, and provide an additional increment of USAID funding of U.S. $5,230,000, bringing the total amount of obligations to date to $21,000,000;

NOW, THEREFORE, the Parties hereby agree as follows:

1. Section 2.3 Annex 1, Amplified Description of the Strategic Objective Grant Agreement is hereby deleted, substituting therefore the Revised Annex 1 attached to this Amendment No. 1. The Revised Annex 1 may be changed by written agreement of the authorized representatives of the Parties without formal amendment of this Agreement.

2. The first sentence in Section 3.1(a) of the Grant Agreement is revised to read as follows:

The Grant. To help achieve the Objective set forth in this Agreement, USAID, pursuant to the Foreign Assistance Act of 1961, as amended, hereby grants to the Grantee under the terms of the Agreement an additional increment of not to exceed U.S. 5,230,000, bringing the total obligation to date to Twenty One Million United States ("U.S.") Dollars ($21,000,000) (the "Grant").

3. The first sentence in Section 3.1(b) of the Grant Agreement is revised to read as follows:

Total Estimated USAID Contribution. USAID's total estimated contribution to achievement of the objective will be U.S. $21,000,000, which will be provided in increments.

Except as amended herein, the Grant Agreement is unchanged, and, as amended, remains in full force and effect.

IN WITNESS WHEREOF, the Republic of Indonesia and the United States of America, each acting through its duly authorized representative, have caused this amendment/Strategic Objective Grant Agreement to be signed in their names and delivered as of the day and year first above written.

UNITED STATES OF AMERICA

Barbara J. Spaid
Director
Office of Population,
Health & Nutrition (PHN)

REPUBLIC OF INDONESIA

MINISTRY OF HEALTH REPUBLIC OF INDONESIA

Dr. E. Sutarto, SKM
Secretary General
Ministry of Health

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The Grant. To help achieve the Objective set forth in this Agreement, USAID, pursuant to the Foreign Assistance Act of 1961, as amended, hereby grants to the Grantee under the terms of the Agreement an additional increment of not to exceed U.S. 5,230,000, bringing the total obligation to date to Twenty One Million United States ("U.S.") Dollars ($21,000,000) (the "Grant").

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Except as amended herein, the Grant Agreement is unchanged, and, as amended, remains in full force and effect.

IN WITNESS WHEREOF, the Republic of Indonesia and the United States of America, each acting through its duly authorized representative, have caused this amendment/Strategic Objective Grant Agreement to be signed in their names and delivered as of the day and year first above written.

REPUBLIC OF INDONESIA

E. Sutarto, SKM
Secretary General
Ministry of Health

UNITED STATES OF AMERICA

Barbara J. Spaid
Director
Office of Population,
Health & Nutrition (PHN)

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AMPLIFIED DESCRIPTION

I. INTRODUCTION

This annex describes the results to be achieved and activities undertaken with funds obligated under this Agreement. It also describes the larger strategy and objectives of which this Agreement is a key element, as well as related results and activities not funded by this Agreement. This Agreement continues activities funded under the HIV/AIDS Prevention Project (HAPP), Project Agreement 497-0380, and identifies clear results that are expected to be achieved as part of USAID's new strategy for fostering sustainable improvements in health and reduced fertility, and reflects a new orientation to programming for results. The activities funded by this agreement focus on the HIV/AIDS objective of USAID's strategy, designed to increase the use and quality of sexually transmitted infection (STI)/HIV/AIDS prevention programs and develop sound policies. This program will continue to be known as the HIV/AIDS Prevention Project (HAPP).

A. Problem

Over the past 25 years, Indonesia has made impressive progress in improving health and reducing fertility. Fertility has declined from 5.6 births per woman in 1971 to 2.9 in 1994, due largely to an increase in contraceptive use. Infant mortality has declined from 142 per 1000 live births in 1971 to 57 per 1000 in 1994. Considerable progress has also been made in establishing sustainable programs and institutions for delivering health and family planning services. Indonesian institutions have a depth of technical and managerial capability and are models for countries around the world.

However, significant challenges remain, particularly in addressing STIs including HIV/AIDS. The global HIV/AIDS epidemic may be at a critical stage in its evolution in Indonesia, and may have entered the exponential growth phase. While only a few cases of HIV infection and of AIDS have been officially reported, some analyses have projected that the number of HIV infections may be anywhere between 300,000 and 600,000. Several factors known to facilitate the rapid spread of the virus are present in Indonesia. An extensive commercial sex industry caters to large numbers of mobile, male workers -- many of whom are from countries with very high HIV prevalence. High rates of STI prevalence have also been found among groups whose behavior places them at increased risk for contracting the virus. 1996 data show a 40% prevalence rate of STIs among commercial sex

workers in Jakarta and Surabaya. In addition, limited survey results have indicated that high rates of STIs might be appearing among the general population as well: data collected in a small survey from six reproductive health clinics in North Jakarta indicate an STI prevalence rate of 29% among low-income, married women. Prevalence of STIs is very closely associated with vulnerability to HIV infection; research has shown that the risk of HIV transmission is five to 20 times higher in the presence of another STI.

In 1994, a National AIDS Strategy for Indonesia was developed, and the President issued a decree establishing a multi-sectoral National AIDS Commission. The national strategy and the Presidential decree represent the starting point of a concerted effort to respond to HIV/AIDS in Indonesia. With the assistance of several multinational and bilateral donors, the Government is preparing to implement a coordinated and comprehensive STI/HIV/AIDS intervention program. With prompt and appropriate action, Indonesia could be in a position to greatly limit the impact of HIV/AIDS on national development. However, if prevention activities are not greatly accelerated now, Indonesia could experience the rapid epidemic spread that has occurred in other countries in Asia and the developing world. While the Government of Indonesia has recently acknowledged that HIV/AIDS is a potential problem, the integrated, coordinated effort needed to implement the National Strategy is not yet fully operational. This is partly due to incomplete knowledge of effective HIV/AIDS prevention strategies, and partly due to divergent views on what responses are possible and appropriate within the Indonesian political, social and religious context. The policy environment surrounding HIV/AIDS is dynamic, but emergent.

Institutional and organizational capacity to respond to HIV/AIDS is clearly in incipient stages. Information about HIV/AIDS and other STIs, high quality STI diagnosis and treatment services, and counseling services for risk reduction and vulnerable populations are not yet widely available. Knowledge and awareness of STI/HIV/AIDS is highly variable, and often extremely low among groups who consistently practice high risk behaviors, among groups who are vulnerable to contracting the virus through their regular partners, and within the general population. At the same time, community support for risk reduction is lacking. Public and private sector health care providers are just beginning to have access to STI/HIV/AIDS training. It is still problematic to market condoms for disease prevention, and demand for condoms is very low. Both donors and the GOI will likely look to NGOs to take the lead in providing outreach education. While several NGOs have successfully carried out intervention activities and a few are self-reliant, they require continued support to develop sufficient financial and technical expertise in HIV/AIDS programming.

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B. Background

In March 1995, the Ministry of Health and USAID signed a Project Grant Agreement for the HIV/AIDS Prevention Project (HAPP). HAPP is currently being implemented through three financing mechanisms: reimbursement to the Government of Indonesia for local contracts and other activities; a Participating Agency Service Agreement (PASA) with the U.S. Centers for Disease Control for STI technical advisory services; and a contract with Family Health International (FHI) for technical advisory and management services.

During the first two years of HAPP, considerable progress was made in effectively launching the program. HAPP offices were established in all three demonstration areas -- Jakarta, Surabaya and Manado, and activities with NGOs and implementing partners in all three areas are underway. Baseline data were collected for all indicators, several important policies were approved by the National AIDS Commission, and the GOI doubled its budget for HIV/AIDS activities.

In addition to activities under HAPP, USAID supported a cooperative agreement with PATH (1993-1997) under the AIDS Initiative Project (AIP) to implement HIV/AIDS prevention and NGO strengthening services in seven locations throughout Indonesia, including Irian Jaya. USAID is continuing to provide support to the AIDS Initiatives in Irian Jaya Project (AIIJP) through PATH, which extends AIDS prevention interventions in Irian Jaya initiated under the AIP project, targeted at high risk groups, and channeled through local NGOs in collaboration with the Provincial AIDS commission. The Enabling Private Organizations to Combat HIV and AIDS (EPOCH) program, implemented through a grant to Project Concern International and in partnership with Private Agencies Collaborating Together (PACT), provided funding to NGOs working at the grassroots level in Jakarta, Surabaya and Bali.

In 1995, as part of an Agency-wide effort to focus programming on achieving results rather than inputs, USAID redefined its overall strategy in Indonesia to concentrate on five strategic objectives, one of which is to contribute to sustained improvements in health and reduced fertility. Strategic objectives are broader in scope than projects previously had been, and provide a mechanism for ensuring that activities work together toward a common purpose, and that all activities supported by USAID contribute to specified objectives. Results necessary for achieving objectives are identified, and activities necessary for results are grouped into results packages. HAPP and related activities for HIV/AIDS prevention are included in one of three results packages contributing to USAID's objective of sustaining improved health and reduced fertility. The program under this Agreement, also known as the HIV/AIDS Prevention

Project (HAPP), continues the program launched under the original Project Grant Agreement and related activities, and encompasses all activities under this results package: RP 2.2, "Increased use and quality of effective STI/HIV/AIDS prevention programs and sound policies developed."

Strategic objective agreements have replaced most of USAID's project agreements with the Government of Indonesia in other areas as well, providing a more comprehensive approach to joint efforts. This agreement provides a more comprehensive articulation of the synergistic relationships among all activities supported under USAID's strategic objective of sustained improvements in health and reduced fertility.

II. STRATEGIC OBJECTIVE AND INTERMEDIATE RESULTS

USAID's agency wide strategic goal in health and population is to protect human health and stabilize world population. This goal encompasses four areas for the Agency's entire health and population portfolio worldwide: reducing unintended pregnancies; reducing child mortality; reducing maternal mortality; and reducing transmission of STIs/HIV/AIDS. USAID's strategic objective in Indonesia is sustained improvements in health and reduced fertility, and focuses on three of the four Agency objective areas. Key to the objective in Indonesia is the notion of sustained improvements, reflecting the transition nature of USAID's program in this area and concern with sustainability.

Success in achieving the overall strategic objective will be measured by: (1) a reduction in the total fertility rate; (2) an increase in the proportion of births attended by trained personnel; (3) a reduction in the STI prevalence rate among high risk populations in demonstration areas; and (4) effective replication of the Klaten integrated health care reform/managed care model in at least five provinces.

A. Agreement Results

This Agreement is the primary vehicle for achieving one of three intermediate results contributing to USAID's strategic objective: increased use and quality of STI/HIV/AIDS prevention programs and sound policies developed. The other two intermediate results are closely related, but funded outside this Agreement.

Success pertaining to this Agreement and the result of increased use and quality of STI/HIV/AIDS prevention programs and sound policies developed will be measured by the following indicators:

1. Increase in the adoption of risk reduction strategies in relationships by those at risk in demonstration areas from a baseline of 36% to 65% by the year 2000.

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2. Increase in the percentage of people at high risk correctly diagnosed and treated in STI clinics in demonstration areas from a baseline of 9% to 70% in the year 2000.

3. Increase in the knowledge of prevention practices among the population in demonstration areas from a baseline of 71% to 80% by the year 2000.

4. Increase in the number of National AIDS policies developed from one to seven between 1994 and 2000.

5. Increase in the amount of national health resources allocated to STI/HIV/AIDS activities from $2.5 million in 1996 to $10 million in the year 2000.

Attachment A includes tables identifying annual targets for each of these indicators.

B. Related results

One of the other three results in USAID's strategy for population and health is increased use, quality and sustainability of family planning and other reproductive health services. Achievement of this result will be measured by an increase in contraceptive prevalence; an increase in the proportion of contraceptive users served by the private sector; and an improvement in maternal health indicated by increased referral of and reduction in obstetric complications, and increase in the proportion of pregnant women consuming iron supplementation; an increased proportion of services provided through the private sector; and the institutionalization of a National Clinical Training Network.

Specific technical assistance from these U.S. based institutions will be provided to implement this result for family planning and reproductive health: Pathfinder International, the Population Council, Johns Hopkins University Program for International Education in Reproductive Health (JHPIEGO), Johns Hopkins University/Population Communication Services (JHU/PCS), the Future's Group International (POLICY Project), University of North Carolina (International Training in Reproductive Health - INTRAH), Association for Voluntary and Safe Contraception (AVSC), John Snow International (MotherCare Project), Program for Appropriate Technology in Health (OMNI Project), Helen Keller International, (OMNI Project), Macro International (Demographic and Health Survey), and East West Center. Activities are focused to reduce barriers to the availability of long term contraceptives and increase their use; improve quality of care; institutionalize a national clinical training system and introduce competency-based training for essential maternal health and family planning; strengthen BKKBN's capacity for strategic planning; facilitate the role of midwives in reproductive health

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service delivery; and increase and improve the sustainability and service delivery capacity of BKKBN and NGOs such as: IBI, PKBI, NU, Mohammadiya, and IDI. To assist USAID in managing this comprehensive strategy, USAID employs technical advisors through fellowship mechanisms such as: Johns Hopkins Health and Child Survival Fellowship Program, the Public Health Institute Population Leadership Program and the Technical Advisors in AIDS and Child Survival Program

Much of USAID's assistance in this area has supported BKKBN's efforts to expand service delivery capacity at the local level and ensure its long-term sustainability. This expanded capacity at the local level presents powerful opportunities for instituting HIV/AIDS information and prevention programs in conjunction with other health programs at the community level.

The third result in USAID's strategy is to foster **sustainable financing of health services**. USAID has been assisting the Ministry of Health to develop key components of the Health Care Financing Reform Strategy, including the JPKM managed care strategy since 1988 through the Health Sector Financing (HSF) Project. Working with the Ministry of Health's Directorate of Community Health, Division of Community Participation, USAID is supporting a field trial for an integrated health care financing reform model in Klaten, Central Java. Under this model, the population is provided access to a basic benefits package of preventive and curative health care and family planning services at an affordable cost. USAID is providing technical assistance in key areas of health care financing reform, including: market research and strategic planning, development of a reliable regulatory system, improvement in quality of health care services through the practice of standards of care and rational drug use strategies, social marketing to promote increased membership in the program, and sustainable financing strategies. USAID is also supporting loan guarantees through the Microenterprise and Small Business Enterprise Development Program (MSED), operated through private financial institutions in Indonesia, and targeted toward privately owned small businesses such as ambulatory service practitioners, private hospitals, and entities providing management and administrative services to the JPKM schemes. The Project Assistance Completion Date (PACD) has been extended from March 31, 1998 to September 30, 1998 for the sole purpose of continuing long-term technical assistance to the MOH during the start-up of new JPKM management bodies and for the procurement of essential medical supplies to support child survival programs, necessitated by the current economic crisis.

III. PROGRAM ACTIVITIES

A. Overview

Through implementation of the HIV/AIDS Prevention Project, USAID seeks to support Indonesia as a partner in the fight against HIV/AIDS. All HAPP activities will be integrated into the Indonesian National AIDS Program, guided by the National AIDS Strategy and guided by the basic principles of the Indonesian National AIDS Strategy. Therefore, all activities conducted under the HIV/AIDS Prevention Program will:

- be carried out by the community and the government, with community members as primary actors and government in a leadership role. Local technical assistance will be utilized whenever possible.

- be carried out within the context of the cultural and religious norms of Indonesia. In order to accomplish this, HAPP will work collaboratively with the GOI and other religious and community organizations in order to assure that project activities are relevant and culturally appropriate for Indonesia.

- aim to strengthen the resilience and welfare of the family and traditional social support systems rooted in the community.

- focus on IEC to reinforce healthy behaviors and behavior change for those who practice high risk behaviors.

- provide accurate information to enable people to protect themselves and others from HIV infection.

- promote and preserve the dignity and self-respect of all persons affected by the HIV/AIDS epidemic.

- include pre- and post-test counseling and informed consent before any diagnosis is performed.

- support the application of the laws and regulations of the Republic of Indonesia and the National AIDS Strategy.

- provide services to those at risk of HIV/AIDS without discrimination.

HAPP interventions and results will primarily focus on preventing the heterosexual transmission of HIV/AIDS and other STIs, the predominant mode of transmission in Indonesia. This will be accomplished through the implementation of interventions targeted primarily at those whose behavior places them at higher risk of

HIV/AIDS infection. Interventions will include a two-pronged strategic approach: implementation of national-level activities targeted towards the general population and implementation of interventions targeted toward higher risk groups in the HAPP demonstration areas of North Jakarta, Surabaya and Manado.

HAPP is designed as an integrated results package comprised of four primary technical components, as described below: Information, education and communication for behavior change; policy support and dissemination; improved management and control of HIV and other STIs; and expanded access to and promotion of condoms through the commercial sector. In the implementation of the program, activities and interventions developed as part of these four components will be combined to interact and support each other to achieve the specified results.

The Government of Indonesia has recognized the critical role played by all members of society, including the private sector, in the fight against AIDS. As stated in the National AIDS Strategy, "NGOs play an important role and are recognized as full partners in the national HIV/AIDS campaign in Indonesia to reach individuals and groups with special interests and needs... as well as those excluded or unreached by government programs..." The role of the business community is also recognized. The National AIDS Strategy states that "the business community are important partners to accelerate and broaden outreach of HIV/AIDS".

As such, HAPP will collaborate with government agencies, NGOs, universities, community organizations, the private sector and donor agencies to implement activities, mobilize resources, and secure community participation in HIV/AIDS prevention.

It is anticipated that by the end of the program, the Government of Indonesia (GOI) will have implemented a national HIV/AIDS control program; public policy-makers, religious and NGO leaders will have endorsed effective measures to reduce HIV/AIDS transmission; and the GOI and NGOs will have cooperated in the design and implementation of prevention activities.

B. Program Components

Described below are examples of the kinds of activities that will be implemented under each technical component. All activities will support the Indonesian National AIDS Strategy and GOI Five Year Plan of Action. Specific activities to be financed under this Agreement will be agreed upon collaboratively by the GOI HAPP Project Director and USAID/PHN through development of annual HAPP Workplans in order to maintain flexibility to meet changing programmatic needs over the course of the program.

This program has been designed to allow flexible selection and modification of activities over time in order to best achieve the strategic objectives and Agreement results identified above. The emphasis under this program will be on achievement of agreed-upon results, not simply completion of specific activities. Consequently, activities to be financed under this Agreement, such as technical assistance and training, have not been specified in detail in this Annex.

Although the program therefore offers significant flexibility in selecting, suitable activities to be financed under this Agreement, to be eligible for financing hereunder, any technical assistance, training or other activities must (1) contribute to the strategic objective and Agreement results identified above, (2) be supported by cost estimates that are reasonable and reasonably firm, and appropriate analysis and planning, including feasibility analyses, where appropriate, with regard to institutional, technical, financial, social soundness, or other measures of feasibility, and (3) be likely to be completed within the time frame and budget specified in the proposal.

Additional criteria for selection of activities may include customer demand, USAID comparative advantage, previous experience/"lessons learned", sustainability and cost-sharing.

1. <u>IEC for Behavior Change Component:</u>

The purpose of this component is to increase public awareness of transmission and prevention of HIV/AIDS and to motivate people to reduce high risk behaviors. The National AIDS Strategy identifies IEC as a key program area. IEC activities supported under HAPP will be guided by the National AIDS Strategy and will be integrated into the GOI's national IEC program for HIV/AIDS. Therefore, HAPP IEC activities will support the provision of accurate and appropriate information and education about HIV/AIDS and will promote a spirit of mutual support and non-discrimination for persons whose lives are touched by HIV/AIDS.

Experience from other countries has shown that prevention programs must concentrate on curbing the spread of HIV/AIDS by motivating people to improve health-seeking behavior, maintain healthy practices and modify those behaviors which place them at risk. IEC is considered the key to bringing about behavior change at individual and group levels as well as changes in associated social norms. Therefore, the HAPP IEC component will support a two-pronged multi-media approach:

- development of national-level mass-media and training activities to increase knowledge and awareness of transmission and prevention of HIV/AIDS and reinforcement of healthy behaviors, targeted towards the general public.

culturally-appropriate mass media and interpersonal IEC interventions in demonstration areas promoting behavioral change for those whose activities place them at higher risk.

