Evaluation Report

A Performance Review of Selected USAID HIV/AIDS Programs
In Indonesia

December 2013

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Executive Summary

In October 2013, USAID-Indonesia commissioned an evaluation team to assess the performance of selected USAID-funded HIV/AIDS activities in Indonesia since Fiscal Year 2010. The evaluation served both to assess past progress as well as to recommend appropriate measures for future work, including for work that will begin in 2015. USAID's main support and partnership with the Government of Indonesia (GOI) in addressing HIV/AIDS continues to focus on preventing sexual transmission among key populations and capacity building efforts for civil society and local governments.

Evaluation team members embarked upon a series of site visits in Jakarta, East Java, and Papua in order to interview key stakeholders, including from the organizations themselves, about the work of FHI 360 and TRG in implementing the Scaling Up for Most at Risk Populations I and II (SUM I and II), and of RTI in implementing Kinerja Expansion in Papua. Based on these site visits, interviews with a range of government counterparts, beneficiaries, and implementing partners, and a review of relevant documents including quarterly and annual program data, the team made a series of recommendations. These are summarized immediately below, and elaborated further in the report, as are the findings that support the recommendations:

1. **Future work should continue to include support to CSOs**. Currently, this work is done largely through the work of SUM II as it works to build organizational capacity among its CSO partners. Not only are the majority of CSOs interviewed able to keep better financial records, they have also expanded their reach to key populations, and some are better able to plan and account for this as a result of the M&E technical support. Further, a number of CSOs (although not the majority of CSOs we interviewed) were able to leverage additional (new) funding outside of USG after the provision of SUM II's support and some also obtained legal status with the government.

2. **Continued support to CSOs should include specific technical assistance in HIV programming.** Many stakeholders interviewed, including CSOs themselves as well as the MoH, identified the current lack of effective, up-to-date, and innovative programmatic technical assistance (TA) to be a gap in the program. Such specific technical assistance will result in CSOs being able to focus their efforts on the members of the risk communities that have the highest risk of HIV in Indonesia: female sex workers who work in brothels and on the streets; men who have sex with men (particularly younger men); and *waria* who do street based sex work.

3. **In Papua, the primary program focus should be on Papuan women sex workers, most of whom work on the streets or in small 'wisma', with a secondary focus on brothel-based sex workers, almost all of whom are not Papuan**. If men who have sex with men and waria can be found then these communities should also be served. The general Papuan population and 'high risk men' should not receive prevention services through SUM II.

4. **USAID-Indonesia and its partners should follow with interest the recent MoH Test and Treat circular, as this could open an important policy window with respect to**

HIV testing and entry into care. It is necessary for civil society organizations to prepare people for treatment when they encourage them for testing and then conduct activities to get as many people into treatment as possible. Operational research by a team of health scientists and community members to determine the constraints to achieving universal access to Test and Treat and their removal should take place in the sites where the Test and Treat rollout begins. This includes Malang, Surbaya Kota, Jayawijaya, Jayapura, and Jakarta Barat.

5. **CSOs and local government should closely monitor the sex work environment in Dolly and for sex workers who have worked in Dolly after the brothels close.** Instead of making predictions about what will happen to the women who work there at present, the CSOs and local government should make preparations in order to be able to quickly adjust their programming to meet the needs of female sex workers most at need of services when the brothels close.

6. **Urgent action should be taken to resolve persistent condom stockouts in Papua.** This was a problem for at least one CSO in Papua.

7. **Efforts should be taken to ensure non duplication between Kinerja and SUM II interventions in Papua**. USAID-Indonesia should also work with Kinerja to strengthen the governance component of the intervention at the higher level within the health system as opposed to the organizational components.

8. **Future work should continue to include support for Condom Social Marketing (CSM).** Continued support should include a clearer action plan on how to improve the overall condom supply chain management system at the national, provincial, and local levels, including routine monitoring of consumption data at the implementing sites. There needs to be a sharper, clearer direction on the next steps/plans for CSM activities in Indonesia and in the development of the national condom strategy.

9. **Future work should continue to include technical support on strategic information at the national and provincial level, especially in the area of iBBS and population size estimation.** However, given the suboptimal quality of the selected implementation tools and guidelines reviewed in this evaluation and the wide array of preventable issues identified during the course of the 2013 iBBS implementation in Papua, there needs to be vast improvements in the quality of technical support provided in the future at all phases of the study, starting from the preparation phase to final dissemination of the report. This may also require an increased level of oversight by USAID's technical area experts in strategic information and the USAID management team.