Indonesia has many strengths -- a culture which emphasizes religion, moral values and the family; well-organized community groups which include most members of the society; and an extensive network of broadcast and print media reaching most villages across the archipelago. HAPP will build upon these strengths in the development of IEC activities by reinforcing existing healthy behaviors through efforts to strengthen family resilience and traditional support systems as well as through activities which promote behavior change for those who practice high risk behaviors. The program will support community organizations which are already working with selected target groups in demonstration areas.

2. Policy Support and Dissemination:

The purpose of the policy support and dissemination component of HAPP is to enable decision-makers to adapt and implement effective HIV/AIDS prevention policies at the local, provincial and national levels based on the GOI National AIDS strategy and GOI five year Plan of Action.

Indonesian leaders have already demonstrated a commitment to the fight against HIV/AIDS by issuing a Presidential Decree, establishing a National AIDS Control Commission and developing a National AIDS Strategy and a GOI Five Year Plan of Action for the National HIV/AIDS Prevention Program. The challenge that lies ahead will be the dissemination of the National AIDS Strategy to local, provincial and national leaders, the training of those leaders on the adaptation and implementation of effective policies and programs at all levels based on the GOI Five Year Plan of Action developed from the National AIDS Strategy. HAPP will work collaboratively with national and demonstration area policy-makers involved in the design and implementation of interventions related to the major technical components of this project: STI management, IEC and condom promotion.

3. Improved Management and Control of HIV and other STIs:

The purpose of the improved management and control of HIV and other STIs component is to improve access to appropriate quality diagnostic and treatment services.

According to the National AIDS Strategy, "the close association between STDs and vulnerability to HIV infection has been proved around the world. Thus, identification, prevention and effective treatment of STDs must play an important role in the campaign to prevent HIV infection".

Epidemiological research shows that sexual contact is the predominant route of transmission of HIV in Indonesia. Prevention of STIs in the population should reduce the transmission of HIV/AIDS even if individuals continue to engage in unprotected sex.

Most people infected with STIs, including HIV/AIDS, are not aware that they are infected and do not seek appropriate treatment. Therefore, increasing treatment-seeking behavior in those at risk is critical to the prevention and control of STIs. The best way to increase treatment-seeking is to enable those at risk to identify their own vulnerability to disease, and then provide them with appropriate information regarding STI transmission, symptoms, realistic methods of prevention, and access to high-quality services. Critical to the effective control of STIs, is the existence of reliable diagnostic services, including the upgrading of diagnostic skills of health care providers and of laboratory equipment.

4. Expanded Access to and Promotion of Condoms to Prevent HIV/AIDS/STDS for Persons at Risk:

The purpose of the expanded access to and promotion of condoms component is to prevent transmission of HIV/STIs for persons at risk through collaboration with the commercial condom marketing sector.

Prevention is another key program area of the National AIDS Strategy. According to the Strategy, strong prevention programs play a critical role in ensuring that "the necessary supplies, services, information and support will be available to anyone wanting to take action to protect themselves and others from being infected or from spreading HIV to others". HAPP will support the national AIDS prevention program by expanding access to and promotion of preventive devices (condoms) to those whose behaviors place them at risk of HIV/STIs.

Apart from behavior change to reduce the number of sexual partners, correct and consistent use of latex condoms is the best means of preventing sexual transmission of HIV/AIDS. For those who have multiple sexual partners, such as male and female prostitutes and their clients, condoms present the most viable option to reduce the sexual transmission of STI/HIV/AIDS.

The program will use a social marketing approach with the commercial sector to increase condom demand for HIV/STI prevention and to make high quality affordable condoms more widely accessible to persons at risk. The social marketing approach will allow the project to take advantage of the relatively sophisticated commercial condom market. Promotion of locally manufactured condoms will lead to a more sustainable prevention effort.

C. Implementation mechanisms

HAPP will be implemented through the kinds of mechanisms supported under the original Project Grant Agreement, including:

1. Reimbursement to the Government of Indonesia for its funding of various local contracts and other activities. The GOI will solicit, manage, pre-finance and evaluate approximately $3.1 million in host country contracts and other activities which will be eligible for reimbursement under the provisions of Implementation Letters (ILs). Activities potentially funded under this mechanism include, but are not limited to, training of government health and family planning workers, HIV/AIDS mass media development; health provider training in STI diagnostics and treatment and development of STI standards and protocols.

   In order to assure that project personnel and GOI staff are familiar with the financial management systems and requirements for funding, workshops may be conducted as necessary for those who will be performing this function. USAID will require the GOI to use competitive procedures for the procurement of contractors in accordance with USAID Handbook 11/Automated Directives System (ADS) requirements for host country contracting.

2. A Participating Agency Service Agreement (PASA) with the U.S. Centers for Disease Control for long and short term STI technical advisory services. The CDC PASA is a contractual mechanism used by USAID to procure technical assistance. The services of a long term advisor in STI Control/Medical Epidemiology will be procured through a CDC/PASA to assist in implementing the STI control component of the project. The GOI Project Director will approve the Scope of Work and activities and outputs requested through the PASA with CDC.

3. An institutional contract for technical advisory services to assist the GOI implement HAPP and provide support to NGOs. A procurement for a performance based institutional contract has been competed for the achievement of key performance objectives relating to the four program components. This contract will be implemented with the services of four long-term technical advisors: one expatriate Chief of Party, who will manage and coordinate implementation of project activities, supervise the technical and administrative HAPP staff and serve as a management advisor; one Indonesian Deputy Chief of Party who will assist the Chief of Party; one IEC Advisor who will assist in implementing IEC activities; and one Social Marketing Advisor, who will assist in implementing social marketing activities.

Achievement of results under this contract will also be carried out by short-term technical assistance, and support to NGOs.

D. Technical assistance:

All technical assistance advisors provided through the above mechanisms will be approved by both the GOI Project Director and USAID/PHN. The HAPP technical advisors will be responsible for:

- supporting and supervising HAPP national-level activities;
- supervising HAPP activities in the demonstration areas through the local HAPP offices; and
- coordinating the activities of subcontractors/partners providing technical assistance and implementing prevention interventions.

The five long-term technical advisors will work together as a HAPP technical assistance team. The four technical advisors funded under the institutional contract will work under the supervision of the Chief of Party; the CDC Medical Epidemiologist will coordinate her/his activities with the Chief of Party. All five long-term technical advisors will be stationed in Jakarta and will operate out of the HAPP Office, which will be located in the Ministry of Health.

All HAPP technical advisors, both long- and short-term, will be supported in the Jakarta HAPP office by administrative and support staff funded under the HAPP contract, including an office manager, financial officer, secretaries and drivers. Support staff at the demonstration areas outside Jakarta will include a program manager, a deputy program manager, one administrative assistant and one driver.

E. Procurement of Commodities

Commodities to be procured through HAPP include: STI laboratory equipment for program activities; and equipment for HAPP implementation, including personal computers, printers, computer hardware updates, computer software, vehicles, office furniture, VCRs and monitors, fax machines, photocopiers, books and journals. All commodities will be procured directly by the institutional contractor. As a result of the 1998 economic crisis it is anticipated that the institutional contractor will be able to utilize savings which have accrued from the rupiah devaluation to procure additional and urgently needed medical equipment for HIV/STI diagnosis.

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IV. PROJECT MANAGEMENT

This project will be under the overall direction of the Director General of the Directorate of Communicable Disease Control & Environmental Health (CDC/EH) as the Project Director. He will be assisted by a full-time MOH/HAPP Project Manager who will report to the Project Director and will oversee activities of the Executive Secretariat. The GOI will be reimbursed for the salary of the Project Manager as established in Implementation Letters (ILs).

Three Assistant Project Managers will also be appointed to work part-time on HAPP. These Assistant Project Managers will come from the following divisions of the Ministry of Health: the Directorate of Directly Transmitted Disease Control of Directorate General for CDC/EH; the Center for Communicable Disease Research, National Institute on Health Research Development (LitBangKes); and the Center for Health Education (PKM) The individuals mentioned above will comprise the MOH HAPP Management Team. The specific responsibilities of the MOH HAPP Management Team will be:

- To review, discuss and approve yearly workplans for each component of the project.
- To assure timely commitment of USAID and GOI funds in accordance with yearly workplans.
- To review and approve scopes of work for short-term domestic and overseas technical assistance.
- To assist in preparation of host country contracts.
- To identify training needs and possible suitable training opportunities to support each component of the project.
- To supervise and monitor project implementation.
- To assist the GOI in meeting all USAID financial and managerial requirements.

USAID, by virtue of its accountability to the U.S. Congress, has contract management administrative and authority for the institutional contract and the CDC PASA, as well as responsibility for technical decisions regarding cost-effective use of resources under HAPP. The USAID Project Officer and Project Manager will participate in the development, review and approval of annual and five-year HAPP Workplans. The Project Manager will monitor and supervise all financial and contractual actions of the project.

The USAID HAPP Technical Advisory Team -- comprised of the five

long term advisors -- will be appointed by USAID to work as counterparts to the MOH HAPP Management Team to collaboratively implement the project. Specifically, the technical advisory team will include the Chief-of-Party/Management Advisor, the Deputy Chief-of-Party, IEC Specialist, and Social Marketing Specialist supported by the HAPP contract, and the Medical Epidemiologist from CDC. The MOH HAPP Management Team and the USAID HAPP Technical Advisory Team will together form the HAPP Executive Secretariat.

All project activities will be conducted by the HAPP Executive Secretariat under the guidance and direction of the GOI Project Director and the MOH Project Manager. This collaborative effort by the MOH and USAID/PHN will facilitate smooth implementation of project activities as well as institutionalization of the AIDS prevention effort over time.

The GOI Project Director, HAPP Executive Secretariat and USAID/PHN will collaboratively develop annual HAPP workplans in line with the five year plan developed in 1996, which covers the entire $21 million HAPP budget including NGO activities. They will also cooperatively plan, review and approve project activities as set forth in the HAPP annual workplans and Implementation Letters (ILs) and carry out progress reviews every six months. This will enable all participants to jointly agree to and approve all HAPP activities and implementing agencies. Yearly reviews of the HAPP contract, CDC and GOI/PIL expenditure patterns will be conducted to ascertain that funds are being expended by the most expeditious mechanism.

In an effort to preserve flexibility and responsiveness to local conditions, changes to the annual HAPP workplan will be possible during the course of the year, with the approval of the GOI Project Director and USAID/PHN.

While the Ministry of Health will have primary responsibility for managing and implementing HAPP activities, the National AIDS Commission will be responsible for coordinating HAPP activities with those conducted by other GOI agencies, NGOs and other donors. Through liaison with the National AIDS Commission, the project will work cooperatively with a number of other government agencies, such as the Ministries of Population/Family Planning, Religious Affairs, Social Welfare; Planning (BAPPENAS), Education and others represented on the National AIDS Control Commission.

NGOs will also be key members of HAPP implementation. Recognizing the sensitivity of NGO participation, criteria for the selection of NGOs under the institutional contract should have prior concurrence from the GOI and USAID. Preferably, two types of NGOs will be selected for support:

1. NGOs with previous experience with HIV/AIDS prevention

programs who can apply their experience to stronger program efforts

2. NGOs which do not have proven capability but which have demonstrated a strong interest in HIV prevention and have demonstrated capability in other areas as well as specific experience which makes them likely implementors.

The following criteria will also guide the selection of NGOs:

- Epidemiologic significance of the chosen target audience and the NGO's relationships with that target audience
- Estimated absorptive capacity of the NGO
- NGO management and financial accountability
- NGO credibility and registration with the GOI
- Previous track record with donor agencies and government organizations in relevant development work.

All NGO activities funded under HAPP will be included in the annual HAPP workplans which will be approved by the GOI and USAID.

V. FINANCING

A. Overview

Changes may be made to the budget by representatives of the Parties named in the Strategic Objective Grant Agreement without formal amendment of the Agreement, provided such changes do not cause either (1) USAID's grant contribution to exceed the amount set forth under Section 3.1 of the Agreement; or (2) the GOI's contribution to be less than the amount set forth under Section 3.2 of the Agreement. Authorized representatives of the Parties may increase or decrease the funding used for any budget line item by up to fifteen percent (15%) of the amount shown in the Budget without formally revising the Agreement Budget.

Any reallocation of funding to or from a Budget line item which would cause that line item to increase or decrease by more than 15% of the amount shown for that line item in the then agreed upon Budget will require a formal revision of the Budget by the Parties. In the event the Budget agreed to by the representatives of the Parties is subsequently revised by them, the adjustments in Budget line items permitted above may be applied to the new Budget in the same manner and subject to the same limitations as stated above.

Future USAID obligations are subject to availability of funds and mutual agreement of the Parties to proceed.

B. Total Cost Estimate

The total estimated cost of HAPP is $28 million including USAID funding of $21 million and GOI funding of $7 million in cash and in-kind contributions. Table 1 includes a table showing the total budget for USAID and GOI contributions.

C. Host Country Contribution

The host country contribution (HCC) will be equivalent to at least $7 million over the five year effort. In signing the Strategic Objective Grant Agreement, the GOI assumes responsibility for arranging a HCC at least equal to 25% of the total project value. The HCC will be both in the form of in-kind and cash contribution and will support technical and project management assistance, training and commodities in support of expanding STI prevention activities, HIV/AIDS education and STI/HIV/AIDS policy dissemination. The GOI will provide USAID with quarterly reports concerning its contribution to the program.

In order to promote the achievement of the objective and results stated herein, the institutional contractor may select and award sub-contracts to local NGOs which are expected to contribute some of their own resources to project activities. Recognizing the sensitivity of NGO participation, the HAPP contractor will not process or award any sub-contracts without prior concurrence from the GOI and USAID.

VI. MONITORING, EVALUATION AND AUDITS

A. Monitoring

Each annual workplan prepared by the HAPP technical assistance team will provide benchmarks and indicators for monitoring the progress of HAPP implementation. The GOI Project Director and/or Project Manager, HAPP Executive Secretariat and USAID/PHN will meet at least every six months to review progress under the HAPP Program against these benchmarks and indicators. A management information system (MIS) will be maintained to track project accomplishments and expenditures. The MIS reports will be the basis for quarterly reports to USAID/PHN and the GOI on the implementation of the project. The quarterly reports will analyze program accomplishments and expenditures against the targets established in the workplans.

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B. Evaluation

In addition to monitoring the impact of the HAPP program through the indicators outlined in section II, the four HAPP technical components (both demonstration area and national levels) will undergo regular monitoring and evaluation. Funding will be set aside, additional to the $21 million, to carry out an assessment in August 1998 in collaboration with the GOI to assess the methodology, progress and achievement of HAPP against objectives, indicators and benchmarks established in annual HAPP workplans. This assessment will examine the adequacy of resources and of the time frame for achieving the HAPP targets; assess whether the scope of activities should be revised, and whether the targets are appropriate; and assess prospects for sustainability. Based on the results of the assessment, revisions may be made to agreement with the approval of the GOI Project Director and USAID/PHN. Funds made available from programmatic shifts as a result of the assessment will be reallocated to other activities, as mutually agreed upon by the GOI Project Director and USAID/PHN.

A final evaluation will be conducted in the year 2000. This evaluation will assess the degree to which HAPP has met all the benchmarks set for the program, and any issues raised in the previous assessment, and provide recommendations for the nature and scope of any follow-on activities.

C. Audits Management

1. Audits:

As required under subsections (c) and (e) of Section B.5 in Annex 2, annual audits are required for the Government's use of program funds in the amount of $25,000 or more, and use by any other subrecipient of program funds receiving $100,000 or more in any one calendar year, except as indicated below.

With respect to all subrecipients receiving funds directly from USAID under the Program, such as direct USAID contractors or direct USAID non-governmental grantees under the Program, in lieu of an audit plan provided under subsection (e) the USAID agreement with these entities will contain appropriate audit requirements (including audit thresholds) for these funds and funding for such audits from program funds where appropriate.

For host country contracts or any other subrecipient receiving funds directly from the Government, the following subrecipient audit plan will be used. Cost-reimbursable host country contracts and subcontracts exceeding $250,000 must be audited to verify the costs claimed and to finalize provisional overhead rates. Audits of U.S. firms will be coordinated by USAID.

Audits of firms not U.S.-based will be conducted annually by BPKP, provided such contracts are included in the GOI DIP (current account budget), or an independent audit agency acceptable to USAID. Guidelines issued by USAID's Office of the Inspector General are to be followed in selecting auditors and in planning, conducting, and reporting on the results of the audit, in accordance with the Memorandum of Understanding signed by BPKP and USAID on January 17, 1994. Contracts other than those described above will be audited when there is reason to question contractor representations concerning source/origin, use of U.S. flag carriers or other matters, and shall be conducted in accordance with the above procedures. All audits of host country contracts will be financed by the GOI, as part of their contribution to the Program.

2. Government Record-Keeping:

As required under subsection (b) of Section B.5 in Annex 2 of the Strategic Objective Grant Agreement, the GOI has agreed to maintain project books and records, including books and records concerning the GOI's contributions to the program, in accordance with generally accepted accounting principles prescribed by the laws of Indonesia.

VII. COORDINATION

Due to the multi-sectoral approach being taken by the GOI in addressing the AIDS epidemic and the large numbers of donors involved in funding parts of the National AIDS Strategy in numerous locations across Indonesia, structured donor/GOI coordination will be necessary to ensure collaboration and adequate coverage and to avoid duplication of effort and resources.

Key partners for coordination include:

- The National AIDS Prevention and Control Commission, under the Coordinating Ministry of People's Welfare, will be responsible for all coordination between HAPP, USAID, other donor agencies and other GOI agencies involved in HIV/AIDS prevention.

- Other Government of Indonesia agencies: Through liaison with the National AIDS Commission, HAPP will also continue to work cooperatively with a number of other government agencies, such as the Ministries of Religious Affairs, Education and Culture, Planning (BAPPENAS), BKKBN, and other represented on the National AIDS Commission.

- Other donors, including the World Health Organization (WHO), United Nations Development Programme (UNDP), The Ford Foundation, Australian International Development Assistance Bureau (AIDAB), The German Development Bank (KfW), the European Union (EU) and the Government of Japan, are either already providing or are interested in providing assistance to the GOI for HIV/AIDS prevention and control.

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TABLE 1
HIV/AIDS PREVENTION PROGRAM
BUDGET SUMMARY ($000)

	USAID Grant Obligations to date			Life-of-Project Funding		
Funding category	Obligations previous amendmnts	Current amendment	Total	USAID Grant	GOI Contribution	Program Total
Technical Assistance: Salaries & all associated costs	5,616	2,946	8,562	8,562	100	8,662
Local Programs: Project offices/staff, Operational Prog. Costs Program Managers, Marketing advisors and NGO sub-Agreements	5,617	800	6,417	6,417	1,760	8,177
GOI-Managed PIL Activities	2,250	950	3,200	3,200	N/A	3,200
TRAINING	1,165	216	1,381	1,381	2,010	3,391
COMMMODITY	790	200	990	990	2,900	3,890
EVALUATION/AUDIT	332	118	450	450	230	680
GRAND TOTAL	15,770	5,230	21,000	21,000	7,000	28,000

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

JAKARTA

May 17, 1999

Dr. Achmad Sujudi, DSB, MHA
Director General for Communicable Disease
Control and Eradication, Ministry of Health
Jl. Percetakan Negara No. 29
Jakarta 10560

Subject: Strategic Objective Grant Agreement between the Republic of Indonesia and the United States of America for A.I.D. Project No. 497- 0380: HIV/AIDS Prevention Project (HAPP)
Project Completion Date Extension and provision of HIV test kits
Project Implementation Letter No. 7

Ref:
1. MOH Letter No. KU.07.4.243, dated April 1, 1999
2. MOH Letter No. KU.01.4.242, dated March 31, 1999

Dear Dr. Sujudi:

We have received the above ref. letters requesting for a no cost extension of the HAPP completion date and provision of HIV test kits. After carefully reviewing HAPP estimated remaining budget and pipeline figures, USAID is pleased to advise that the Project Completion Date for the Strategic Objective Grant Agreement has been extended from April 30, 2000 to September 30, 2000.

The extension of the Completion Date will provide five (5) additional months to complete the project. No additional funds from USAID will be required for the extension. This no-cost extension will allow all of us to prepare for HAPP phase II adding new demonstration areas, increased surveillance and continued support for local NGOs.

In response to your request (Ref. no. 2) for an additional 400,000 HIV test kits, we also realigned the budget allocation to enable us to provide the required HIV test kits. Attached, please find the Revised Budget Summary, Table I of Annex I the Amplified Project Description to the Strategic Objective Grant Agreement. Family Health International (FHI) will assist us in procuring the additional 400,000 HIV test kits as soon as we amend FHI's contract.

Your signature below represents your concurrence with the Completion Date extension and Summary Budget Revision - Table I of Annex I the Amplified Project Description of the Strategic Objective Grant Agreement.

Thank you very much for your continued collaboration. With best regards.

Sincerely,

Leslie B. Curtin

Leslie B. Curtin
Director
Office of Population, Health and
Nutrition (PHN)

Concur:

Dr. Achmad Sujudi, DSB, MHA
Director General for CDC&E
Ministry of Health

cc:
1. Dr. Arwati Soepanto, MOH HAPP Project Manager
2. Ms. Jane Wilson, FHI Country Director, HAPP
3. BAPPENAS - 3
4. SetKab - 3
5. Bank Indonesia, Bagian Dana Proyek - 2

BEST AVAILABLE COPY

Completion Report

29 September 2000

HIV/AIDS Prevention Project

IHAPP I

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The HIV/AIDS Prevention Project - IHAPP, implemented by the Government of Indonesia - CDC Partnership

I. EXECUTIVE SUMMARY

The HIV/AIDS Prevention Project Completion Report provides a summary of the activities conducted by Family Health International (FHI) under the HIV/AIDS Prevention Project (HAPP) during the period of the performance-based contract from 1 September 1997 to 30 September 2000. During that period, FHI worked in parallel with the Government of Indonesia and many implementing partners, which included thirty-five Indonesian non-governmental organizations (NGOs), six International Private Voluntary Organizations (PVOs), two universities, the Komisi Penanggulangan AIDS (KPA - National AIDS Commission) and the three Komisi Penanggulangan AIDS Daerah (KPAD Provincial AIDS Commission). In addition, HAPP collaborated with the US Center for Disease Control, US Naval Medical Research Unit 2, Jakarta (US NAMRU); and other national and international organizations.

The HIV/AIDS Prevention Project was a bilateral partnership between the Government of Indonesia (GOI) and the US Agency for International Development (USAID), being authorized by the Government through Project Implementation Letters (PILs), by Family Health International and by a Participating Agencies Service Agreement (PASA) with the United States Center for Disease Control, Atlanta.

HAPP consisted of two main phases reflecting the two contractual mechanisms used by USAID. Phase I was from 1996 to 1997 and was part of USAID's worldwide initiative, AIDSCAP, which was implemented by FHI. Phase II, from 1997 to 2000, was a performance-based contract directly between FHI and USAID Jakarta.

The overall goal of HAPP was to reduce the rate of HIV transmission in order to promote the general health and economic well being of people in Indonesia. The project's purpose was work in collaboration with the Government of Indonesia to develop and implement programs aimed at preventing HIV and other STDs based upon the documented effectiveness of interventions and to encourage and support the development and implementation of related policies supporting HIV and STD control. HAPP was implemented during a period of major economic, political and social changes within Indonesia. At the beginning of HAPP, Indonesia was considered a low prevalence country in relation to HIV/AIDS. However, evidence was beginning to accumulate by the end of the project that suggested that Indonesia had transitioned from a low prevalence country to one with a concentrated epidemic among a limited number of vulnerable populations in diverse geographic settings.

HAPP activities took place primarily in three provinces that served as demonstration sites, selected by USAID and the Ministry of Health (MOH): North Jakarta; Surabaya, East Java; and Manado/Bitung, North Sulawesi. HAPP's project office was located within the Ministry of Health (MOH) in Jakarta and its provincial branch offices were in the Ministry of Health (MOH) offices in Surabaya and Manado, facilitating a strong HAPP-GOI partnership.

The main activities carried out during the project included information, education and communication for Behavior Change, Condom Social Marketing, Sexually Transmitted Disease (STD) Management and Control; and Policy Support and Dissemination. An important focus of HAPP was to encourage collaboration with the national and provincial government offices and capacity building with partners. HAPP interventions concentrated on targeted populations known to have behavior that put them at greater risk of HIV infection, such as sex workers, *warias*, and their male clients.

Accomplishments

HAPP accomplished a number of activities associated with technical and non-technically related outcomes that improved the overall capacity to make informed decisions about current and future HIV/AIDS and STD programming in Indonesia. Some of the specific accomplishments, both at the national level and provincial levels within the HAPP demonstration sites, can be summarized as:

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- HAPP generated reliable and valid epidemiological data that was used to develop a national consensus on the epidemiology of HIV/AIDS. These data were foundational to long-range planning, designing, targeting, prioritizing and evaluating Indonesian HIV/AIDS prevention interventions.

- HAPP partners created innovative Information / Education / Communication materials to enhance behavior change communication for HIV/AIDS prevention strategies and accomplished outreach education to a large number of individuals at risk of infection.

- HAPP partners were successful in condom social marketing and in facilitating the formation of a Consortium of Concerned Condom Manufacturers (CCCM) through a partnership approach, evidenced by the successful marketing of condoms in non-traditional outlets.

- The Ministry of Health, HAPP, and the US Center for Disease Control, Atlanta effectively implemented the use of standard guidelines for the diagnosis and treatment of sexually transmitted diseases and there was evidence of improved capacity of health care providers in STD case management.

- HAPP partners completed many capacity building activities with NGOs, in cooperation with the Provincial AIDS Commissions (KPADs), and supported policy development at the national and provincial levels working through the National AIDS Commission (KPA) and KPADs.

- HAPP collaboration with a number of key partners assisted in the rapid assessment of populations whose vulnerability to HIV infection was emerging including injecting drug users.

Lessons Learned

Overall the HAPP Completion Report provides a range of lessons learned in relation to program development, implementation, and evaluation. The following highlights some lessons learned in relation to key program areas:

Policy Support

- Advocacy of the provincial parliaments was provided through open communication, access to information and briefings to government, religious / political leaders, and other policy makers to support the political will to ensure budget allocation for HIV/AIDS prevention activities through local provincial governments.

Epidemiological Surveillance

- Although HAPP provided critical national and provincial level data for monitoring behavioral trends and decision making, local qualitative data collection and assessments related to program development should be used to strengthen local programs in the future.

Technical Assessment

- Technical assessments of risks relating to vulnerable populations, specifically *waria* (transvestites), men who have sex with men (MSM), and injecting drug users; provided valuable information in relation to the changing dynamics of the HIV epidemic in Indonesia.

Condom Social Marketing

- The use of a consignment mechanism for condom sales improved retailers' attitudes towards condoms, by reducing concerns about investment for excess stock, and was frequently mentioned during a survey of 475 retail outlets in the three HAPP demonstration sites.

- Trained counselors are better able to discuss issues related to sexuality, safe sex practices, condom use and negotiation, and to help overcome communication barriers related to partner notification since counselors have fewer time constraints than clinicians serving sex workers at STD clinics. Using trained counselors helped to overcome communication barriers that may be related to gender issues between male clinicians and female patients who sought treatment for STDs.

- Successful referral systems occurred when project outreach workers/ peer educators worked closely with STD clinic personnel in identifying potential patients and assisting them in getting access to the clinic. Clients were more willing to utilize STD services when they were briefed on what to expect during an STD examination.

Sexually Transmitted Disease Management and Control

- HAPP-supported technical assistance emphasized that STD/HIV/AIDS prevention services need to remain accessible and of high quality in Indonesia.

- There was evidence in Manado that efforts to refer or bring in sex workers to a designated clinic was less effective than providing mobile services which brought health care workers to the sex workers in their workplace, increasing sex worker participation. The provision of mobile diagnostic service needs to be further evaluated for future HIV/AIDS initiatives.

- There were consistent problems of antibiotic self medication for STDs among sex workers and their male clients coupled with STD clinics lacking appropriate medications. Assisting STD treatment facilities to maintain adequate supplies in drugs is essential.

- The use of syndromic management alone among women had very limited benefits due to the asymptomatic nature of many STDs in women. Laboratory screening, when available, provided more systematic information for identification and treatment of STDs among women.

Planning and Coordination

- The provincial/district level GOI partners and religious leaders should be included as collaborative partners from the early planning stages to make it easier to introduce new programs at the local level.

- Participatory planning proved to be a key element leading to the successful cooperation and collaboration between the Government of Indonesia and HAPP partners.

Capacity Building

- Capacity building to enable increasing organizational independence must be balanced by ensuring that independently led activities adhere to sound epidemiological priorities and 'best practices' guidelines.

Partnerships and Collaboration

- Clear understanding of the mechanisms for collaboration and clear expectations of roles and responsibilities of partners are necessary to provide an appropriate framework for program success and harmony among stakeholders.

Recommendations

The Completion Report details a number of recommendations for future programming by the Government of Indonesia and future HIV/AIDS prevention partners in relation to individual program areas and within the overall framework of implementing HIV/AIDS and STD programs. The following highlights some key overall recommendations:

- Limited resources for HIV/AIDS in Indonesia need to be clearly prioritized towards attaining the greatest impact on an expanding epidemic within a diverse range of vulnerable populations across the country. Therefore, prioritized resources need to not only be geographically and programmatically focused, but also be critically balanced between capacity building efforts and the implementation of interventions.

- Future programming should strengthen Provincial AIDS Commissions (KPADs), and potentially district level commissions, with respect to initiating and implementing their own activities and in collaboration with NGOs, since the Government of Indonesia will continue to play a critical leadership role with a particular need at the local decentralized level.

- Due to the importance of the role of the Government of Indonesia, future programming should consider establishing proactive policy development to promote HIV/AIDS prevention strategies and progressively expand research and development programs on HIV/AIDS awareness.

- The KPAD Program Advisor (PA) was perceived by all the KPAD in the three sites to be a staff of HAPP and, therefore, did not integrate completely with the KPAD in the respective provinces, especially in Surabaya and Jakarta. To integrate the roles of the KPAD PA (and secretary) better with the KPAD, the recruitment process could be done in greater consultation with the KPAD and the two could be either a part of KPAD or hired as KPAD consultants.

- To sustain the efficiency and effectiveness of the KPADs, it is important to provide technical and informational support to members of the provincial parliament and officials from the different sectors to ensure their support for budget allocation for HIV prevention activities, both through the KPAD and through the different sectors. A multi-sectoral approach is very important and should be continued.

- HAPP used an integrated, participatory approach with the government of Indonesia and NGO partners in provision of technical assistance, implementing capacity building, and facilitating policy implementation that should be extended in the future. In meeting the demands conferred on the HAP Project, a participatory style of management provided the opportunity to view issues from different points of view and facilitated creative problem-solving. This required high levels of facilitating skills on part of supervisors/managers to maintain objectivity, manage expectations, deal with potential conflicts, and ensure effectiveness given the available timeframe.

- Local initiatives will be the basis for sustainable and appropriate responses to the changing epidemic in Indonesia. Therefore, future efforts to enhance capacity building for NGOs could be provided to improve the local effectiveness of programs, to enhance the collaboration with government and donor organizations, and optimize the capability and efficient use of human resources.

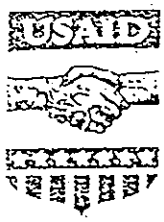
- The NGO Forum needs further institutional strengthening in terms of: (a) members' ability to work as a team; (b) legalization of its role; (c) its function and structure as a proper organization with a clear vision and mission as well as accountability and transparent management and financial systems; and (d) technical and managerial skills including ability to generate income. Priorities should be addressed based on the severity and urgency of these issues. When it is viable, activities should include a systematic framework to measure and evaluate capacity development.

- The foundation for collaboration and partnership between the NGO Forums and the KPADs has been built through membership of the NGOs in the Core Group and Working Groups of the KPADs and joint activities between the two parties. However, their ability to work as a team needs to be further strengthened by providing an opportunity for the exchange of information through briefings, frequent dialogue, and discussion. An appropriate mechanism to promote equal partnership between them such as an equal representation of NGOs in the KPADs at the decision-making level of the KPADs might also be considered.

- Epidemiological surveillance related to HIV/AIDS produces knowledge about the advancement of an epidemic and the performance of prevention programs combined with the impact of other factors, such as the economic crisis. A carefully phased approach within 'priority provinces', based upon epidemiological criteria and provincial capacity, would be the most appropriate strategy for programming with limited resources.
- Future programming in Indonesia will need to tailor responses to the changing local epidemiological dynamics in different regions of the country. Therefore, maintaining a flexible approach to program management will provide the ability to adapt and respond quickly to this important challenge.

- Due to the complexities in diagnosis and treatment of STDs, future programming should consider improving laboratory facilities and logistical support, such as specimen transportation costs, for screening and testing for STDs and HIV.

In August, 1999, USAID signed a Strategic Objective Grant Agreement (SOAG) with GOI protecting the health of the most vulnerable women and children. One component of the SOAG is STD/HIV/AIDS prevention, which primarily focuses on reducing the transmission of STDs and HIV by increasing prevention interventions to promote risk reduction behavior and increase the utilization of STD/HIV/AIDS services among high-risk individuals in Indonesia. Through a competitive bidding process, the government of Indonesia, Ministry of Health and United States Agency for International Development selected Family Health International to continue to work collaboratively with GOI on a new HIV/AIDS program called AKSI Stop AIDS (ASA) implemented under the USAID SOAG through July, 2003. The ASA program will have continuity with HAPP by maintaining linkages with the GOI, local NGOs, other international donors, including UNAIDS / WHO, STD/HIV technical and data resources for SOAG partners. There are five key results in relation to attaining the goal of the ASA program; (1) increasing risk reduction behavior and practices among high-risk individuals, (2) strengthening the quality, accessibility, and utilization of HIV and std prevention services, (3) enhancing the capacity and quality of government of Indonesian STD/HIV surveillance systems, (4) strengthening the capacity for local organizations to plan, finance, manage, and coordinate STD/HIV responses, and (5) increasing the potential of leveraging of non-program financial resources for programmatic interventions. The lessons learned and recommendations of the HAPP will be used as a development tool for the ASA Program.



UNITED STATES GOVERNMENT
Memorandum

DATE : May 21, 2001

FROM : Ratna Kurniawati, COTR and PEB Team Leader, HPN

SUBJECT : Contract No. 497-C-00-97-00011- Family Health International (FHI): Performance Evaluation and Award Fee Determination Report

THROUGH : Mr. Thomas M. Stephens, Contracting Officer, CM

TO : Ms. Sharon Cromer, Fee Determination Official, DD

In compliance with Section E.4. of the subject Contract Award Fee Evaluation Procedures, a new Performance Evaluation Board (PEB) was established on April 24, 2001 by the Fee Determination Official (FDO), Deputy Director.

Based on the PEB's assesment of FHI's overall HAPP achievement of performance objectives and benchmarks for the final period of FHI/HAPP contract from October 1, 1999 to September 30, 2000, and examination of all evidence of the contractor's performance for this period, including but not limited to a review of lessens learned, the FHI/HAPP Annual Workplan, the FHI/HAPP Internal Assessment Report, the HAPP Completion Report, regular meetings with the Ministry of Health HAPP Project Manger and FHI/Chief of Party, and the COTR's Contract Performance Report (CPR), the PEB concludes and submits the preliminary report of FHI Award Fee Determination, which recommends the following:

> The total amount of award fee payable to the Contractor for the period October 1, 1999 to September 30, 2000 is $25,530.75.

Attached please find:

1. PEB's Preliminary Report on the 2000 FHI's Award Fee Determination Report
2. 2000 FHI's Contract Performance Report
3. Memo on Establishment of Performance Evaluation Board

These reports were sent on May 10, 2001, which would permitted FHI seven (7) working days to rebut the PEB's findings and recommendations. FHI has agreed with

the findings and recommendations, therefore, the PEB shall submit the Preliminary Report to you as the Fee Determination Official (FDO) for final approval. Upon approval by you, FHI will be notified and can at that time submit an invoice for the amount of award fee.

Recommendation: Based on the above comments, the PEB requests that you determine and approve the total amount of award fee payable to FHI for period of October 1, 1999 to September, 30, 2000.

Approved: Sharon Cromer

Ms. Sharon Cromer
Fee Determination Official, DD

Date: 5/22/01

cc: PEB members

Drafted:PHN:RKurniawati:5/18/2000

Clearance: HPN:JSPollock: JSP

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USAID/INDONESIA PERFORMANCE EVALUATION BOARD
PRELIMINARY REPORT ON
2000 FAMILY HEALTH INTERNATIONAL (FHI)
AWARD FEE DETERMINATION
Contract No. 497-C-00-97-00011-00

This report includes an assessment of technical and non-technical progress for the period October 1, 1999 to September 30, 2000. This assessment is based on the results of the University of Indonesia/Behavior Surveillance Survey and the JEN/STI Case Management and sero-prevalence survey; trip reports; regular meetings with the Ministry of Health HAPP Project Manager and FHI/Chief of Party; a review of lessons learned; the HAPP Completion Report; and the FHI Internal Assessment Report.

I. TECHNICAL PERFORMANCE
(See Attachment 1)

Overall Achievement: As Indonesia continues along a difficult road of economic, political and social unrest, FHI's overall project performance remained good. Only one out of the seven (14.3%) Contract Performance Objectives (CPO7) achieved the annual target, and four out of eight (40%) Sub-Results (1b, 1d, 1e, and 2a) achieved the benchmark targets.

CPO1: Achievement for 2000: 41% of female sex workers (FSWs) reported use of condoms at last sexual encounter.

Standard Target for 2000: 50%

Condom use among FSWs did not improve as was expected. After an increase from 37% in 1998 to 48% in 1999, condom use, as reported by FSWs, declined to 41%, nine percentage points below the 2000 standard target.

Sub-result 1.a.:

Achievement for 2000:	FHI provided 9,517 Repeat Outreach Contacts (ROCs) to FSWs.
2000 Benchmark Target:	At least 12,000 ROCs to FSWs.

FHI did not meet the 2000 benchmark target.

Sub-result 1.b.:

Achievement for 2000:	FHI provided 11, 233 ROC to clients of FSWs.
2000 Benchmark Target:	At least 6,000 ROCs to clients.

FHI exceeded the 2000 benchmark target (by 187%).

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Sub-result 1.c.:

Achievement for 2000:	65% of outlets carrying HAPP-supported commercial condom brands in HAPP demonstration areas.
2000 Benchmark Target:	70% of outlets carrying HAPP-supported commercial condom brands in HAPP demonstration areas.

FHI did not meet the 2000 standard target.

Sub-result 1.d.:

Achievement for 2000:	Sales of HAPP-supported commercial condom brands increased to 57,385(*) gross of condoms in HAPP demonstration areas.
2000 Benchmark Target:	85,000 gross of condoms.

The sales of HAPP-supported condom brands increased from 50,000 gross in 1999 to 57,385 gross in 2000. However, this achievement fell short of the standard target.

(*) AC-Neilson report on condom sales, estimate based on gross condom sales reported January-June 2000.

Sub-result 1.e.:

Achievement for 2000:	Increase to 400% for commercial sector condom consortium members investment in condom promotion/marketing activities.
2000 Benchmark Target:	50%.

FHI met the standard target, as commercial sector condom consortium members investment in condom promotion/marketing activities increased from 0% in 1998 to 400% in 2000 (exceeded the standard target by 700%).

Discussion: Condom use among FSWs was constant (average 37%) for the initial three years. In 1999 condom use increased to 48%, but fell in 2000. The decrease in condom use among FSWs is most probably the result of the impact of brothel closures, and community and political pressures on commercial sex establishments and workers. Several approaches to increase condom use were implemented during HAPP, including: (1) FHI/HAPP-supported NGO outreach programs among FSWs and male clients; (2) the development and distribution of Information, Education and Communication (IEC) materials, which were focused on key problems rather than merely to increase knowledge and awareness; and (3) collaboration with The Future Group (TFG) and three local condom manufacturers to launch condom social marketing activities starting in April 1999 through 2000.