Introduction

In October 2013, USAID-Jakarta commissioned a team to evaluate selected USAID-funded HIV/AIDS activities in Indonesia. Indonesia's national epidemic remains one categorized as concentrated, with most HIV infections occurring among high risk groups. National level prevalence of HIV remains approximately 0.3%, with the exception of Papua which continues to experience a low-level generalized epidemic with an HIV/AIDS prevalence of 2.4%.[1][2]

The United States Government through the U.S. Agency for International Development has had a longstanding role in supporting the Government of Indonesia's efforts in the prevention of HIV/AIDS. Presently, USAID's strategy focuses on preventing the sexual transmission of HIV; building capacity of local government and NGOs to better deliver services and improve use of data for strategic planning and implementation; technical support to the National AIDS Commission and MOH; and expanding access to services in Papua, largely through support to local NGOs and strengthening the local health system.[3]

The evaluation team assessed progress toward these goals from 2010 to date through the work of three programs: Scaling up for Most at Risk Populations (**SUM I and II**) supports accelerated condom availability and use among high risk groups (SUM I), as well as builds the capacity of local governments and NGOs in order to ensure a sustainable response to HIV/AIDS (SUM II). In Papua, program funding is also channeled through the **Kinerja** program, a democracy and governance program that works to improve the local government's response to the epidemic.

The purpose of the evaluation is to assess progress and impact of USAID's HIV/AIDS programs and to recommend appropriate measures toward revision of interventions and strategies. Findings and recommendations may also serve to help inform design of future programming.

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1 Further analysis of the HIV/AIDS epidemic in Indonesia can be found in the recent report "Recommendations for USAID-Indonesia's 2015 HIV/AIDS Program Design." June 2013.
2 Prevalence information for Papua may be updated when results are available from the current Integrated Biological and Behavioral Surveillance (IBBS), 2013.
3 USG Strategy for HIV/AIDS in Indonesia 2011-2016

Evaluation Purpose and Questions

The purpose of this evaluation is to assess the performance of three implementing partners from 2010 to date in order to assist both USAID and the partners in understanding strengths and areas where technical, administrative and management efforts could be improved. It will also provide evidence and learning for improving USAID/Indonesia future program designs, strategies and policies. Specifically, the evaluation aims to:

- Provide information on the performance of each component of program to prevent and control HIV/AIDS program in Indonesia including relevant issues, sustainability, and cost effectiveness;

- Assess how well various components work together and foster multi-sector engagement;

- Determine to what extent the USAID HIV/AIDS Program is meeting the objectives and what challenges, weakness, and lessons learned can be drawn from implementation of this program;

- Examine whether programs contribute as intended to the goals of the Indonesian government's response to the epidemic; and

- Provide recommendations for USAID to better target efforts, audiences and resource investment.

The following questions informed the design:

1. To what extent have the program activities mitigated the risks of sexual transmission for HIV/AIDS?

2. To what extent have the program activities improved technical and organizational capacities for Civil Society Organizations Indonesia in reducing the transmission of HIV/AIDS in Indonesia?

3. To what extent have the program activities improved the capacity of the health service in preventing and controlling HIV/AIDS in Indonesia?

4. To what extent have the program activity strengthen capacity of the national and sub-national (province and district) government, private sector, community, and other stakeholders?

5. What is the contribution of each project to the overall HIV/AIDS program at national and provincial level?

6. How replicable, adaptable/adoptable, sustainable are the programs/program components?

7. How effective has the collaboration/coordination among the programs been in maximizing efforts and achieving greater results?

8. Have program interventions effectively enhanced local and national ownership and future commitment to continued implementation of good practices/lesson learned be enhanced?

Methodology and Limitations

In October 2013, an evaluation team comprised of two independent consultants and a senior advisor from USAID-Washington began work to assess the performance of selected USAID-funded HIV/AIDS programs in Indonesia since Fiscal Year 2010. Team members completed site visits in Jakarta, East Java, and Papua in November 2013, accompanied by USAID-Indonesia HIV experts as appropriate.

Sites were chosen in these three areas for their relevance to the work of SUM I, SUM II, and Kinerja expansion in Papua, the three programs that were part of the assessment. Each of the three programs has approximately 18 months left in its current agreement; therefore, there is opportunity for midway corrections in addition to improvements in future programs and agreements. Evaluators met with each of the three program headquarters' staff in Jakarta before completing interviews in East Java and Papua. A detailed program agenda can be found at Annex 2.

The evaluation team applied a range of data collection and analysis methods, including:

1. Review all relevant background materials, including country planning and program documents, such as:

- Program background documents, including contracts, co-operative agreements and other key design and implementation guidance documents;
- Performance Management Plans;
- Annual work plans;
- Quarterly/Annual Reports;
- Assessments, Studies and Reviews related to these projects.
- Selected survey tools and documents from the 2013 IBBS

2. Conduct in-depth interviews and focus group discussions with the following organizations:

- Ministry of Health and National AIDS Commission
- International Development Partners including AusAID, CHAI, and HCPI
- Implementing partners: FHI 360, TRG, NAC and RTI
- Province and District Health Offices
- Provincial and District AIDS Commission
- Health Facilities
- Civil Society Organizations

- Program beneficiaries
- Technical Assistance Providers

3. Conduct field visits to program implementation site in Jakarta, East Java and Papua.

Upon completion of the data collection, including site visits, team members debriefed USAID-Indonesia of preliminary findings. High level findings and recommendations were also shared with the Mission Director.

There were limitations to this performance review. First, compressed timing due to external events precluded a team meeting with all evaluation members before interviews began. Background documents were available to evaluation team members shortly before field work began and none of the informants saw the evaluation tool that was developed by the team. As in any performance assessment where the main informants are program implementers, there is a possibility that the informants presented their work in a positive light. The evaluation team triangulated findings in order to reduce this bias.

Findings and conclusions

Background analysis: Reducing the sexual transmission of HIV

The sexual transmission of HIV can be decreased in a few ways. The oldest scientifically demonstrated method to decrease the odds of both HIV acquisition and transmission is the consistent use of male latex condoms. There is also evidence that reducing the number of sexual partners decreases the odds of both HIV acquisition and transmission. These are the only two interventions that have been conclusively shown to decrease HIV transmission risk that have also been included in Indonesia's national strategic plan.

There are newer methods that have been demonstrated to reduce transmission[4]. Adult circumcision has definitively been proven to decrease the odds of HIV acquisition for men but not for their women partners. The use of antiretroviral treatment by either men and women has recently been shown to decrease the odds of transmission among either member of serodiscordant couples. It is unknown whether decreased transmission would also occur in populations of female sex workers, men who have sex with men, people who inject drugs, or *waria*. Large community trials are ongoing but results will not be available for at least two years. Pre-exposure prophylaxis with antiretroviral medications has also had the same effect in serodiscordant couples. None of these three new interventions is included in the current Indonesian national strategic plan for HIV.

The care of people with sexually transmitted infections is often presented as a method to decrease transmission of HIV. Although this intervention has biological plausibility, large community trials have failed to show that it is an effective method to reduce sexual transmission

4 Cohen et al, Antiretroviral treatment of HIV-1 prevents transmission of HIV-1: where do we go from here? Lancet Online, 21 October 2013, http://dx.doi.org/10.1016/S0140-6736(13)61998-4

of HIV. [5] The care of people with sexually transmitted infections produces public health benefits on its own and is included in the Indonesia national strategic plan: National HIV and AIDS Strategy and Action Plan 2010 – 2014. For the latter reason it is included in the program and this analysis of the program.

HIV counselling and testing is often said by program implementers to be effective in reducing the sexual transmission of HIV. However, a recent state of the art Cochrane review[6] has demonstrated that there is no evidence that HIV counselling and testing decreases transmission in most instances. There no evidence that condom use increases or the number of partners decreases among people who test negative. Condom use does increase and the number of partners decreases among people who test positive. Safer behavior after a positive HIV test occurs even in the absence of 'positive prevention' programs.

As the majority of people who undergo counselling and testing in Indonesia are seronegative, there is little evidence to promote testing as an effective method to decrease HIV transmission. Nevertheless, HIV testing is the gateway to treatment and must be promoted as the first step in increasing universal access to treatment.

SUM I: Scaling Up for Most At Risk Populations, Technical Assistance

The overall objectives of the SUM I Project included the following:

1. Provide the targeted assistance in key technical areas required to scale up effective, integrated HIV interventions that lead to substantial and measurable behavior change among MARPs.
2. Provide targeted assistance to government agencies and civil society organizations working on strategic information efforts related to the HIV response for MARPs, including integrated bio-behavioral surveillance (IBBS) and monitoring and evaluation (M&E).