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Although knowledge of HIV/AIDS is high and condoms are accessible and affordable to the HAPP target populations, there remains a lack of perception of personal risk, little behavior change, and low condom use practices among groups at high-risk. During HAPP implementation, FHI focused its strategy on FSWs as the primary change agents for condom use. In order to create increased demand and use of condoms, a lesson-learned from HAPP is the need to focus interventions more toward clients of FSWs, to directly change the behavior of clients to protect themselves with condoms.

Decision: Although FHI did not meet the CP01 target, we consider the achievement status for CPO1 to be acceptable with reservation given the impact of the economic crisis and political situation in Indonesia through September 2000. Despite these difficulties, FHI was able to increase condom sales and to expand condom distribution through outlets carrying HAPP-supported commercial condom brands in HAPP demonstration areas. In addition, FHI was able to significantly increase the investment of condom consortium members in condom promotion/marketing.

Award fee for CPO1 = 0% x $34,967 = $0.00 (see Attachment 2)

CPO2: Achievement for 2000: 62% FSWs seek medical care for last STI symptom/disease in the past year.

Standard Target for 2000: 90%

The percentage of FSWs who sought medical care for their last STI symptom/infections in the past year slightly decreased from 63% in 1999 to 62% in 2000. FHI did not meet the 2000 standard target, and the shortfall is 28%. It is unclear whether or not those FSWs who did not seek medical care for their STD symptoms were those who self-treat.

Sub-result 2.a.:

Achievement for 2000: FHI provided STI referral information to 2,503 FCWs in HAPP demonstration areas.

2000 Benchmark Target: 1,500 CSWs received STI referral information.

Thus, FHI exceeded the 2000 standard target by 67%.

Discussion: The economic crisis may have had a negative effect on this CPO2 as a result of reduced purchasing power by FSWs to seek and pay for health services. FHI has shown good progress in providing STI referral information to FSWs. However, health seeking behavior by FSWs has declined. This will be further explored in the new ASA program.

Decision: Although FHI did not meet the target, we consider the achievement status for CPO2 to be acceptable with reservation due to the input of the economic crisis and political unrest. FHI was able to provide STI referral information to 2,503 FSWs, which exceeded the 2000 standard target by 67%. However, FHI needs to identify new strategies to motivate FSWs and their clients to increase demand for and better utilize STI services in their communities.

Award fee for CPO2 = 0% x $15,908 = $0.00 (see Attachment 2)

CPO3: Achievement for 2000: 48% of those at risk of STIs who were served at HAPP supported clinics according to standard STI diagnosis and treatment protocols

Standard Target for 2000: 70% of those at risk of STIs who are served at HAPP supported clinics according to standard STI diagnosis and treatment protocols.

FHI did not meet the 2000 standard target of 70%.

Sub-result 3.a.:

Achievement for 2000:	More than 2,150 persons were trained and 22 health facilities were equipped to provide STI services to males at risk and female CSWs.
2000 Benchmark Target:	Train health providers and equip 55 health facilities.

The 2000 benchmark target of Sub-result 3.a for training and service delivery upgrading was not met. Only 22 out of 45 health services were upgraded to enable doctors, paramedics and laboratory workers to more effectively use the national syndromic approach guidelines to diagnose and treat STIs.

Sub-result 3.b.:

Achievement for 2000:	FHI upgraded 8 public hospitals, 6 primary health centers and 6 private clinics to provide STI services.
2000 Benchmark Target:	At least 5 hospitals, 20 health centers and 20 private clinics upgraded to provide STI services.

FHI did not achieve the overall benchmark target, although the number of upgraded hospitals exceeded the 2000 target. However, as public hospitals are not the preferred choice for STI treatment among the target groups (relative to health centers and private clinics) this target was not reached.

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Discussion: The 2000 achievement for the correct diagnosis and treatment of STIs was 48%, well below the 2000 standard target. One reason for this under achievement is the lack of availability of appropriate drug supplies in the health facilities. However, between 1997 (38%) and the end of the project in 2000 (48%) there was a 26% improvement (or 10% increased in the percentage of patients) correctly diagnosed and treated.

Decision: FHI did not met the CPO3 standard target (48% vs 70%), however, we consider the achievement status for CPO3 to be acceptable with reservation, since the achievement of CPO3 depends on PIL implementation activities and drug availability, of which FHI was not directly responsible. The HAP Project provided an important lesson for FHI's future STI programs, the need to strengthen the quality of STI prevention services, including STI diagnosis and treatment for CSWs and their partners, and to improve access to and demand for quality services, all in coordination with the Directorate General Communicable Disease Control and Environmental Health (CDC&EH), MOHSW.

Award fee for CPO3 = 0% x $18,499.50 = $0.00 (see Attachment 2)

CPO4: Achievement for 2000: Knowledge of FSWs who can correctly name at least two acceptable ways to prevent themselves from HIV infection increased to 86% and among high risk males increased to 88%. The average knowledge among these target groups was 87%.

2000 Standard target: The average standard target for knowledge among target groups is 90%.

FHI did not meet the target.

Discussion: There has been a consistent increase in knowledge of HIV prevention practices among FSWs and high risk males since 1996. However, this CPO4 just fell short of the 2000 benchmark. A decrease in knowledge was measured among lokalisasi-based FSWs in Surabaya. The overall change percentage among target groups from the baseline in 1996 (76%) showed an improvement to 87% in 2000.

Decision: Achievement of CPO4 was slightly below the standard target for 2000 (87% vs 90%). The team considers the achievement status for CPO4 to be acceptable with reservation, due to the fact that the knowledge level among high risk groups seemed to have reached an optimal level with further increases exceedingly difficult to achieve.

Award fee: 0% x $7,921.50 = $0.00 (see Attachment 2)

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CPO5: Achievement for 2000: 30% of those at risk received STI/AIDS counseling.

2000 Standard Target: 50%.

FHI did not achieve the 2000 target.

Discussion: The proportion of those at risk who received STI/AIDS counseling decreased sharply from 61% in 1999 to 30% in 2000 in all three HAPP areas. In Jakarta, it fell from 22% to 14%; in Surabaya, it feel from 22% to 14%; and in Manado, it fell from 79% to 69%.

Decision: Achievement of CPO5 in 2000 was far below the standard target. FHI failed to achieve the CPO5 standard target.

Award fee: 0% x $4,403.50 = $0.00 (see Attachment 2)

CPO6: Achievement for 2000: The STD prevalence rate among FSWs decreased from 44% in 1998 to 39% in 2000.

2000 Standard Target: A decrease of the STD prevalence rate among FSWs to 30%.

FHI did not meet the standard target.

Discussion: CPO6, measuring changes in the prevalence of STDs among FSWs, was evaluated every two years (1996, 1998 and 2000) by means of the STI prevalence study conducted by the Indonesian Epidemiology Network (Jaringan Epidemiology National/JEN) in the three cities. The 2000 JEN revealed evidence of decreasing of STI prevalence among FSWs in FY 2000 as compared to FY 1998. This was largely due to the decrease of STI prevalence in Surabaya 60.5% (1998) to 31.3% (2000), while in the other cities, especially Jakarta, STI prevalence increased from 40.2% (1998) to 52.3% (2000).

Decision: Achievement of CPO6 by FHI was below the standard 2000 target. The team considers the achievement status for CPO6 to be acceptable with reservation, given the impact of the economic crisis and political situation in Indonesia may have had a negative effect on STI treatment as a result of reduced purchasing power by FSWs to seek treatment/health services.

Award fee: 0% x $4,403.50 = $0.00 (see Attachment 2)

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CPO7: Achievement for 2000: All organizations who received HAPP Capacity Building Support showed an incremental change of greater than 0.5 in management and development areas as measured by the Institutional Development Framework (IDF).

2000 Standard Target: Organizations receiving HAPP Capacity Building Support will show an incremental change of at least of 0.5 in management and development areas as measured by the Institutional Development Framework (IDF).

Discussion: In 1999, FHI developed a capacity building indicator to measure progress among HAPP participating organizations. This indicator was first used in 2000 as part of the Annual Self Assessment Report. This indicator is from the Institutional Development Framework (IDF), a tool developed by Management Systems International. More than 50 organizations were reached with capacity building activities as part of HAPP. Thirteen organizations (nine NGOs, three KPADs, and the Jakarta HAPP Office) were assessed by Business Dynamics using the IDF. On a scale of 0 - 4, organizations with score of 2.5 and above are considered well-developed in the particular indicator category, with a score of 4.0 reflecting the highest level of sustainability. All of organizations (NGOs, KPADs, HAPP Office) showed an average IDF score of 2.5 or above. (Note: The minimum target for this CPO is an average increase the IDF score greater than 0.5). FHI exceeded all targeted objectives specified by the IDF assessment criteria related to planning, monitoring and evaluation, staff skills and development, participatory management, mission, and vision.

Decision: Although FHI adequately met the target for CPO7, this CPO7 falls under the category "other deliverables", with no award fee attached to CPO7.

Award fee = 0 (see Attachment 2)

The Sub-total award fee for FHI's Technical Performance is $0.

II. NON-TECHNICAL PERFORMANCE

Discussion:

a. Business Management Efficiencies:

1. Program Planning and Management:

Program Planning: FHI/HAPP showed improvement in the process of development and finalization of the final HAPP Annual Workplan in contrast with the previous three year's workplans. HAPP's effectiveness and ability to achieve its planned activities needs further attention. Collaborative planning,

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the empowerment of partners and improved use of resources are required to further improve FHI's bottom-up style of planning.

Program Management: One of the greatest challenges of the FHI/HAPP was creating a technical and management marriage among the many institutional and individual stakeholders involved in the project. FHI/HAPP managed a partnership involving the GOI and Provincial AIDS Commissions (KPADs), USAID, US-based PVOs, local NGOs, universities and professional organizations. FHI incorporated considerable time to meet the bureaucracy and consultative requirements of all parties involved, including donor agencies to mobilize resources to support HIV/AIDS prevention activities, including prevention strategies for injecting drug users.

HAPP Staff Management Skills: Further improvements are required to strengthen HAPP staff's ability to understand their roles and responsibilities; communication and coordination; and awareness of routine program activities, including (a) the planning and scheduling of the completion of sub-agreement preparation and submission of reports; (b) responsibility for maintaining regular contact with TA partners; (c) responsibility for monitoring and support to local NGOs, and (d) the coordination and balancing of administrative and program responsibilities. In addition HAPP staff need to pay additional attention to USAID regulations and requirements in order to support FHI's ability to effectively respond to necessary program actions.

2. Human Resource Management:

FHI organized several domestic and international study tours for KPAD and key program staff from Jakarta, Surabaya and Manado, in addition to a gender study tour of HIV/AIDS activities in Nepal. These study tours helped to improve staff knowledge of other country/organization AIDS prevention program strategies and experiences, and served to strengthen staff's program planning skills.

3. Cooperative Work Environment with Counterparts:

FHI continued to be most cooperative and responsive to the USAID/SO8 HIV/AIDS RP requests for urgent actions. This included being pro-active in supporting implementing agency (NGO) bridge activities during the program transition to the new FHI cooperative agreement, and the excellent demonstration of responsiveness and contacts in the planning and management of a special briefing session on narcotic use with Indonesia's top experts in July 2000.

Working relationships with three Provincial AIDS Commission (KPADs), US-based PVO partners and local NGOs have been improved through the

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capacity building effort across many organizational needs, technical areas and varying capacities.

4. Recognizing Critical Problem Areas and Opportunities:

Identifying problems: FHI was well positioned to recognize the newest and most alarming area of HIV and Hepatitis B+C transmission, through injecting drug use. FHI/HAPP collaborated with the GOI and other international donors to plan and manage an eight-city Rapid Assessment and Response (RAR) study. HAPP was responsible for managing this study in the three HAPP demonstration sites.

FHI/HAPP effectively utilized the Rapid Response Fund (RRF) mechanism (small activity funding) to develop NGO forums, especially in Manado, which contributed to the increased capacity of new NGOs and enhanced their role in program implementation.

5. Information System and Technology Utilization:

Communication: HAPP developed a useful and appropriate computer network system with standardized word processing and data management software which allowed for the sharing of data and simultaneous communication between the country office, field offices and the Asia Regional and Arlington offices. HAPP's systems were enhanced with a useful, dedicated lease line.

Electronic Project Management systems: FHI/HAPP staff were able to produce improved planning documents using MS Outlook and MS Project and to facilitate program management and communications.

FHI's computerized accounting system (MTX): After hiring a full-time computer specialist, who was responsible for designing and standardizing the office software and managing the new MTX financial management system. FHI's Finance Unit's reporting was greatly improved. The MTX system allowed for improved monthly reporting to FHI/ARO and facilitated shortened processing and reimbursement of implementing agency monthly financial reports.

b. Cost Control:

Accuracy of funding projections: Overall, most expenditures were within budget, however, the accuracy of funding projections (ratio of expenditures vs planned budget) could have been strengthened. During this final implementation year, FHI carried a large pipeline which was not fully absorbed by the project completion date. However, FHI's internal audit control system, with annual country office audits, has served as an effective cost control tool.

Use of cost savings measures: As a part of its financial supervision and control function, FHI managed financial audits of its seventeen NGO partners by an external audit agency in the final year of HAPP implementation. Only two of the 17 NGOs were identified to have financial issues requiring correction prior to activity close-out.

Thoroughness and accuracy of financial reporting: FHI began to more effectively utilize its Flow of Disbursement System to monitor and detect gaps in funding based on the Recipient Monthly Financial Reports submitted by Implementing Agencies (IAs) for reimbursement. This new system greatly increased the speed of HAPP reimbursement to its local partners.

Decision: The team rates FHI's Non-Technical Performance in this final year as good. (FHI receives 80 points, and therefore receives 30% of the remaining total award fee) The remaining total award fee: $85,102.50 - $0 = $85,102.50.

Award Fee: 30% x $85,102.50 = $25,530.75 (see Attachment 2)

The Sub-total Award Fee for FHI's Non-Technical Performance is $25,530.75.

SUMMARY:

The Sub-total Award Fee for FHI's Technical Performance:	$ 0
The Sub-total Award Fee for FHI's Non-Technical Performance:	$25,530.75
The Total Award Fee for Technical and Non-Technical Performance:	$25,530.75

(See Attachment 2: Summary of FHI's Award Fee Calculation).

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ATTACHMENT 1: FHI CONTRACT PERFORMANCE OBJECTIVES AND ANNUAL STANDARDS

CONTRACT PERFORMANCE OBJECTIVES	SUB-RESULTS	BENCHMARKS	PERFORMANCE STANDARDS:	FHI'S ACHIEVEMENT	MET/ UNMET
No. 1: Increase Percentage of Commercial Sex Workers (CSWs) reported condom use at last sexual encounter to 50%.			1996: 36% -BL 1997: 40% 1998: 50% 1999: 50% 2000: 50%	1997: 36% 1998: 37% 1999: 48% 2000: 41%	UNMET UNMET UNMET UNMET
	No.1.a. Provide at least 52,000 Repeat Outreach Contacts to CSWs.	1997: 8,000-BL 1998: 20,000 1999: 14,000 2000: 12,000		1998: 9,200 1999: 14,319 2000: 9,517	UNMET MET UNMET
	No.1.b. Provide at least 26,000 Repeat Outreach Contacts to male clients of CSWs promoting condom use.	1997: 4,000-BL 1998: 10,000 1999: 6,000 2000: 6,000		1998: 9,021 1999: 14,612 2000: 11,233	UNMET MET MET
	No.1.c. 70%of outlets carrying HAPP-supported commercial condom brands in HAPP demonstration areas by the EOP.	1997: 40% - BL 1998: 60% 1999: 60% 2000: 70%		1998: 45% 1999: 67% 2000: 65%	UNMET MET UNMET
	No. 1.d. Sales of HAPP-supported commercial condom brands increased to 85,000 gross in HAPP demonstration areas by the EOP.	1997: 57,000-BL 1998: 72,000 1999: 80,000 2000: 85,000		1998: 50,000 1999: 72,000 2000: 57,385	UNMET MET UNMET
	No. 1.e. Increase to 50% for commercial sector condom consortium members' investment in condom promotion/ marketing activities by the EOP.	1997: 0% - BL 1998: 25% 1999: 45% 2000: 50%		1998: 0% 1999: 245% 2000: 400%	UNMET MET MET
No.2.: Increase percentage to 90% of CSWs who seek medical care for last STD symptom/diseases in the past year.			1996: 70% 1997: 75% 1998: 80% 1999: 85% 2000: 90%	1997: 73% 1998: 73% 1999: 63% 2000: 62%	UNMET UNMET UNMET UNMET

CONTRACT PERFORMANCE OBJECTIVES	SUB-RESULTS	BENCHMARKS	PERFORMANCE STANDARDS:	FHI'S ACHIEVEMENT	MET/ UNMET
	No.2.a.: Provide STD referral information to at least 4,950 CSWs.	1997: 300-BL 1998: 1,800 1999: 1,500 2000: 1,500		1998: 1,357 1999: 2,221 2000: 2503	UNMET MET MET
No. 3: Increase the proportion of those at risk of STDs who are served at HAPP supported clinics according to standard STD diagnosis and treatment protocols to ratio of 70%.			1996: 9% - BL 1997: 25% 1998: 40% 1999: 55% 2000: 70%	1997: 38% 1998: 41% 1999: 47% 2000: 48%	MET MET UNMET UNMET
	No.3.a.: Train health providers and equip at least 55 health facilities to provide STD services to male and female CSWs.	1997: 15 - BL 1998: 30 1999: 45 2000: 55		1998: 18 1999: 20 2000: 22	UNMET UNMET UNMET
	No.3.b.: Upgrade at least 5 public hospitals, 25 primary health centers (Puskesmas) and 25 private facilities to provide STD services.	1997: 2,8,5–BL 1998: 3,13,15 1999: 5,20,20 2000: 5,25,25		1998: 8,4,6 1999: 8,6,6 2000: 8,6,6	UNMET UNMET UNMET
No. 4: Increase to 90% those at risk who are exposed to IEC campaigns and able to correctly identify two ways to prevent HIV/AIDS.			1996: 77% (BL) 1997: 83% 1998: 86% 1999: 88% 2000: 90%	1997: 83% 1998: 87% 1999: 88% 2000: 87%	MET MET MET UNMET
No. 5: Increase proportion of those at risk receiving STD/AIDS counseling to 50%.			1996: 10% 1997: 15% 1998: 25% 1999: 40% 2000: 50%	1997: 23% 1998: 50% 1999: 61% 2000: 30%	MET MET MET UNMET

CONTRACT PERFORMANCE OBJECTIVES	SUB-RESULTS	BENCHMARKS	PERFORMANCE STANDARDS	FHI'S ACHIEVEMENT	MET/ UNMET
No. 6: A decrease of STD prevalence rate among CSWs to 20%.			1996: 33% -BL 1998: 30% 2000: 30%	1998: 44% 2000: 39%	UNMET UNMET
No. 7: Policy Support.	Organize six annual (in 1997, 1998, 1999) National Conferences for national leaders such as World AIDS Day Workshop and Annual National AIDS Seminar in collaboration with the GOI and other donor agencies during the base period of the contract.		1997: 2 1998: 2 1999: 2	1998: 2 1999: 2	MET MET
	Conduct seven (7) Policy Study Tours for a minimum of seventy (70) Indonesian policy-makers.		1997: two study tours for 20 policy-makers		
			1998: two study tours for 20 policy-makers	1998: two study tours for 20 policy-makers	MET
			1999: three policy study tours for 30 policy-makers	1999: four study policy tours for 75 policy-makers	MET
			2000: 50 institutions involved in HAPP capacity building show incremental change of at least 0.5 in manag - ement and development points as measured by Institutional Development Framework (IDF) or move from 2.5 to above 2.5 on the IDF criteria.	2000: More than 50 institutions involved in HAPP capacity building showed incremental change greater than 0.5 in management and development points as measured by Institutional Development Framework (IDF) or move from 2.5 to above 2.5 on the IDF criteria.	MET

p:\cm\fhi-cpo achm00

ATTACHMENT 2: SUMMARY OF FHI's AWARD FEE CALCULATION

Award fee calculation for FHI's contract:

Total amount of contract	$	12,053,953	
Base fee is:	$	349,991	(2.90% of the total amount of contract)
Total award fee:	$	272,329	(2.26% of the total amount of contract).