Based on recommendations from the SUM management review conducted in 2012, these objectives set in 2010 translated into greater focus in Years 3 and 4 (2012 - present) of the project:

1. For objective 1, targeted assistance in key technical area translated into the inclusion of a new condom social marketing (CSM) and promotion component, while substantially decreasing its targeted assistance in other technical areas due to poor performance in Years 1-2 (please refer to 2012 SUM Management Review Report).
2. For objective 2, give priority focus to the implementation of IBBS in Tanah Papua while shifting the role as the M&E technical provider for CSOs to SUM II.

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5 Wawer and Gray, Reassessing the hypothesis on STI control for HIV prevention. The Lancet, Volume 371, 21 June 2008, p 2064

6 Fonner, Denison, Kennedy, O'Reilly, Sweat, Voluntary counselling and testing (VCT) for changing HIV related risk behaviour in developing countries. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD001224. DOI: 10.1002/14651858.CD001224.pub4.

Evaluation team members interviewed SUM I staff, selected puskemas' staff in Jakarta, Papua, and Surabaya, DHOs in Papua and Surabaya, and the NAC and MoH in Jakarta. Only the strategic information (SI) consultant reviewed the IBBS related tools and documents mentioned in the SI section of this report.

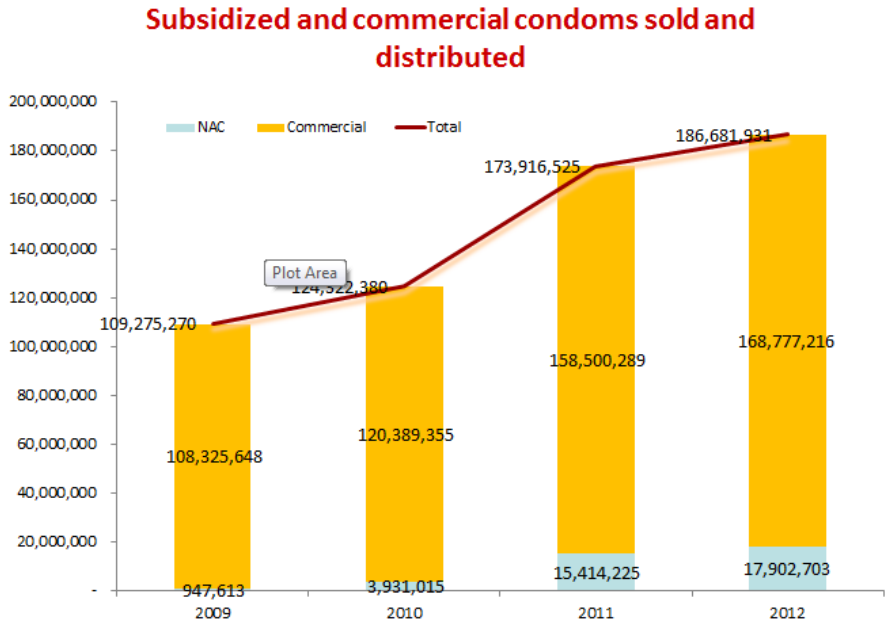
Condom Social Marketing

Year 3 of the SUM I project included a substantive new condom social marketing (CSM) and promotion component to work with the Government of Indonesia (GoI), Global Fund, and other key stakeholders to impact three key areas that influence condom use: 1) advocacy; 2) distribution and market dynamics; and 3) promotion and demand creation.

At the national level, SUM I successfully negotiated an agreement with the MoH and NAC to develop a 5 year national condom strategy. It is providing on-going technical assistance to mobilize the condom technical working group as part of this development. SUM I has also provided technical support to PAC by facilitating PACs, DACs, and CSOs on the management and development of BCC materials for consistent condom use among FSWs and HRM. They are also assisting the NAC in the development of new condom BCC materials and TV public service announcements for key populations nationally and for the general population in Papua.

The NAC and MoH both recognized the critical role that SUM I is playing in the development of the national condom strategy, and agreed that SUM I's technical support in the area of CSM has been of high quality and should be commended. However, both organizations believe that there needs to be a sharper, clearer focus and direction on the next steps for CSM in Indonesia. Condom distribution has almost doubled over the last five years. It was noted that despite the dramatic increase in the number of free condoms distributed, commercial condoms and socially marketed condoms through DKT continue to have the greatest market share in country (see Table 1) and the national condom strategy should include the engagement of the private sector. Furthermore, stakeholders at the national level stated that the medium and long term goals of the national condom strategy must be well articulated with concrete and measurement outcomes.

Table 1.



*Data source: UNGASS report, Nielsen retail audit data and Global Fund PRs report

Regarding the national condom supply chain management, SUM I had provided training on recording and reporting of condom logistic management system for NAC and PAC staff and is providing technical support at the puskesmas level. However, it is challenging to determine whether there has been actual improvement in the management of condom supply chain at the national or provincial level given that this specific activity was only initiated in recent months. There were also reports of near stock-outs at a few puskesmas and an actual stock-out in Papua by one CSO at the implementation level. However, the evaluators recognized that the improvement of a national supply chain system for condoms and its downstream effects at the local level may require longer term investment and it is difficult to demonstrate such improvement in one year's time.

As part of the CSM implementation, SUM I conducted a geographic information systems (GIS) mapping of hotspots and condom outlets in Jakarta, East Java, and Papua in close partnership with the PAC, DAC, and local CSOs. The findings were disseminated to key stakeholders including PAC, DHO, puskemas and CSOs in the three provinces. The majority of the key stakeholders found the mapping exercise to be an important activity in designing and monitoring condom coverage and access and agreed that the training on GIS mapping was particularly useful in building local capacity. The GIS condom mapping study has generated interest in other government districts beyond the SUM I supported geographical districts/areas. SUM I has been asked by local PACs to provide technical support as three districts in DKI Jakarta and 7 "regions" in Kota Malang will conduct GIS condom mapping exercises using local government funding.

In DKI Jakarta, SUM I facilitated the signing of the agreement among owners and managers of entertainment venues to commit to having a consistent condom supply and IEC materials available inside their venues and access to STI testing and treatment for their employees. At Puskesmas Pasar Rebo in Jakarta Timur, there was good documentation of monthly condom

consumption/distribution data. The number of condom outlets in the puskesmas had increased from two (at VCT and Family Planning areas) to nine (with one outside in the parking area/security post) since SUM I started providing technical support in June 2012 and condom distribution has increased from 1,540 in July 2012 to 11,844 in October 2013. While there was no indication of a condom stock out at the time of the visit, it was recorded that there was a near stock out recently due to increasing demand. However, according to the staff at Puskesmas Pasar Rebo, the distribution of condoms to the puskesmas is based on availability of stock at the PAC as opposed to monthly puskesmas consumption data submitted to the DHO. One MSM CSO that works closely with Puskesmas Rasar Rebo encountered similar issues with the distribution of condoms from the PAC and has had near stock-outs the past year.

With the technical support from SUM I, representatives from the DHO and DAC of Kota Malang stated that there has been noticeable decrease in stigma associated with condom use and an increase in condom outlets in the puskesmas and public hospitals in the area. However, the actual number (or percent) of increase of condom outlets in Kota Malang during this period is unclear. With the technical assistance provided by SUM I, Puskesmas Dinoyo was able to demonstrate nearly a 270% increase in condom distribution between July 2012 (260 condoms distributed) and October 2013 (700 condoms distributed that month). There is also general consensus among government officials and puskesmas staff in Malang that GIS mapping of hotspots and condom outlets was a valuable exercise in assessing the availability and accessibility of condoms in the area and the findings enabled the government to expand the number of condom outlets more strategically and effectively. This GIS mapping study conducted in Kota Malang also attracted much interest in seven other regions nearby and there are plans to conduct similar mapping exercises in these seven areas with the support of local government funding to improve HIV prevention programs for key populations.