CPO # (CLIN #)	Total fees	9/3/97-9/2/98 12 months	9/3/98-9/2/99 12 months	9/3/99-9/30/00 12 months
1	111,894	41,960	34,967	34,967
2	50,906	19,090	15,908	15,908
3	59,199	22,200	18,499.50	18,499.50
4	25,349	9,506	7,921.50	7,921.50
5	14,091	5,284	4,403.50	4,403.50
6	10,890	4,084	3,403	3,403
7	0	0	0	0
Total:	272,329	102,124	85,102.50	85,102.50

The maximum award fee for 9/3/98-9/2/99 period of contract is $ 85,102.50, which will cover Technical and Non Technical standard award fees.

Scoring and calculation of an award fee:

Points	Remark	% of Award Fee
100	Superior	50 %
90	Excellent	40 %
80	Good	30 %
70	Satisfactory	0 – 20 % (Proporsional)
60	Acceptable w/reservations	0 %
50	Unsatisfactory	0 %

Calculation of award fee for Technical Standard is based on the annual achievement of each Contract Performance Objective (CPO) against each annual standard target.

Calculation of award fee for Non Technical Standard is based on Business Management Efficiencies and Cost Control performance.

MET CPOs:

CPO #	Cond-ition	Point	Status	Award fee ($)		Remark
CPO 7	Met	N.A.	Good	0	0	CPO7 is considered as other deliverables, which will contribute to all of CPOs. No award fee is attached to CPO7.

UNMET CPOs :

CPO #	Cond-ition	Point	Status	Award fee ($)		Remark.
CPO 1	Unmet	60	Acceptable with reservation	0% x 34,967	0	9% under the target (41% vs 50%)
CPO 2	Unmet	60	Acceptable with reservation	0% x 15,908	0	28% under the target (62% vs 90%)
CPO 3	Unmet	60	Acceptable with reservation	0% x 18,499.50	0	22% under the target (48% vs 70%)
CPO 4	Unmet	60	Acceptable with reservation	0% x 7,921.50	0	3% under the target (87% vs 90%)
CPO 5	Unmet	60	Acceptable with reservation	0% x 4,403.50	0	20% under the target (30% vs 50%)
CPO6	Unmet	60	Acceptable with reservation	0%x3.403	0	19% under the target (39% vs 20%)

Total award fee for Technical Standard is: $ 0 (I)

Maximum award fee for Non Technical Standard is: $85,102.50 - $0 = $85,102.50

After reviewing the non technical performance, PEB decides that FHI's Non Technical Performance rate is GOOD, and is entitled to receive 30% of the maximum non technical standard fee.

Total award fee for Non Technical Standards is: 30% x $85,102.50= $25,530.75 (II)

Grand total FHI award fee this year is: (I) + (II) = $ 0 + $25,530.75 = $ 25,530.75

=========

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UNITED STATES GOVERNMENT
Memorandum

DATE : April 24, 2001

FROM : Mr. Thomas Stephens, Contracting Officer, CM

SUBJECT : Contract No. 497-C-00-97-00011- Family Health International (FHI): HIV/AIDS Prevention Project (HAPP)
Establishment of New Performance Evaluation Board

TO : Ms. Sharon Cromer, Fee Determination Official, DD

As we know, the subject contract contains provision for an award fee. Section E.4. of the contract establishes the award fee evaluation procedures. An initial step in the award fee process is formation of a Performance Evaluation Board (PEB).

On December 3, 1998, a PEB was established and approved by you. (A copy of the memo is attached). However, two of the PEB members left Indonesia, and one member has been hired by FHI as an USAID funded STI/HIV/AIDS Prevention Support Program ("Aksi Stop AIDS" program) staff. Therefore, we request you to establish a new PEB. Below are the individuals proposed to constitute the new PEB. With your approval of this memorandum the PEB will be formed and will proceed with the award fee evaluation in accordance with the procedures set forth in the contract.

The New PEB members:

1. Ratna Kurniawati, COTR and PEB Team Leader, HPN
2. Joy Pollock, HPN
3. Thomas Stephens, Contracting Officer, CM
4. Dr. Sigit Priyohutomo, MOH, CDC&EH

Approved: _____
Ms. Sharon Cromer
Fee Determination Official
Deputy Director

U.S. Agency for International Development

Contractor Performance Report

The sections in RED indicate information required for COMPLETED EVALUATIONS. If you supply this information for evaluations in progress, it will not be recorded. ☐

GOTO: ☐ BOTTOM ☐ RATINGS ☐ SUBCONTRACTS ☐ CONTRACTOR KEY PERSONNEL ☐ CUSTOMER SATISFACTION

☒ Final Report ☐ Interim Report (Check One) ☐ Evaluation process has been completed for this reporting period.

Reporting Period From 10/01/1999 (REQUIRED) To 09/30/2000 (MM/DD/YYYY) (REQUIRED)

Contracting Office:	Contract Number:	Task Order Number:
USAID/Indonesia	497-C-00-97-00011-00	

Contractor Name
FAMILY HEALTH INTERNATIONAL (REQUIRED)

Address:
P.O. Box 13950,
Research Triangle Park, NC 27709
U.S.A.

TIN: 237143005 (REQUIRED)

DUNS: (OPTIONAL)

SIC: 8742 (REQUIRED)

Commodity Code: (OPTIONAL)

Contract Type
R-Cost-Plus-Award-Fee

Contract Award Date:	Contract Expiration Date:	Contract Value:
09/01/1997 (MM/DD/YYYY REQUIRED)	09/30/2000 (MM/DD/YYYY REQUIRED)	$12,053,953 (REQUIRED- Convert to U.S. $ If applicable)

Description of Requirement
Provide technical services to the Government of Indonesia for the prevention of HIV/AIDS for USAID/Indonesia, Office of Population, Health and Nutrition (PHN/SpO11).

RATINGS

GOTO: ☐ BOTTOM ☐ TOP ☐ SUBCONTRACTS ☐ CONTRACTOR KEY PERSONNEL ☐ CUSTOMER SATISFACTION

Summarize contractor performance and check the number which corresponds to the rating for each category.

QUALITY OF PRODUCT OR SERVICE

☐ 0 Unsatisfactory ☐ 1-Poor ☐ 2-Fair ☒ 3-Good ☐ 4-Excellent ☐ 5-Outstanding (REQUIRED)

Comments (REQUIRED and limited to 2000 characters) As Indonesia continues along a difficult road of economic, political and social unrest, FHI's overall project performance was good. Contract Performance Objective #7 (CPO7) met the annual standard target, which was target for institutional capacity building efforts. During a time of imprecedented political and economic crisis, good progress was made in meeting key sub-results benchmark target, such as sub-result 1.d.: Increased to 400% for commercial sector condom consortium member's investment in condom promotion and marketing activities (the 2000 benchmark was 50%); and sub-result 2.a.: Providing STI referral information to 2,503 female sex workers (FSWs) in 2000 (the 2000 benchmark was 1,500 FSWs). However, the key CPO#1 - Percentage of condom use among FSWs in the last sex encounter decreased from 48% in 1999 to 41% in 2000 (the 2000 target was 50%), condom use among clients increased from16% in 1999 to 28% in 2000 (well below the 2000 target of 50%).

COST CONTROL

☐ 0 Unsatisfactory ☐ 1-Poor ☐ 2-Fair ☒ 3-Good ☐ 4-Excellent ☐ 5-Outstanding (REQUIRED)

☐ N/A – Not Applicable (REQUIRED FOR FIXED PRICE CONTRACTS)

Comments (REQUIRED FOR COST TYPE CONTRACTS, OPTIONAL FOR FIXED PRICE CONTRACTS. Limited to 2000 characters)

FHI began to more effectively utilize its Flow of Disbursement System to monitor and detect gaps in funding based on the Recipient Monthly Financial Reports submitted by Implementing Agencies (IAs) for reimbursement. Effective implementation of the system has greatly increased the speed of HAPP reimbursement to its IAs. Internal audits implemented by an external auditing agency for all HAPP IAs as part of FHI's routine financial supervision identified two out of 17 IAs with financial problems. Overall, most expenditures were within budget, however, the accuracy of funding projections (ratio of expenditures vs planned budget) could have been strengthened. FHI maintained a large pipeline budget, which was not absorbed in a timely basis.

TIMELINESS OF PERFORMANCE

☐ 0 Unsatisfactory ☐ 1-Poor ☐ 2-Fair ☒ 3-Good ☐ 4-Excellent ☐ 5-Outstanding (REQUIRED)

Comments (REQUIRED and limited to 2000 characters) Despite the uncertain political situation in Indonesia, FHI and HAPP partners were able to complete several crucial activities, such as The Future Group's (TFG's) condom social marketing efforts, the Rapid Assessment for Response among IDU's, the Internal HAPP Assessment, and the final Lessons Learned workshop. FHI was able to complete most requirements within or close to contract deadlines; however the HAPP Completion Report was not completed in accordance with contract provisions (report timing, its content and necessary reviews).

BUSINESS RELATIONS

☐ 0 Unsatisfactory ☐ 1-Poor ☐ 2-Fair ☐ 3-Good ☒ 4-Excellent ☐ 5-Outstanding (REQUIRED)

Comments (REQUIRED and limited to 2000 characters) FHI continued to be cooperative and responsive to USAID/HPN/SO8 - HIV/AIDS-RP's requests for urgent actions. This included being pro-active in supporting IA bridge activities during the program transition to the new FHI cooperative agreement, and excellent responsiveness with the management of strong collaborating partnerships on the critical Injection Drug Use behavior assessment, and the management of an excellent briefing session for a visiting Undersecretary of State with Indonesia's key narcotics experts. Routine meetings between COP/CD, MOH HAPP Project Manager and USAID/HPN/SO8 - HIV/AIDS-RP have been very useful to discuss project implementation activities.

MEETING SMALL DISADVANTAGED BUSINESS SUBCONTRACTING REQUIREMENTS/GOALS

☐ CHECK IF NOT APPLICABLE

☐ 0 Unsatisfactory ☐ 1-Poor ☐ 2-Fair ☒ 3-Good ☐ 4-Excellent ☐ 5-Outstanding

Comments (REQUIRED if performance criterion is applicable and limited to 2000 characters) In a timely manner, FHI was able to contract with the Initiatives Inc., a qualifying Grey amendment organization to provide technical assistance and training support to a health center in Surabaya on Universal Precautions/infection control. This activity is crucial to train health center workers in the area of STI/HIV/AIDS prevention.

SUBCONTRACTS

GOTO: ☐ BOTTOM ☐ TOP ☐ RATINGS ☐ CONTRACTOR PERSONNEL ☐ CUSTOMER SATISFACTION

Are subcontracts involved? ☒ YES ☐ NO (Check one)

Comments: (Please comment on those subcontractors that have provided a significant contribution to performance)

The Futures Groups (TFG) was able to manage quality condom marketing and promotion strategies and efforts. TFG established links with (1) a consortium of condom manufacturers to promote condom use and to improve communication in collaboration with local NGOs, and (2) commercial sex establishment owners to promote condom use. In addition, TFG managed a dedicated condom advertising campaign through TV and radio. Project Concern International (PCI) was able to conduct a needs assessment of organizational and administrative management, focusing on monitoring and evaluation of HAPP IAs, and to provide capacity building assistance and support to local NGOs.

CONTRACTOR KEY PERSONNEL

GOTO: ☐ BOTTOM ☐ TOP ☐ RATINGS ☐ SUBCONTRACTS ☐ CUSTOMER

SATISFACTION

CONTRACTOR MANAGER/PRINCIPAL INVESTIGATOR (last name, first name)
Ms. Wilson, Jane, FHI Country Director and Chief of Party

Comments (limited to 2000 characters)
Ms. Wilson has strong experience in HIV/AIDS programming. Her educational background is adequate (Education and Psychology). Ms. Wilson developed and maintained good long-term relationship with key government officials, counterparts, donors, key national organizations and experts. However, Ms. Wilson's understanding of USAID regulations and contract requirements remained below performance expectations. It was most unfortunate that Ms. Wilson departed her post as Country Director during the important program completion period. As a result, critical close-out reporting was inadequately managed or left incomplete.

CONTRACTOR KEY PERSON (last name, first name)
Dr. Roesin, Runizar, Deputy Chief of Party

Comments (limited to 2000 characters)
Dr. Roesin has strong experience in HIV/AIDS programs and policy issues, especially in strengthening collaboration with GOI key officers. His educational background is appropriate (MD and MPH). Dr. Roesin's management skills and professional interests did not adequately meet program management needs. This included weak leadership of the KPAD Master Plans planning process, and inadequate support for the 100% condom use policy, and local government programming support.

CONTRACTOR KEY PERSON (last name, first name)
Ms. Roesdiana, Dian, HAPP IEC/BCC Advisor

Comments (limited to 2000 characters)
Ms. Roesdiana has more than four years experience in designing and directing AIDS program among youth. Her educational background is appropriate (anthropology). However, Ms. Roesdiana lacks the skills and experience to lead, advise and manage directed IEC and behavior change strategies and interventions.

CUSTOMER SATISFACTION

GOTO: ☐ BOTTOM ☐ TOP ☐ RATINGS ☐ SUBCONTRACTS ☐ CONTRACTOR KEY PERSONNEL

Is/ was the contractor committed to customer satisfaction? (USAID) ☒ YES ☐ NO (Check one)
Is/ was the contractor committed to customer satisfaction? (End User) ☐ YES ☐ NO (Check one)
If this is the **Final Report** after contract expiration would you recommend the selection of this contractor again?
(REQUIRED IF Evaluation Process Completed Box Is Checked On Top of Page1) ☒ YES ☐ NO (Check one)

Comments
One of the greatest challenges of FHI/HAPP was creating a technical and management "marriage" among the many institutional and individual stakeholders involved in the project. FHI/HAPP managed a partnership between the GOI and Provincial AIDS Commission (KPADs), USAID, US-based PVOs, and local NGOs, universities and professional organizations. FHI incorporated considerable time to meet the bureaucracy and consultative requirements of all parties involved. Collaborative planning, the empowerment of partners and improved use of resources are required to further improve FHI's bottom-up planning. Through a competitive bidding process, a new three year Cooperative Agreement was awarded to FHI for the management and implementation of a STI/HIV/AIDS Prevention Support Program in Indonesia.

USAID PROJECT OFFICER (last name, first name) Kurniawati, Ratna
Is this a Foreign Phone Number? ☒
Phone [213]435-9407 (REQUIRED) ((###) ###-#### FOR U.S. PHONE NUMBERS) Extension 9407 Fax: 21 380-6694
Internet Address: rkurniawati@usaid.gov Date: 03/06/2001 (REQUIRED MM/DD/YYYY)

CONTRACTING OFFICER CONCURRENCE (Initials) TMS (Required)

CONTRACTOR REPRESENTATIVE (last name, first name) Schellstede, William
Is this a Foreign Phone Number? ☐
Phone (REQUIRED) ((919) 544-7040 FOR U.S. PHONE NUMBERS) Extension Fax: 919-544-7261
Internet Address: wschellstede@fhi.org
Date: (REQUIRED MM/DD/YYYY) (Note: Evaluation must be checked as Completed before data in the Red Section is saved

CONTRACTOR'S REVIEW

Were comments, rebuttal, or additional information provided? ☐ Yes ☐ No (Check one)

If YES, Documentation is on file in (location): ☐ Foreign *(Phone)* Ext

AGENCY REVIEW:

Were contractor comments reviewed at a level above the contracting officer? ☐ Yes ☐ No (Check one)
(Check Yes if the contracting officer and the contractor are unable to agree on a final rating and this needs to be referred to an individual one level above the contracting officer)

If YES, Documentation is on file in (location): ☐ Foreign *(Phone)* Ext

CONTRACTING OFFICER (last name, first name) STEPHENS, Thomas M. (Required)

Is this a Foreign Phone Number? ☒

Phone 021-3435-9000 (REQUIRED) ((###) ###-#### FOR U.S. PHONE NUMBERS) Extension 9490 Fax: 3435-9916

Internet Address: tstephens@usaid.gov

Date: 03/06/2001 (REQUIRED MM/DD/YYYY)

GOTO: ☐ TOP ☐ RATINGS ☐ SUBCONTRACTS ☐ CONTRACTOR KEY PERSONNEL ☐ CUSTOMER SATISFACTION

OMB CLEARANCE NO. 9000-0142

SOURCE SELECTION INFORMATION/ CONFIDENTIAL

WARNING!!! The sections in RED indicate information required for COMPLETED EVALUATION. Information for evaluations in progress will not be recorded.

CONTRACT CLOSE OUT - COMPLETION STATEMENT
TYPE OF CONTRACT: COST REIMBURSEMENT

1. CONTRACT NUMBER : 497-C-00-97-00011-00 2. LAST MODIFICATION NO: 03
3. CONTRACTOR : FAMILY HEALTH INTERNATIONAL
4. ADDRESS : 2101 Wilson Boulevard, Suite 700 , Arlington22101
5. CONTRACT AMOUNT : $12,053,953
6. COMPLETION DATE : September 30, 2000 7. TECHNICAL OFFICE: PHN

****

I. TECHNICAL OFFICE:

The contractor has :

	Yes	No.	N/A
1. Completed all requirements, terms and conditions	✓		
2. Completed all requirements of Reports Clause	✓		
3. Complied with all requirements of the Patent Rights Clause	✓		
4. Submitted final inventory and disposed of nonexpendable Property	✓		
5. Submitted Patent, Copyright and/or royalty reports			✓
6. Disposed of all Classified material			✓

BASED ON THE FOREGOING, I RECOMMEND THE CLOSE OUT OF THIS CONTRACT :

Technical Officer's Printed Name : Ratna Kurniawati

Signature : Ratna

Date : 27 Sept 2001

II. CONTRACT SPECIALIST

	Yes	No.	N/A
a) Has a final audit been done ? (Applicable to contracts over $500,000)		✓	
1. Are all questioned costs resolved ?	✓		
2. Has the final price been established ?	✓		
3. Has the Contractor's release been filed on AID Form 1420-40 ?	✓		
4. If not, has a Final Release been prepared under the Disputes Clause ?			✓
5. Has the Contractor settled all subcontracts ?	✓		
6. Have indirect costs been settled ? (FAR 42.708)			✓

	Yes	No.	N/A
b) Has a Desk Audit been done : (Applicable to contracts of $500,000 or less)	____	____	____
1. Are the direct costs acceptable ?	____	____	____
2. Are any disallowed costs resolved ?	____	____	____
3. Have the final indirect costs been determined ?	____	____	____
4. Amount of funds obligated ahs not been exceeded	____	____	____
5. Has he final price been established ?	____	____	____
6. Has the Contractor's Release been filed on AID Form 1420-40 ?	____	____	____
7. If not, has a Final Determination been prepared under the Dispute Clause ?	____	____	____
c) Have all contract administration actions been satisfactorily accomplished ?	____	____	____

BASED ON THE FOREGOING, I RECOMMEND THECLOSE OUT OF THIS CONTRACT FILE :

Contract Specialist's Printed Name : Thomas M. Stephens

Signature : Thomas M. Stephens

Date : 4/23/02

III. OFFICE OF FINANCIAL MANAGEMENT

a) Has Final Voucher No. 0200057, dated _____ been paid ? Yes ✓ No. _____

b) Have all unused funds, if any, been decommitted : Yes _____ No. ✓ will de-commit thru JV 02-119 ✓

c) Have all payment advances been liquidated ? Yes ✓ No. _____

d) Total amount paid : _____ Total amount decommitted : 61,869.00

AW 02/5/02

BASED ON THE FOREGOING, I RECOMMEND THE CLOSE OUT OF THIS CONTRACT FILE :

Controller's Printed Name : N. Keith Romwall

Signature : [signature]

Date : 2/22/02

IV. CONTRACTS OFFICE

Based on the recommendations contained in Parts I through III, above, it is hereby determined that all required contract administration actions have been fully and satisfactorily accomplished.