The GIS mapping study of hotspots and condom outlets conducted in Kota Surabaya was helpful in identifying availability of condoms at the current state, but DHO and KPA officials from Kota Surabaya stated that it has limited medium- to long-term utility with the impending closure of Dolly. SUM I had conducted training on condom reporting and recording at a number of puskesmas in Kota Surabaya (including Puskasmes Sememi and Perak Timur) and puskesmas staff who were interviewed stated that condom consumption data is reported monthly to the DHO. However, during the discussion with DHO and KPA officials in Kota Surabaya, they seemed to be unclear on condom consumption data within their kota and were not able to provide information or estimation on monthly condom consumption within their district. In Puskesmas Sememi, of the nearly 3,200 condoms it distributes per month, approximately one-third (around 1,200 condoms) are distributed to the 100-150 female sex workers (FSW) seen at the clinic. Puskemas Sememi and Puskasmes Perak Timur both acknowledged the technical support provided by SUM I had contributed to the increase in condom outlets in their clinics (from 0 to 15 outlets in Puskasmes Sememi and 1 to 9 in Puskasmes Perak Timur since 2012). However, it is unclear whether the increase in condom outlets translated into an increase in condom distribution in Puskemas Perak Timur as staff members were not able to provide accurate consumption data or documentation of such data during the site visit.

While commercial condoms are available in Papua, the evaluators did not see the presence of any free condoms at the sites visited in Timika, Jayapura, and Wamena. However, only one of the

SUM II-supported CSOs operating in Wamena complained of a condom stock-out that has been ongoing for at least a few months. Stakeholders agreed that the lack of free condoms disproportionately affects street-based sex workers as they are often the ones who cannot afford to purchase commercial condoms compared with venue-based sex workers who usually have greater financial means. According to the KPA official in Wamena, condom forecasts in Papua are based on the estimated number of key populations in the area, and therefore, the general population is not included in the condom forecast projections and distribution system at the NAC and PAC. While the actual demand for condoms in the general population in Papua is unclear, there seems to be a chronic shortage of condoms in the Tanah Papua based on interviews with various stakeholders in Papua and donors/implementing partners in Jakarta.

Strategic Information

SUM I provided technical support to the MoH with the implementation, data analysis, report writing, and dissemination of the 2011 integrated bio-behavioral surveys (IBBS) among key populations (MSM, *waria*, direct and indirect sex workers, people who inject drugs) and other populations (youth and high risk men) in 12 provinces in Years 1-2 of their project. When the 2011 IBBS draft report was released in January 2012, there was widespread agreement among key stakeholders, including the SUM Management Review Team, that the quality of the analysis and presentation of the IBBS report were suboptimal. It was recommended by the SUM Management Review Team that the data needed further analysis and the report had to be revised (details are listed in the 2012 SUM Management Review Report). It is unclear, however, to what extent these specific recommendations provided to SUM I by the SUM Management Review Team were incorporated into the final 2011 IBBS report given that the evaluators were only provided with the Bahasa Indonesian version of the final report. But based on the review of graphs and figures alone, minimal changes were incorporated into the final document.

In Years 3-4, SUM I focused its technical support in the implementation of the 2013 general population IBBS in Tanah Papua under the leadership of the MoH. SUM I is the secretariat that supports the 2013 IBBS Steering Committee and serve a major role in the technical and overall coordination/management support for the planning, implementation, and data analysis of the IBBS. SUM I also provided technical and management assistance to the MoH in the finalization of survey tools, including standard operating procedures (SOPs) and the behavioral questionnaire. FHI 360 Asian Pacific Regional Office (APRO) in Bangkok also provided periodic technical guidance during the planning and implementation process.

SUM I/Indonesia was responsible for the training of Master Trainers (MOT) in Jakarta as well as the Train the Trainer (ToT) trainings in Jayapura. Field staff and supervisors were not interviewed as part of this evaluation, and therefore, the effectiveness and quality of these trainings cannot be evaluated in this report. Given the limited institutional and technical capacity in Papua, it was recognized that the implementation of the 2013 IBBS would be a challenge. There is widespread consensus among key partners and government officials that SUM I had played an important role as the coordinating body for the IBBS and collaborated well with other key stakeholders/partners in the training and implementation of the survey in the field. However, a number of significant technical issues were discovered along with missed opportunities for

course-correction. It is unclear whether these issues would compromise the quality of the biological component and the primary outcome (HIV prevalence) of the study.