[signature]
Thomas M. Stephens
Contracting Officer

4/23/02
Date

PASA CLOSE OUT - COMPLETION STATEMENT

1. PASA NUMBER : 497-0380-P-00-6003-00 2. LAST MODIFICATION NO :03

3. PARTICIPATING AGENCY (PA) : U.S. Center for Disease Control (CDC)

4. ADDRESS : Division of STD Prevention, International Activities
National Center for HIV, STD, TB Prevention
Centers for Deseas Control and Prevention,
1600 Clifton Rd (Mailstop E02), Atlanta, Georgia 30333

5. PASA AMOUNT : $1,673,308

6. COMPLETION DATE : September 30, 2000 7. TECHNICAL OFFICE : HPN/SO8

****

I. TECHNICAL OFFICE:

The PA has:

	Yes	No	N/A
a. Completed all requirements, terms and conditions	✓		
b. Completed all requirements of Report Clause	✓		
c. Submitted final inventory and disposed of nonexpendable property	✓		
d. Disposed of all Classified material			✓

BASED ON THE FOREGOING, I RECOMMEND THE CLOSE OUT OF THIS PASA:

Technical Officer's Printed Name for: RATNA KURNIAWATI

Signature: Ratna

Date: 25 May 2001

II. CONTRACT SPECIALIST

a) Has a final audit been done?
(Applicable to PASA over $500,000)

	Yes	No	N/A
1. Are all questioned costs resolved?	✓		
2. Has the final price been established?	✓		
3. Has the amount due the Grantee been settled?	✓		✓
4. Has the amount due the Government been settled?	✓		

b) Has a Desk Audit been done:
(Applicable to PASA of $500,000 or less)

	Yes	No	N/A
1. Are the direct cost acceptable?			
2. Are any disallowed costs resolved?			
3. Have the final indirect costs been determined?			
4. Do the PA and A.I.D agree on all disbursed, obligated, and claimed amounts?			
5. If no, has appropriate action been taken to resolve any differences?			

BASED ON THE FOREGOING, I RECOMMEND THE CLOSE OUT OF THIS PASA:

Contract Specialist's Printed Name: Thomas M. Stephens

Signature:

Date: 2/4/02

III. OFFICE OF FINANCE

	Yes	No	N/A
a) Has the final voucher, or "Request for Advance or Reimbursement (RAR)", or Financial Status Report been received?	✓		
b) Have all excess payment advances been recovered?	✓		
c) Have all interest payments been submitted to USAID	✓		
d) Have all unused funds been decommitted?	✓		
e) The total PASA expenditure:	$ 1,544,953.06		
Total Amount Decommitted:	$ 128,354.94		

BASED ON THE FOREGOING, I RECOMMEND THE CLOSE OUT OF THIS PASA:

Controller's Printed Name: N. Keith Romwall

Signature:

Date: 01/22/2002

IV. GRANTS OFFICE

Based on the recommendations contained in Parts I through III, above, it is hereby determined that all required PASA administration actions have been fully and satisfactorily accomplished.

Thomas M. Stephens
Grant Officer

2/4/02
Date

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

January 14, 2002

Thomas M. Stephens
Contracting Officer, Contracting Management Office
USAID, American Embassy
Jl. Merdeka Selatan No. 3-5
Jakarta 10110
Indonesia

Dear Mr. Stephens:

I am writing this letter to respond to your request to Mr. Carmine J. Bozzi (letter dated May 25, 2001) about the necessary actions to facilitate formal closeout of PASA No. 497-0380-P-00-6003-00. As stated in the final status of the voucher (see attachment), the US Centers for Disease Control and Prevention (CDC) needs to refund $7,470.16 to USAID Mission. The CDC has refunded this amount in two installment ($3,930.26 in August 2001 and $3,540.41 in January 2002). For your inquiry about the final inventory of all residual non-expandable property, I have submitted this list of final inventory in my letter to you dated July 30, 2001 (see attachment). We have submitted our Final Report on this PASA. All other inquiries (final patent report, final copyright report, final royalty report, and procurement report) are not applicable for this PASA.

I am sorry for the delay in this formal closeout of PASA. Please feel free to contact me if you have any questions or concerns.

Thank you and Happy New Year.

Sincerely,

M. Riduan Joesoef, MD
Project Officer

CC: Ratna Kurniawati
Kathy Parker
Pam Schultz
Shirley Davis
Christina Bailey

Attachment: Final status of PASA voucher
List of non-expandable equipment purchased with PASA No.497-0380-P-00-6003-00

Optional Form 1017-G (9-79)
Title 7, GAO Manual
501017-810

JOURNAL VOUCHER

J.V. No. 497-02-102

Date January 18, 2002

REFERENCE	EXPLANATION	DEBIT	CREDIT
	EARMARK/COMMITMENT **PROJECT 4970380.00**		
P04 dtd. 01/14/02	72X1095 HCDX-97-23497-KG13 PASA-US Center for Deseas Control (CDC) E.C.NO : A710321 RESCTRNO : P701710 COMDOCNO : PS-497-0380-P-00-6003 E/C COMDOCNO : LC-497-0380-P-00-6003 E/C PASA NO : 497-0380-P-00-6003-00		$ 65,855.41 $ 62,499.53
	To de-commit/de-earmark unused funds.Activities completed. (PACD 09/30/2000) Clearance/Approval Ratna Kurniawati, HPN Thomas M. Stephens, CM		
	Total	$ 0.00	$ 128,354.94

Prepared by Anna Manullang
(Signature)
Project Accountant
(Title)

Funds verified by ~~Approved by~~ Dennis Brazil
(Signature)
F M O
(Title)

U.S. GOVERNMENT PRINTING OFFICE : 1985-0-479-171

67

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention

July 30, 2001

Thomas M. Stephens
Contracting Officer, Contracting Management Office
USAID, American Embassy
Jl. Medan Merdeka Selatan No. 3-5
Jakarta 10110
INDONESIA

Dear Mr. Stephens:

Enclosed is a list of non-expandable equipment (unit cost > $500) purchased by PASA no. 497-0380-P-00-6003-00 as you requested. All these good equipment have been transferred to FHI/USAID to be used for the new USAID HIV/AIDS prevention program. If you need further information, please feel free to contact me.

Thank you.

Sincerely,

M. Riduan Joesoef, M.D.
Project Officer, International Activity Unit
Division of STD Prevention, CDC

List of non-expandable equipment purchased with PASA no. 497-0380-P-00-6003-00

Description	Cost new	Condition
Computer desktop, AMD K6 200 MHz, 64 MB RAM, PCI bus, 3.2 GB HD, 6.1 GB HD, 24x CD-ROM, 36x CD-ROM, 56K Modem, Win95	$ 1,397.95	Good
Monitor, 17" Sony Trinitron Multiscan 200 sf	$ 749.99	Good
Computer laptop IBM ThinkPad 380, Pentium 133 CPU, 32 MB RAM, CD-ROM, 1.6 GB HD, v.90 PCM CIA modem, Win98	$ 2,290.14	Good
Computer laptop Toshiba Win95	$ 2,320.00	Unserviceable
Portable Brother Printer MP-21Cdx + accessories	$ 529.85	Good

All good equipments have been transferred to FHI/USAID to be used for the new USAID HIV/AIDS prevention program.

PASA NO. 497-0380-P-00-6003-00
ST96-014

	TIME PERIOD		FOR PARTICIPATING AGENCY	FOR AID DIRECT IN-COUNTRY	TOTAL	CUMUL TOTAL		FOR PARTICIPATING AGENCY DIRECT	OH	TOTAL	CUM TOTAL
ORIGINAL		1996	856,888.00	$70,362.00	927,250.00	$927,250.00		738,696.55	118,191.45	856,888.00	856,888.00
AM1		1997	443,579.00	$302,479.00	746,058.00	$1,673,308.00		382,395.69	61,183.31	443,579.00	1,300,467.00
TOTAL			1,300,467.00	$372,841.00	1,673,308.00			1,121,092.24	179,374.76	1,300,467.00	

TOTAL FOR FY 1996		
OBLIGATED THROUGH FY 1996		856,888.00
CARRY-OVER TO FY 1997	0.00	
FY 1997 FUNDING		856,888.00
TOTAL FOR FY 1997		443,579.00
OBLIGATED FOR FY 1997		$1,300,467.00
CARRY-OVER TO FY 1998	(374,605.50)	
FY 1998 FUNDING		$925,861.50
TOTAL FOR FY 1998		$0.00
OBLIGATED FOR FY 1998		$925,861.50
CARRY-OVER FOR FY 1999	(278,092.47)	
FY 1999 FUNDING		$647,769.03
TOTAL FOR FY 1999		$0.00
OBLIGATED FOR FY 1999		$647,769.03
CARRY-OVER FOR FY 2000	(234,574.53)	
OBLIGATED FOR FY 2000		$413,194.50
CARRY-OVER FOR FY 2001	(285,799.13)	
		127,395.37

	BILLED	OBLIGATED	DIFFERENCE
FY 96	$0.00	0.00	0.00
FY 97	$374,605.50	(374,605.50)	0.00
FY 98	$278,092.47	(278,092.47)	0.00
FY 99	$238,725.99	(234,574.53)	4,151.46
FY 00	$289,118.34	(285,799.13)	3,319.21
	$1,180,542.30	($1,173,071.63)	$7,470.67

NEED TO REFUND TO USAID/INDONESIA

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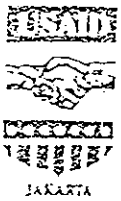

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

April 11, 2001

Prof. Dr.Umar Fahmi Achmadi, MPH
Director General for CDC & EH
Ministry of Health
Jalan Percetakan Negara No. 29
Jakarta 10560

Subject: A.I.D. Project 497-0380 (G)
HIV/AIDS Prevention Project (HAPP)
Project Implementation Letter (PIL) for de-commitment excess funds of the PILs No. 4, 5, 6 and 8
Project Implementation Letter No. 9

Ref: MOH letter No. KU.05.04.4, dated January 22, 2001

Dear Prof. Dr. Fahmi:

As we know, the HIV/AIDS Prevention Project (HAPP) was completed on September 30, 2000. GOI and USAID agreed to continue the HIV/AIDS prevention program under the new GOI/USAID SOAG No. 497-0393 "Protecting the Health of the Most Vulnerable Women and Children". The new STI/HIV/AIDS Prevention Support Program is called Aksi Stop AIDS (ASA).

Thank you very much for sending us the reference letter with the final status report of all pre-financed HAPP PIL activities and reimbursement by USAID.

The purpose of this Project Implementation Letter (PIL) is to seek your concurrence in the de-commitment of excess/unused funds under HAPP PILs No. 4,5,6, and 8. After concurrence is given, these funds will be formally de-obligated from HAPP, and we will request approval from USAID/Washington to reprogram the funds as add-on budget to the GOI/USAID SOAG No. 497-0393 for Aksi Stop AIDS (ASA) program. As you know the ASA program is managed by Family Health International (FHI) under a Cooperative Agreement with USAID.

Below, please see the break down calculation of the remaining funds under PIL 4, 4A, 5, 5A, 5B, 5C, 6, 6A, 6B, 8, 8A, 8B:

.....2/

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AMERICAN EMBASSY, JL. MEDAN MERDEKA SELATAN No. 3 - 5, JAKARTA 10110 - INDONESIA
TELEPHONE : (62 21) 344-2211 FAX : (62 21) 380 6694

PIL NO:	Earmark (in US$)	Commitment (in US$)	Expenditures (in US$)	Remaining Funds (in US$)
PIL 4 *	80,514	14,677	14,677	0
4A*		11,060	11,060	0
Available for reservation	80,514	25,737		54,777
Sub-total remaining funds				54,777
PIL 5 *	418,971	12,245	12,245	0
5A		95,116	28,914	66,202
5B		111,973	42,648	69,325
5C		63,344	33,559	29,785
Available for reservation	418,971	282,678		136,293
Sub-total remaining funds				301,605
PIL 6	255,267	54,854	46,136	8,718
6A		110,466	94,484	15,982
6B		38,009	29,981	8,028
Available for reservation	255,267	203,329		51,938
Sub-total remaining funds				84,666
PIL 8	245,248	118,383	33,459	84,924
8A		62,732	38,065	24,667
8B		59,293	23,876	35,417
Available for reservation	245,248	240,408		4,840
Sub-total remaining funds				149,848
Total Remaining Funds	1,000,000	752,152	409,104	590,896

(*) including the de-committed and de-earmarked excess funds, after completion of activities.

The majority of these excess funds are the result of the huge exchange rate fluctuations, especially after the economic crisis of 1997 (from Rp 2,432 to Rp 8,840 per US$). In accordance with the Rupiah budget calculation, the remaining funds represent only 17% of the total funds committed. (Total PIL commitment funds are Rp 2,105,918,000, and the total PIL expenditures are Rp 1,742,235,218).

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Please indicate your concurrence with this PIL by countersigning in the space provided below.

If you have any questions about this PIL, please contact us. Thank you for your continued cooperation and support. USAID wishes the Ministry of Health success in the implementation of ASA activities in partnership with Family Health International (FHI).

Sincerely,

Leslie B. Curtin

Leslie B. Curtin
Director
Office of Health, Population
and Nutrition (HPN)

Prof. DR. Umar Fahmi Achmadi, MPH

May 15th 2001
Date:

cc: Dr. Arwati Soepanto, HAPP MOH Project Manager
Drs. Erdison Saragih, PimPro HIV/AIDS, MOH
BAPPENAS –3
DepLu-3
SetNeg-3
Bank Indonesia – Bagian Dana Proyek -2

Annex - I

GOI CONTRIBUTION - ALLOCATED AND CUMULATIVE USED
HIV/AIDS PREVENTION PROJECT (HAPP)
Project No 497 - 0380 (Grant)

(US $)

CATEGORY	BUDGET	1 (DIP) FY 2000 (in kind and cash) allocated	2 CUMULATIVE Allocated	3 CUMULATIVE Used Up to end of Sept.2000
I. In Kind	-	1,162,410.4	5,184,490.3	4,784,225.3
1. Salary a. 3 Ass. + 3 Chief of Provincial CDC	-	30,687.4	143,914.4	130,885.2
b. 15 Staffs of Sub. Dit. STD Control		41,258.7	159,653.2	145,900.3
c. 2 Staffs of Management Project		4,934.4	19,110.8	17,466.0
d. 30 Staffs of Provincial CDC	-	18,598.3	71,967.4	65,757.9
2. Office of Jakarta H.Q, Surabaya and Manado	-	38,045.9	154,148.8	141,466.9
3. NFPCB	-	-	15,122.3	15,122.3
4. STD drugs	-	14,316.9	30,236.4	30,236.4
5. IEC	-	-	77,617.3	77,617.3
6. STD Control & treatment : - Central		1,014,068.3	2,536,164.0	2,198,141.0
- 27 Provinces		-	179,702.3	179,702.3
7. Dep. of Social Welfare		-	92,312.2	92,312.2
8. KPA (Central & Provinces)		-	567,701.8	567,701.8
9. Dep. of Education and Culture		-	122,332.2	104,598.4
10. Local Govt. of DKI Jakarta		-	23,057.1	23,057.1
11. Local Govt. of East Java		-	15,150.5	15,150.5
12. Local Govt. of North Sulawesi		-	39,728.0	39,728.0
13. Additional Expenditures FY 1995/96 + 1996/97 *)		-	936,572.2	936,572.2
II. In Cash	7,000,000.0	1,309,478.4	4,673,511.4	3,542,207.3
I E C	2,700,000.0	308,643.3	914,463.2	657,537.4
- Training, workshop, Seminar	-	246,648.7	753,726.1	558,794.9
- Commodities		61,994.6	160,737.1	98,742.5
Policy Support	740,000.0	49,294.7	87,669.7	38,375.0
- Study tour, Coference, Coordination		49,294.7	87,669.7	38,375.0
- Policy, Letter of Degree, etc		-	-	
STD Management	3,310,000.0	732,927.2	2,421,131.1	1,857,170.0
- Training, Review, Dev. SOP Pre testing	-	389,070.5	1,182,090.5	832,114.6
- Commodities	-	343,856.7	1,239,040.6	1,025,055.4
Audit and Evaluation	250,000.0	77,983.8	254,803.8	137,983.5
Evaluation, Supervision	-	77,983.8	254,803.8	137,983.5
Management	-	140,629.4	995,443.6	901,141.9
- Operational cost		44,200.8	172,406.0	131,024.4
- Office equipment		71,428.6	533,065.3	605,145.2
- Honoraria (non-government personnal)		-	119,555.3	119,555.3
- Annual plan		25,000.0	70,417.0	45,417.0
	7,000,000.0	2,471,888.8	9,858,002.3	8,426,433.6

1 $ = Rp. 2226

*) = See our letter dated 3 August 1998 No. KU.07.4 780 H

By Name, : Dr. Arwati Soepanto

Signature :

Title : Project Manager

Date : Sept 29 ,2000

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A CRITIQUE OF THE PERFORMANCE BASE CONTRACT

Family Health International
Submission to USAID's External Assessment Team
8 - 26 February 1999

1.0 Introduction

The government of Indonesia (GOI) and The US Government agreed to develop and implement the HIV/AIDS Prevention Project (HAPP) in 1995. The bilateral agreement was subsequently implemented through three different mechanisms, as follows:

- A Project Implementation Letter (PIL) with the GOI;
- A Partnership and Services Agreement (PASA) with the Centers for Disease Control and Prevention (CDC); and
- Two contracts with Family Health International (FHI)
  - AIDSCAP – Nov. 1995 to Sept. 1997
  - Bilateral Performance Based Contract - Sept. 1997 to April 2000

2.0 The development of the Performance Based Contract (PBC)

Under the AIDSCAP Contract, FHI carried out a number of baseline studies through the University of Indonesia (UI) and the Indonesian Epidemiological Network in 1996. The studies were the Behavioral Surveillance Survey (BSS), the WHO Program Indicators PI 6 (Diagnosis and Treatment) and PI 7 (Counseling), and STD Prevalence studies. The results of these studies were utilized by USAID in the formulation of the contract performance objectives (CPOs) and the benchmarks for the performance-based contract.

The PBC was put out to tender on March 11, 1997 through request for proposal (RFP) Indonesia #97-004. The RFP specified the requirements of the contract including the following:

"From the RFP the concept of using performance based contracting to achieve development change is relatively new to the USAID procurement environment. The concept, as being proposed for this requirement, will present offerors with a unique opportunity to develop and implement a strategy which contributes to the achievement of USAID's Strategic Objective No.2: Sustained improvements in health and reduced fertility (results Package (RP2) increased use and quality Sexually Transmitted Infection STI/HIV/AIDS prevention programs and sound policies developed.) Performance-based contracting emphasizes that all aspects of an acquisition be structured around the purpose of the work to be performed, as opposed to the manner in which the work is to be performed.

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It is designed to ensure that Contractors are given freedom to determine how to meet the Government's performance objectives, that appropriate performance quality levels are achieved and that payment is made for services which meet these levels.

3.0 The Contract

3.1 The Type of Contract

The HAPP contract is a completion plus award fee contract. The base fee is paid to the contractor without specific performance requirements but the award fee is dependent on the achievement of measurable, quantifiable performance standards on an annual basis.

The RFP and the contract itself specify a number of deliverables as well as the contract performance objectives and sub results, these are laid out in attachment 1 "*FHI - USAID Contract Deliverables.*"

3.2 The Award Fee

The award fee process is specified in FHI's contract. The Performance Evaluation Board (PEB) is to be formed by the Fee Determination Official (FDO), the Mission Director or Deputy Mission Director. The Board can consist of GOI officials, USAID personnel, and consultant(s) hired by USAID. The Board's role is to review all evidence of the contractor's performance, including possible discussion with the contractor, for the period in question. This will result in an Award Fee Determination Report recommending an amount for the award fee.

At the time of writing, the PEB has met several times to deliberate on the contractor's performance for 1997 and 1998. Initial impressions are that the complexity of the contract is making these deliberations unduly complex.

4.0 A critique of the Performance-Based Contract for HIV/AIDS Programs

As stated above, performance-based contracts emphasize that all aspects of acquisition be structured around the purpose of the work to be performed, as opposed to the manner in which it is performed. While it is undoubtedly important that due attention be paid to the purpose of the work, public health initiatives involving behavior change do not lend themselves to the degree of certainty (in terms of the relationship between inputs and outcomes) that might be found in other work endeavors. That is to say that the correlation between inputs and outcomes is not always predictable, or precisely measurable. For example, in the construction industry, a role for performance-based contracting would clearly be related to the indisputable correlation between measurable inputs such as the required amount of cement, iron rod, etc., and an outcome such as the structure of a given weight-bearing capacity. These inputs and outcomes could be monitored relatively easily by engineers from the public sector to assure that engineering plans were being correctly followed. And incentives to complete the work within a given

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timeframe could also motivate the construction company to engage staff for longer work weeks to complete the construction more quickly.

This same type of measurement of inputs related to outcomes becomes much less predictable and feasible to measure when it is related to human health and behavior. As one moves further from endeavors of high certainty and indisputable correlations, the less appropriate a performance-based contract becomes, in our view. Determining factors predictive of human behavior and of behavior change is extremely difficult, even when those behaviors are public ones such as smoking and eating. When the subject is one as complex and private as human sexuality, measuring risk behaviors, and the effect of interventions on changes in those behaviors is an imprecise science at best.

Contract Performance Objectives (CPOs) can have value in guiding technical program implementation. They can keep the contractor focused on the behavioral outcomes, as opposed to merely the process of implementation. They can provide evidence of success and movement in the desired direction of change. They can provide an indication to implementing agencies and their funders as to progress achieved on meeting objectives. But they cannot and should not be used to provide a judgment of ultimate "success" or "failure" of the behavior change interventions. Factors which influence human behavior cannot be measured with such a high degree of accuracy, that it would be appropriate to make "black and white" judgments of this nature. The discipline of social science dictates that a mixture of methods be used to measure behavioral concepts, and that the findings be interpreted in terms of "plausibility and a convergence of evidence". In other words, this is not a domain for which it would be prudent to judge performance based on imprecise quantitative measures alone.

4.1 Setting of the Numerical Targets

Having made the above point, it then follows that point estimates of quantitatively measured variables provide only a crude reflection of actual behaviors at any given point in time. Although the surveys and assessments conducted by FHI provide a means to measure progress over time on specific behavior changes, those changes cannot be measured with a high enough degree of accuracy to make definitive determinations about numerical targets. In addition, it is not known how much change is reasonable to expect for individual groups in different settings. In some cases, when HIV/AIDS prevention programs been operating for a period of time, it can become increasingly difficult to detect changes in behavior because interventions are having reinforcing effects rather than new ones. In these situations, the potential for behavior change may become smaller, and the focus should be on maintenance of reported behavior change as opposed to continual declines in risk behavior.

4.2 Attribution of Effects

While behavioral data can document changes in measures of behavior change, it is important to realize that in the absence of a rigorous experimental research, they can

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NOT draw a direct causal link between a particular intervention and a particular level of behavior. Most people are exposed to many sources of information and make decisions based on many, and complex, criteria. Information or activities provided as part of a prevention program will contribute to what people decide and how they behave, but there may be many other factors in the equation. Behavioral data alone are rarely able to isolate and attribute change to a single element. Therefore, the use of behavioral indicators as the main outcome of performance based contracts is inappropriate.

4.3 Management Issues

The complexity of the performance based contract has made it necessary to institute an expensive and elaborate management and reporting system, which has requires a heavy investment of staff time and has drawn resources away from the achievement of program objectives.

4.4 Relative lack of flexibility

Another problematic aspect of the performance based contract, when it is applied to HIV prevention, is its inflexibility in terms of reflecting the latest epidemiological and social situation. In a changing environment, the use of performance based objectives make it difficult for the contractor to respond to a changing environment. In the Indonesia contract, for example, commercial sex workers are the only target audience that is considered in CPO # 1. Other valid target groups such as youth at risk, need special justification to be targeted under this CPO. Once a contractor believes that a CPO is not appropriate for the current context, it is not easily changed.

4.5 Potentially Misleading

The focus on numerical achievement has implications for implementing agencies and for the project as a whole. The focus on subresults is "target oriented" and not "quality oriented." For example, subresult targets were set for Subresults 1a and 1b prior to the formulation of an accepted definition of what an outreach contact is. Multiple interpretations of this seemingly simple figure have been problematic for the project. The focus on the number of activities has downplayed the importance of quality.

4.6 Statistical Issues

Several problems have been experienced with the performance based objectives, their respective targets, and potential methods for determining whether FHI has reached these targets in any given time period. These can be summarized in two different points, both of which are linked to survey measurement and sampling methodologies:

a. Many of the HAPP indicators are behavioral, based on representative sampling methods, such as those found in behavioral surveillance. As such, any indicator which is derived from these samples is merely a point "estimate" of a true population

parameter. Point estimates always have "confidence intervals" associated with them, which depend to a large degree on the sample size used to derive them. In short, the larger the sample, the smaller the confidence interval and the more accurate the point estimate. Likewise, larger samples increase the power to measure statistically significant changes. Therefore, when sample sizes are too small, the failure to detect a change may not mean that the change did not occur, but merely that the sample size was not adequate to detect it. By the same token, if appropriate statistical tests are not conducted in conjunction with outcome evaluation, indicators that appear to have achieved target levels may be merely the result of very wide confidence intervals that happen to include the target value. Unfortunately, these issues of statistical precision are not always taken into consideration when the achievement of targets is being assessed.

Sample sizes are usually calculated according to a combination of the desired levels of change to be measured, combined with the degree of accuracy with which one would like to be able to assess change. However, a compromise is usually necessary between what is desirable and what is feasible. A *reasonable* level of accuracy and detection of change must be agreed upon, which can be quite different depending on what is being measured.

The consensus among participants at a workshop on methodological issues for the BSS workshop in Bangkok in 1997, was that for most behavioral parameters measured by BSS surveys, a 15% level of detection is reasonable. This means for example, that if condom use increases by 15%, then a representative survey should be able to detect this change and show that it is statistically significant. A smaller change, e.g. 10%, on the other hand would not be detected as statistically significant. However, participants felt that the detection of a smaller change than 15% would necessitate prohibitively large sample sizes and would frequently not be meaningful in terms of its effect on the epidemic.

The HAPP BSS was constructed with this recommended level of detection. However, certain CPOs have percentage increases which are significantly below the 15% level. For example, CPO1 currently states that an increase of 4% from 1996 to 1997 (from 36% to 40%) is desired. This is an example of an increase which is both substantively not meaningful and methodologically unrealistic. A 4% increase does not indicate a change in behavior affecting the HIV epidemic in any measurable way. Furthermore, the ability to detect a 4% increase would necessitate sample sizes of BSS populations which would be cost-prohibitive and detract from funds being used for interventions.

There are several indicators which currently have yearly increases specified where the methodology is not designed to detect these change.

b. The concept of representative sampling and the "point estimates" which it produces should influence the determination of whether a given objective has been achieved. If the target level for an indicator is within the confidence interval of the point

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estimate, then it should be considered as having achieved its target, even if the point estimate is below the target level. For example, if the target is 25% for a given CPO in a given year and the survey indicates the level to be 23% with a confidence interval of plus or minus 5%, then that target has been effectively achieved.

Thus, decision-making surrounding the achievements of targets needs to take into consideration the confidence levels of estimates provided each year.

5.0 Recommendation

1. If the extension option of the existing performance-based contract is to be exercised, activities in the extension period be supported and monitored by USAID with a mechanism more appropriate for HIV/STD control. FHI suggests that the Cooperative Agreement developed between USAID/Nepal and FHI be considered as a model.

REPORT DATE: 03/21/02

PROJECT FINANCIAL STATUS REPORT
AS OF: 03/21/02

REPORT
MISSION

PROJECT INFORMATION SUMMARY

CURRENCY CODE: 001
PROJECT NO. : 4970380.00
OFFICE CODE : 008
LOAN NO. :
ORIG AGR DATE: 03/28/95
M. C. CONTRIB: 7,000,000

CURRENCY NAME : U.S. DOLLARS
PROJECT TITLE : HIV/AIDS PREVENTION
PROJECT OFFICER: RATNA KURNIAWATI
IMPL AGENCY : MINISTRY OF HEALTH
PACD : ORIG 08/31/99 CURRENT 09/30/00
:NO OF REVISIONS 02
TERM DISB DATE : 01/31/01

	GRANT
LOP FUNDING :	21,000,000
LOP AUTHORIZED:	21,000,000
AMT. ALLOWED :	21,000,000
AMT. OBLIGATED:	21,000,000
ACCRUED EXP. :	18,863,934
PIPELINE/UNLIQ:	2,136,066

PROJECT SUMMARY BY BUDGET PLAN CODE

BPC	BUDGET ALLOWANCE	OBLIGATED	EARMARKED/ RESERVED	COMMITTED/ RESERVED	NET ACCRUED EXPENDITURES	PIPELINE UNLIQUIDATED
HCDX9723497KG13	5,740,000	5,740,000	5,152,376	5,152,376	5,152,376	587,624
HCD[illegible]9723497KG13	4,730,000	4,730,000	3,782,568	3,782,568	3,782,568	947,432
HDP49523497KG13	2,350,000	2,350,000	2,350,000	2,350,000	2,350,000	0
HDV49523497KG13	3,405,000	3,405,000	3,048,618	3,048,618	3,048,618	356,382
HDV59523497KG13	3,535,000	3,535,000	3,535,000	3,535,000	3,535,000	0
HDV69623497KG13	740,000	740,000	685,855	685,855	685,855	54,145
HDV69623497KG13	500,000	500,000	309,517	309,517	309,517	190,483
GRANT TOTAL	21,000,000	21,000,000	18,863,934	18,863,934	18,863,934	2,136,066
PROJECT TOTAL	21,000,000	21,000,000	18,863,934	18,863,934	18,863,934	2,136,066

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ATTACHMENT 10

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Manual Item 1017 (10-79)
Title 7 GAO Manual
501017.310

JOURNAL VOUCHER

J.V. No. 497-02-111

Date April 8, 2002

REFERENCE	EXPLANATION	DEBIT	CREDIT
	OBLIGATIONS PROJECT 4970380.00		
Memo MGinericl/SCromer did. 04/01/2002	72X1095 HCDX-97-23497-KG13 RESCTRNO : P701710 OBLDOCNO : SOAG02-00		$ 587,623.90
	72X1095 HCDX-98-23497-KG13 RESCTRNO : P801768 OBLDOCNO : SOAG 4970380.00 A#1		$ 947,432.00
	72X1021 HDP4-95-23497-KG13 RESCTRNO : P501547 OBLDOCNO : P-1547		$ 356,382.25
	72X1021 HDV6-96-23497-KG13 RESCTRNO : P601650 OBLDOCNO : P-1650		$ 54,144.96
	72X1021 HDV8-98-23497-KG13 RESCTRNO : P801762 OBLDOCNO : SOAG 497-0380 AMEND 1		$ 190,482.99
	To de-obligate unused funds.Activities completed. (PACD 09/30/2000) **Clearance/Approval** Ratna Kurniawati, HPN Molly Gingerich, HPN James Hope, PRO		
	Total	$ 0.00	$ 2,136,066.10

Prepared by Anna Manullang (Signature)
Project Accountant (Title)

Funds verified by, ~~Approved by~~ N. Keith Ronwall (Signature)
Controller (Title)

EXTERNAL ASSESSMENT OF USAID/INDONESIA'S HIV/AIDS PROGRAM

By:

David L. Piet, Team Leader
Nuning M. K. Masjkuri
Endang Sedyaningsih
Firman Lubis
Waliur Rahman
Kai Spratt

Submitted by:

LTG Associates, Inc.
and
TvT Associates, Inc.

Submitted to:

United States Agency for International Development/Indonesia
Under Contract No. HRN-I-01-99-000002-00, Task Order No. 1

February 1999

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EXECUTIVE SUMMARY

The U. S. Agency for International Development (USAID)/Indonesia requested the assistance of an external team to visit Indonesia to assist in assessing the general human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) situation in the country as well as government of Indonesia (GOI) and donor commitment/funding for HIV/AIDS and related activities. Additionally, USAID/Indonesia's current and future activities as implemented through the five-year $21 million HIV/AIDS Prevention Project (HAPP) and the AIDS Initiative Project in Irian Jaya through Program for Appropriate Technology in Health's (PATH) grant-assisted activities in Irian Jaya were assessed. It was anticipated that the findings and recommendations of the assessment team also would be useful to USAID/Indonesia in the refinement of its population, health, and nutrition (PHN) strategy, especially the HIV/AIDS Results Package.

METHODS/ACTIVITIES

During its 3–week stay, the assessment team met with the key organizations (USAID/Indonesia, Family Health International (FHI)/Jakarta, and the Ministry of Health) as well as a wide array of GOI representatives at both national and provincial levels, HAPP/ partner organizations, donors, international private voluntary organizations/nongovernmental organizations (PVOs/NGOs), local NGO counterparts, commercial advertising and social marketing companies, and end beneficiaries. The assessment team also conducted site visits to the three HAPP field sites in Jakarta, Surabaya, and Manado, as well as PATH field sites in Irian Jaya.

BACKGROUND

Indonesia ranks as the fourth most populous nation on earth. The first case of AIDS was diagnosed in 1987. Early projections of significant HIV transmission rates in the general population have not been substantiated by most recent studies. Recent prevalence studies indicate that HIV transmission continues to evolve slowly, but in an upward trend, in specific high-risk subpopulations: (1) commercial sex workers (CSWs) (less than 1 percent); (2) Jakarta-based male transvestite (waria) sex workers (1.39 percent); and, (3) in Irian Jaya, a province that is socioculturally distinct from the rest of the Indonesian population (0.8 percent).

Sexually transmitted diseases (STDs) are common among high-risk persons in Indonesia, but not among the general population. However, ulcerative STDs, cofactors associated with the greatest risk for HIV transmission, are rare among all groups. Data on HIV and STD prevalence, however, must be considered cautiously. Nationwide surveillance systems are being developed; HIV testing facilities are rare; most STD cases are not reported; STD incidence data are not reliable; and, the number of and the HIV/STD

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prevalence within other high-risk groups, such as injecting drug users (IDU) and men who have sex with men and transvestites, are unknown.

Since 1993, HIV/AIDS has received growing attention from the government of Indonesia (GOI) and the international donor community. The GOI established an intersectoral National AIDS Prevention and Control Commission in 1994, developed a national AIDS strategy to combat AIDS in the same year, and increased resources committed to HIV/AIDS prevention by 256 percent over the past five years. Since 1993, the donor community has worked rapidly to put into place over $79 million in assistance projects to support the GOI's national HIV/AIDS prevention program. Donors have regularly been included in GOI planning and NGO meetings with much evidence of genuine partnerships.

Some donors have worked together in the design of their activities to minimize duplication and overlap. This cooperation operates at many levels and means that projects benefit from lessons learned and ongoing strategic planning.

Recently, however, the devastating economic/political crisis caused USAID to postpone its transition plan and rapidly craft a new five-year strategy. The changes in 1998 have meant that Indonesian government leaders are preoccupied with many pressing issues. This has made it difficult to achieve much progress with HIV/AIDS issues in general government departments at present. Therefore, USAID/Washington and USAID/Indonesia reconsidered plans to phase out support in Indonesia and USAID has carefully reviewed its entire portfolio to ensure that USAID activities support social safety net programs of the GOI to mitigate the impacts of the crisis.

GEOGRAPHIC FOCUS

USAID/Indonesia's geographic focus until the year 2000 is on four specific provinces—three GOI and HAPP–assisted **demonstration** areas in North Jakarta; Surabaya, East Java; and Manado/Bitung, North Sulawesi; and, in Irian Jaya, with PATH assistance.

Beyond the GOI/HAPP demonstration areas, at present there are high-risk behavior areas in eight provinces in Indonesia which should be considered as new or expansion areas either under HAPP or with coordinated GOI and other donor assistance. The eight urban areas of high risk are in Irian Jaya, currently assisted by PATH; Riau, formerly assisted by the World Bank; Maluku; West Java; North Sumatera; South Sumatera; Central Java; and, Bali, currently assisted by AusAID. Of these eight, Irian Jaya, Bali, Riau, and Maluku have the highest prevalence of HIV/AIDS and present major challenges due to high-risk behaviors.

Compelling reasons for USAID/Indonesia to consider an expanded role regarding the STD and HIV/AIDS situation in Indonesia include the decrease in donor funding for HIV/AIDS; the ongoing economic crisis (krismon) and the GOI's current inability to

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provide adequate counterpart funds; eroding economic conditions of the poorest sectors of society which have caused economic stress and which may result in a decreased ability to pay for health care, delayed health seeking for STDs, inappropriate self-medication, poor nutrition, and the movement of women into the commercial sex industry as a short-term strategy to generate income; and, these eight provinces together have the cumulative highest number of HIV/AIDS cases and are demographically and geographically critical provinces in which to focus activities for HIV/AIDS prevention.

While there are yet no comprehensive national data to show that HIV/AIDS is moving from high-risk behavior groups into the general population, given the high rates of STDs in high-risk female populations in most of these provinces, the GOI and its partners should continue to take every precaution and measure to constrain the HIV/AIDS epidemic. The geographic setting, density of population, and overall infrastructure position these provinces as good intervention areas as well as areas for potential expansion of the HIV/AIDS epidemic. Improvements have been made in the last few years in building capacity for STD surveillance and treatment. However, these improvements need to be strengthened and expanded, both in technical areas, such as training in specimen collection, improved diagnosis, syndromic management, and upgrading of laboratory facilities, as well as training in patient counseling by health care providers from all sectors.

SERVICE DELIVERY AS BASIC STRATEGY

Since the bulk of energy, time, and resources should be focused on service delivery, both services and information, education and communication/behavior change communication (IEC/BCC) should continue to be viewed as a unified, two-pronged strategy—where each complements the other. IEC/BCC, primarily focused on community/client-centered behavioral change, should continue to be recognized as the natural adjunct to service delivery in that information and services for STDs and HIV/AIDS, condom promotion/use, and reproductive health are the essential components of the approach.

SUPPORTING ELEMENTS TO STD AND HIV/AIDS SERVICE DELIVERY

Supporting elements in the areas of policy, technical assistance, new or continuing education (training), administration/management, capacity building, biomedical/applied research, strengthening of surveillance systems, and monitoring and evaluation need to be strengthened to support and complement information and service delivery.

STRENGTHS OF USAID/INDONESIA'S HIV AIDS PREVENTION PROJECT (HAPP)

HAPP has been a catalyst for action to several provincial AIDS commissions (KPADs) and appears to have excellent relationships with the KPAD and the GOI. It provides expertise in epidemiology and STD surveillance through a participating agency service agreement (PASA) with the Centers for Disease Control and Prevention (CDC), Atlanta,

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Georgia, and it has demonstrated commitment to improving project management and coordination.

ISSUES/CONCERNS REGARDING HAPP

Areas of concern that need to be addressed include FHI/Jakarta administration, management, and responsiveness, limited delegation of authority, responsibility, and accountability to provincial level HAPP offices, and centralized and lengthy process/decision-making.

USAID/INDONESIA'S AIDS INTERVENTION PROJECT (AIP) II

Program for Appropriate Technology in Health (PATH), the prime contractor for the AIDS Intervention Project (AIP) in Irian Jaya, is currently in the second phase of AIP. Phase I, with the goal of strengthening NGOs in Indonesia, revealed that capacity building was especially needed in Irian Jaya. As a result, a second phase is planned for Irian Jaya as well as evaluating AIP's interventions there.

STRENGTHS OF AIP II (IRIAN JAYA)

PATH staff members in Irian Jaya are well trained and appear to have good relationships with local GOI and NGO staff and timely response to their collaborators' needs, the PATH administration process is efficient, and local GOI representatives are very receptive to AIP and supportive of its programs.

ISSUES/PROBLEMS

There is a need for a full-time secretary and operational budget for KPADs (provincial and districts). Additionally, there is a need for NGO capacity building in several key areas because there is a shortage of staff sufficiently trained to conduct simple data analyses and records management or undertake STD/AIDS and reproductive health programs as well as a lack of technical competence and a steady supply of appropriate diagnostic tests and medication. The PATH IEC and outreach programs need improvement in identifying, training and retaining appropriate outreach workers as well as developing or refining prevention messages for a variety of subpopulations and persuading bar managers to put STD/AIDS IEC materials in their bars. No specific fora exist for the NGOs to exchange information about program activities with each other. The scope of work for staff in the drop-in center at Tanjung Elmo, Jayapura, needs to be completed and the beneficiary groups need to be reconsidered—not all high-risk groups are covered by PATH programs, while some low risk groups are.

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RECOMMENDATIONS

The overall strategy and its interlinked components (e.g., strategic plan, annual work plan, appropriate interventions to address public health and development issues) are very impressive because of their clarity and rigor. The relationships established to date with the GOI and local organizational partners are impressive, also.

It should be noted that, in reality, community-based implementation under the performance-based contract (PBC) did not start until mid–1998 (after concurrence by USAID/Indonesia of the work plan in June 1998 and after the FHI internal review of August 1998). Despite major efforts to have a seamless transition from AIDSCAP interventions to the HAPP PBC, nonetheless a serious gap occurred between the planning/contracting phase and the start-up of field-based activities. In fairness to FHI, the complexity of the technical design, the multiple agency structure, and the time taken to respond to USAID/Indonesia's comments and reach consensus about the annual work plan led to some delays.

The assessment team concurs with the findings and recommendations which emerged from an internal review of FHI/Jakarta's administration and management of HAPP activities, with certain modifications:

- There should be no further changes of FHI's PBC though April 2000.
- The identification and/or refinement of indicators of achievement should take into consideration the time needed to achieve behavioral objectives as well as statistically meaningful/relevant significance.
- The implementing organization and its partner organizations should have primary responsibility for determining and reporting on the subresults.
- A performance-based contract is **not** an appropriate mechanism for development projects in general and public health projects in particular. Confronting and pursuing an HIV/AIDS epidemic demands flexibility in the application of planning, monitoring, and implementation.

(Some of the primary recommendations follow. For recommendations for the GOI, other donors, and USAID/Washington, as well as a complete listing of all recommendations, see section VII of the final report.)

USAID/INDONESIA

Primary Recommendations for Phase I (Through April 2000)

1. USAID/Indonesia should seriously consider switching from the current procurement mechanism, the performance-based contract (PBC) to a stand-alone cooperative

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agreement (CA), or include its HIV/AIDS activities under a new strategic objective agreement (SOAG). The nature, complexity, process orientation, and restrictions of a contract fundamentally impede the ability, immediacy, and flexibility required to respond to and pursue the HIV/AIDS epidemic within the Indonesian context. In reviewing its options in regard to the conversion of the PBC to either a CA or umbrella SOAG, USAID/Indonesia should:

- Undertake rigorous and periodic cost analyses of HAPP activities to ensure that only the required amount(s) of funding are obligated to the PBC to carry activities through April 2000.

- If a new umbrella SOAG is delayed, USAID/Indonesia should consider extending the current HAPP SOAG beyond April 2000 with a no-cost extension for approximately 18 months, if such an extension would **not** jeopardize a change in procurement mechanism.

- Remaining funds, if any, can be decommitted/recommitted to a new agreement.

2. For Phase II planning and in accordance with the USAID/Indonesia timeframe, between March and November 1999, a second team should visit Indonesia to assist in an indepth review and refinement of both PHN's and HAPP's strategies, work plans, and indicators.

3. USAID/Indonesia should carefully review HAPP's current model of using fixed demonstration areas .

4. USAID/Indonesia, in coordination with other donors, should consider focusing resources on the same provinces—Jakarta, Surabaya, and Manado—as well as on possible expansion sites in different provinces (donor coordination).

5. Adequate, reliable, and valid epidemiological data are needed to be able to efficiently design, target, prioritize, and evaluate disease prevention programs.

6. USAID/Indonesia should critically review its HIV/AIDS strategy, multiple U.S.–based implementing partner organizations, and funding requirements for Phase II activities.

7. The HAPP STD adviser should be relocated to the MOH's/CDC offices to improve communication and accessibility.

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FHI/JAKARTA AND PARTNERS (PACT, TFG, PCI, DKT)

Primary Recommendations for Phase I (Present–April 2000)

1. Given the limited time remaining under Phase I and the intensive efforts by all concerned to get activities underway, no fundamental changes should be made to the procurement mechanism (performance-based contract), the HAPP strategic components, and the current annual work plan and its indicators.

2. FHI/Jakarta, in consultation with USAID/Indonesia, should critically review its HIV/AIDS strategy, multiple U.S.–based implementing partner organizations, and funding requirements for Phase II activities. Unless there are clear and compelling reasons for multiple international PVOs under the HAPP umbrella, as well as clearly demarcated roles and responsibilities for each partner under the umbrella, it is neither managerially efficient nor cost-effective to have so many partners. Serious consideration should be given to consolidating the number of international PVO partners required to implement Phase II of HAPP.

3. FHI/Jakarta should delegate true authority, responsibility, and accountability to its HAPP provincial offices and the HAPP–funded NGOs.

4. If given the opportunity by USAID, a different, more flexible procurement mechanism should be utilized.

5. FHI/Jakarta, with FHI/Arlington, ARO/Bangkok, USAID/Indonesia, and the GOI should carefully review the current model of fixed demonstration areas to consider more flexible models of information and service delivery.

6. Given the focus on demonstration areas in three sites, GOI, FHI/Jakarta, and its partner organizations must work toward simple, sustainable, workable, situation-specific models within the Indonesian context that continue once USAID assistance ends.

7. Adequate, reliable, and valid epidemiological data are needed to be able to efficiently design, target, prioritize, and evaluate disease prevention programs. Therefore, FHI/Jakarta should continue to foster communication among organizations it supports and share its data with the aims of maximizing the comparability and thus the usefulness of data collected, and increasing the impact of data collected by sharing and disseminating them.

8. While improving surveillance is a priority, these activities should not be conducted at the expense of the rights and voluntary participation of members of high-risk communities.

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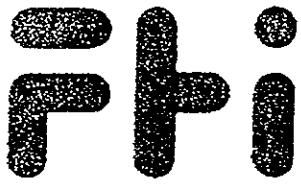
PATH AIP II

Recommendations for Phase I (Until September 2000)

No fundamental changes are recommended during the current phase of activities (until September 2000). However, the following activities should be strengthened during this time period:

1. Adequate, reliable, and valid epidemiological data are needed to be able to efficiently design, target, prioritize, and evaluate disease prevention programs. Therefore, PATH should continue to foster communication among collaborating organizations and share its data with the aims of maximizing the comparability and thus the usefulness of data collected, and increasing the impact of data collected by sharing and disseminating them.

2. To build KPAD capacity, PATH should provide increased technical assistance to aid the district KPADs in developing their specific master plan and to prioritize program sustainability by transferring knowledge and skills to local personnel.



FAMILY HEALTH INTERNATIONAL
2101 WILSON BLVD., SUITE 700
ARLINGTON, VIRGINIA 22201
USA

FAX #: (703) 516-9781
TELEPHONE: (703) 516-9779
URL: http://www.fhi.org/

TO:

NAME: Thomas Stephens/Asuncion L. Juico, Office of Contracts Management

LOCATION: USAID Jakarta

FAX #: (62-21) 3435-9916 and (62-21) 3806694

FROM:

NAME: William P. Schellstede

TELEPHONE: (703) 516-9779

DATE: 04/22/02 TOTAL # OF PAGES: 5 (Including this page)

SUBJECT: 1) Mr. Schellstede's letter dated 4/22/02
2) Certification AID Form 1420-40

The originals are on their way via DHL.

FAMILY HEALTH INTERNATIONAL

April 22, 2001

USAID/Indonesia
C/O American Embassy
Jl Medan Merdeka Selatan 3
Jakarta 10110, Indonesia

Attention: Thomas M. Stephens
Agreement Officer

Subject: FHI/HAPP Contract Formal Closeout

Reference: USAID Fax of April 22, 2002
Contract No. 497-C-00-97-00011-00

Dear Mr. Stephens:

Family Health International (FHI) hereby provides our responses to the "actions required" as set forth in your letter of September 27, 2001, relative to the final closeout of the referenced Contract, as follows:

Item 1	Submitted; receipt acknowledged by USAID
Item 2	FHI met all the requirements of the "Reports" clause in the Contract
Item 3	FHI settled all subcontracts
Item 4	FHI submitted the final inventory of all residual non-expendable property
Item 5	Not applicable
Item 6	Not Applicable
Item 7	Not Applicable

With respect to Item 2, we are arranging to have confirmation copies of the reports sent to the Center for Development Information and Evaluation, Bureau for Program and Policy Coordination, now handled under the "Development Experience Clearinghouse" contract; there may have been some slippage in that transition.

FHI

URL: http://www.fhi.org

Headquarters:
P.O. Box 13950, Research Triangle Park, NC 27709 USA
2224 E NC Highway 54
Durham, NC 27713 USA
Telephone: 919-544-7040 Fax: 919-544-7261

Washington Office:
HIV/AIDS Prevention and Care Department
2101 Wilson Boulevard, Suite 700
Arlington, VA 22201 USA
Telephone: 703-516-9779 Fax: 703-516-9781

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The completed and executed Form AID 1420-40, Contractor's Release and/or Assignment of Refunds, Rebates, Credits, and Other Amounts is attached according to your instruction.

We apologize for the delay of this confirmation. If you have any question, please do not hesitate to contact me at (703) 516-9779.

Sincerely,

William P. Schellstede
Contracts Administrator

WPS/deb

Encl.

cc: Ratna Kurniawati, USAID/Indonesia
Stephen Wignall, FHI/Indonesia
Neil Brenden, FHI/ARO

AGENCY FOR INTERNATIONAL DEVELOPMENT
CONTRACTOR'S RELEASE AND/OR ASSIGNMENT OF
REFUNDS, REBATES, CREDITS, AND OTHER AMOUNTS

I. IDENTIFICATION

1. CONTRACTOR'S NAME AND ADDRESS (hereinafter referred to as Contractor)

Family Health International
P.O. Box 13950
Research Triangle Park
NC 27709
2224 E NC Highway 54
Durham, North Carolina 27713 USA

2. CONTRACT NUMBER (hereinafter referred to as the Contract)

497-C-00-97-00011-00

3. AMOUNT OF RELEASE (in dollars) Balance of Feder al Fund
US $61,869

4. PURPOSE (check appropriate)

__ RELEASE __ ASSIGNMENT XX BOTH

II. CONTRACTOR'S RELEASE

Pursuant to the terms of the Contract and in consideration of the sum set forth in Section I., Block 3., above which has been or is to be paid under the said Contract to the Contractor or its assignees, if any, the Contractor, upon payment of the said sum by the UNITED STATES OF AMERICA (hereinafter called the Government), does remise, release and discharge the Government, its officers, agents, and employees, of and from all liabilities, obligations, claims, and demands whatsoever under or arising from the said Contract except:

1. Specified claims in stated amounts or in estimated amounts where the amount are not susceptible of exact statements by the Contractor, as set fort in the space in the space provided on the reverse of this form (Section V).
2. Claims, together with reasonable expenses incidental thereto, based upon liabilities of the Contractor to third parties arising out of the performance of said Contract: provided that such claims are not known to the Contractor on the date of execution of third release; and provided further that the contractor gives notice of such claims in writing to the Contracting Officer not more than six (6) years after the date of this release or the date of ny notice to the Contractor that the Government is prepared to make final payment, whichever is earlier.
3. Claims for reimbursement of costs (other than expense of the Contractor by reason of his indemnification of the Government against patent liability), including reasonable expenses incidental thereto, incurred by the Contractor under the provisions of the said Contract relating patents.

The Contractor agrees, in connection with patent matters and with claims which are not released as set forth in Section V., that he will comply with all of the provisions relating to notification to the Contracting Officer and relating to the defense or prosecution of litigation.

III. CONTRACTOR'S ASSIGNMENT OF REFUNDS, REBATES, CREDITS, AND OTHER AMOUNTS

Pursuant to the terms of the Contract and in consideration of reimbursement of costs and payment of fee, if any, as provided in the Contract and any assignment thereunder, the Contractor does hereby

1. Assign, transfer, set over and release to the UNITED STATES OF AMERICA (hereinafter called the Government), all right, title and interest to all refunds, rebates, credits, and other amounts (including any interest thereon), arising pout of the performance of the Contract, together with all the rights of action accrued or vested or hereafter accrue thereunder.
2. Agree to take whatever action may be necessary to effect prompt collection of all refunds, rebates, credits, and other amounts (including any interest thereon) due or which may become due and to promptly forward to A.I.D. Paying Office checks (made payable to the Treasurer of the United States) for any proceeds so collected. The reasonable costs of any such action to effect such collection shall constitute allowable costs when approved by the Contracting Officer as stated in the said Contract and may be applied to reduce any amounts otherwise payable to the Government under the terms and.
3. Agree to cooperate fully with the Government as to any claim arising in connection with refunds, rebates, credits, or other amounts (including any interest thereon); to execute any protest, petition, application, power of attorney, or other papers in connection therewith; and to permit the Government to represent him at any hearing, trial, or other proceeding, arising out of such claim.

IV. CERTIFICATIONS

1. IN WITNESS WHEREOF, this release and/or assignment has (have) been executed this day.

*WITNESS

(1)_____

(2)_____

*In the case of a corporation, the signature of two witnesses are not required, but the certificate below must be completed.

William P. Schellsted e
BY

Corporate Contracts Administrato
TITLE

DATE April 22, 20

CORPORATE CERTIFICATE

2. I, W. P. Schellstede certify that I am the Corp Contracts Ad (official title) of the corporation named as Contractor in the foregoing release and/or assignment; that I _____ who signed said release and/or assignment on behalf of the Contractor was the Corp Contracts Ad (official title) of the said corporation; that said release and/or assignment was duly signed for and in behalf of said corporation by authority of its governing body and is within the scope of its corporate powers.

AID 1420-40(11-72)

BEST AVAILABLE COPY

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AGENCY FOR INTERNATIONAL DEVELOPMENT
CONTRACTOR'S RELEASE AND/OR ASSIGNMENT OF
REFUNDS, REBATES, CREDITS, AND OTHER AMOUNTS

I. IDENTIFICATION

1. CONTRACTOR'S NAME AND ADDRESS (hereinafter referred to as Contractor)

Family Health International
P.O. Box 13950
Research Triangle Park
NC 27709
2224 E NC Highway 54
Durham, North Carolina 27713 USA

2. CONTRACT NUMBER (hereinafter referred to as the Contract)

497-C-00-97-00011-00

3. AMOUNT OF RELEASE (in dollars) Balance of Federal Funds: US $61,869

4. PURPOSE (check appropriate)

__ RELEASE __ ASSIGNMENT XX BOTH

II. CONTRACTOR'S RELEASE

Pursuant to the terms of the Contract and in consideration of the sum set forth in Section I., Block 3., above which has been or is to be paid under the said Contract to the Contractor or its assignees, if any, the Contractor, upon payment of the said sum by the UNITED STATES OF AMERICA (hereinafter called the Government), does remise, release and discharge the Government, its officers, agents, and employees, of and from all liabilities, obligations, claims, and demands whatsoever under or arising from the said Contract except:

1. Specified claims in stated amounts or in estimated amounts where the amount are not susceptible of exact statements by the Contractor, as set forth in the space in the space provided on the reverse of this form (Section V).
2. Claims, together with reasonable expenses incidental thereto, based upon liabilities of the Contractor to third parties arising out of the performance of said Contract: provided that such claims are not known to the Contractor on the date of execution of third release; and provided further that the contractor gives notice of such claims in writing to the Contracting Officer not more than six (6) years after the date of this release or the date of ny notice to the Contractor that the Government is prepared to make final payment, whichever is earlier.
3. Claims for reimbursement of costs (other than expense of the Contractor by reason of his indemnification of the Government against patent liability), including reasonable expenses incidental thereto, incurred by the Contractor under the provisions of the said Contract relating patents.

The Contractor agrees, in connection with patent matters and with claims which are not released as set forth in Section V., that he will comply with all of the provisions relating to notification to the Contracting Officer and relating to the defense or prosecution of litigation.

III. CONTRACTOR'S ASSIGNMENT OF REFUNDS, REBATES, CREDITS, AND OTHER AMOUNTS.

Pursuant to the terms of the Contract and in consideration of the reimbursement of costs and payment of fee, if any, as provided in the said Contract and any assignment thereunder, the Contractor does hereby:

1. Assign, transfer, set over and release to the UNITED STATES OF AMERICA (hereinafter called the Government), all right, title and interest to all refunds, rebates, credits, and other amounts (including any interest thereon), arising pout of the performance of the said Contract, together with all the rights of action accrued or which may hereafter accrue thereunder.
2. Agree to take whatever action may be necessary to effect prompt collection of all refunds, rebates, credits, and other amounts (including any interest thereon) due or which may become due, and to promptly forward to A.I.D. Paying Office checks (made payable to the Treasurer of the United States) for any proceeds so collected. The reasonable costs of any such action to effect collection shall constitute allowable costs when approved by the Contracting Officer as stated in the said Contract and may be applied to reduce any amounts otherwise payable to the Government under the terms hereof.
3. Agree to cooperate fully with the Government as to any claim or suit in connection with refunds, rebates, credits, or other amounts due (including any interest thereon); to execute any protest, pleading, application, power of attorney, or other papers in connection therewith; and to permit the Government to represent him at any hearing, trial, or other proceeding, arising out of such claim or suit.

IV. CERTIFICATIONS

1. IN WITNESS WHEREOF, this release and/or assignment has (have) been executed this day.
*WITNESS

(1)_____

(2)_____

*In the case of a corporation, the signature of two witnesses are not required, but the certificate below must be completed.

William P. Schellstede
BY

Corporate Contracts Administrator
TITLE

DATE
April 22, 2002

CORPORATE CERTIFICATE

2. I, W. P. Schellstede certify that I am the Corp Contracts Adm (official title) of the corporation named as Contractor in the foregoing release and/or assignment; that I _____ who signed said release and/or assignment on behalf of the Contractor was the Corp Contracts Adm (official title) of the said corporation; that said release and/or assignment was duly signed for and in behalf of said corporation by authority of its governing body and is within the scope of its corporate powers.

V. Specified claims applicable to Section II.1. of the Contractor's Release are to be set forth in the space provided below.

No Claims

INSTRUCTIONS TO CONTRACTOR

1. This form may be used for three purposes:

   a. As a *Contractor's Release.*

   b. As an *Assignment of Refunds, Rebates, Credits, and Other Amounts.*

   c. As both a *Contractor's Release* and an *Assignment of Refunds, Rebates, Credits, and other Amounts.*

2. In completing Section I., the Contractor is to indicate the purpose (see 1. above) for which he is submitting the completed form as follows:

   a. Contractor's Release — Check *only* the release box in Section I.4. and if a corporation complete the Certificate in Section IV.2.

   b. Assignment of Refunds, Rebates, Credits, and Other Amounts — Check *only* the assignment box in Section I.4. and if a corporation complete the Certificate in Section IV.2.

   c. As *both* a Contractor's Release *and* an Assignment of Refunds, Rebates, Credits and Other Amounts. — Check the *both* box in Section I.4. and if a corporation complete the Certificate in Section IV.2.

3. The form is to be completed in triplicate as follows:

   a. ORIGINAL AND DUPLICATE — When completed, forward these to the cognizant AID Contracting Officer.

   b. TRIPLICATE — Contractor's retain copy

4. The Contractor is responsible for filling in all the information requested on the form. Use the space provided in Section V. for listing outstanding claims as requested in Section II.1. of the form.

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