SUM I consultants had the leading role in drafting all of the related IBBS SOPs and survey instruments. However, upon review of the "Standard Operating Procedure for Field Work" (version 1.0), "Standard Operational Procedures for Blood Sampling and Blood Specimen Management in the Field" (version 1.0) and "Standard Operating Procedure for Laboratory Testing" (version 1.0), it was noted that the quality of these SOPs was less than optimal. For example, a blatant mistake was found in the HIV testing algorithm diagram (p.7) that stated a negative 1st HIV rapid test would be reported as "reactive", when it should be stated as "non-reactive". Similarly, an illustration of the HIV result interpretation of the rapid test kit (p.8) was only included for the 1st HIV rapid test but no diagram was included for the 2nd or 3rd HIV rapid tests as visual illustrations for the field staff. Furthermore, cross-referencing of SOPs, when needed, were minimal or absent. Several sets of SOPs did not have a table of contents, and when one did exist, page numbers of the different SOPs listed in the table of content were missing. All of this potentially created barriers for field staff to effectively follow the procedures that were originally intended for the study.

Furthermore, a SOP for specimen storage for the reference laboratory was not included as part of the study protocol. It is unclear how many blood specimens were discarded by the laboratory technicians after ELISA was performed. This problem was not identified during a series of periodic quality assurance visits that took place throughout the entire implementation process. The issue with early disposal of blood specimens was discovered when a disproportionately high percentage of HIV rapid test results were deemed as indeterminates (discordant results) and the laboratory was asked to retest these samples.

Other Technical Assistance

SUM I also assisted the NAC in a desk review of all available BCC materials that have been produced or still were actively being used/distributed by implementers in country. The results of this desk review were fed into the development of BCC materials for HTC, prevention and treatment of STIs, along with condom promotion (previously mentioned in CSM section).

During Years 1-2, SUM I provided technical support in a number of programmatic areas such as targeted outreach for key populations, STI treatment, HTC, PMTCT, Care, Treatment and Support, and TB/HIV to the national and local governments, puskesmas, and SUM II supported CSOs. The provision of such technical support by SUM I had significantly decreased based on the recommendations in the 2012 SUM Management Review. The review found that the quality and effectiveness of the technical support provided at the implementation level was poor and the interviews conducted in this evaluation, for the most part, corroborated with the findings from 2012. However, a number stakeholders, including the MoH, provincial and district level governments, puskesmas, and SUM II supported CSOs, all agreed that there is a need for targeted HIV technical and programmatic support to complement the organization capacity development provided by SUM II. Many agreed that this is an area where USAID can play an important role but emphasized that in order for the technical support to be effective, it should be specific, targeted, and tailored to the needs of the local environment/context as it relates to

HIV/AIDS. It should not be conducted in a standardized "one-size-fits-all approach" that was previously implemented in Years 1-2.

Finding 1: SUM I's positive contribution in the area of CSM is evident, despite being relatively nascent in its implementation phase. CSM serves as an important prevention strategy in the overall effort to curtail the HIV epidemic in Indonesia. The NAC and MoH both recognized the critical role that SUM I is playing in the development of the national condom strategy, and agreed that SUM I's technical support in the area of CSM has been of high quality. Although the actual increase of free condom distribution attributable to SUM I's CSM activities at the national level remains to be seen (until the 2013 Nielsen and GFATM on condom distribution reports are released), SUM I's direct support did contribute to the increase in the number of condom outlets and number of condoms distributed at a majority of the sites visited in this evaluation.

Finding 2: The MoH and NAC recognized the lack of local capacity in strategic information within their respective agencies and are appreciative of the much needed technical support from SUM I. However, a series of significant issues that were identified over the course of the 2013 IBBS roll out in Papua were, for the most part, preventable or could have been mitigated if proper safeguard mechanisms were effectively put in place in the pre-implementation and implementation phases. The quality of technical support provided by SUM I was below what is expected by normative research standards.

Finding 3: There is a need for more strategic, innovative, and targeted technical assistance in HIV programs that tailors to specific context at all levels-- including the national government down to local implementing partners. But the need is more evident and immediate at the implementing level with CSOs, puskesmas, and the DHOs. A number of stakeholders from various levels identified the current lack of programmatic technical support to be a gap in HIV programs but stated that the previous one-size-fits-all approach to technical support was of minimal value.

SUM II: Scaling Up for Most at Risk Populations, Organizational Performance

SUM II has two overall objectives:

1. Provide targeted assistance in organizational performance required to scale-up effective, integrated HIV interventions that lead to substantial and measurable behavior change among Most at Risk Populations, and

2. Provide and monitor small grants to qualified civil society organizations to support the scale up of integrated interventions in 'hotspots' where there is a high concentration of one or more most-at-risk population and high-risk behavior is prevalent.

For the purposes of this assessment, increased capacity and increased performance are defined as a demonstrable increase in the number of members of key populations served, or a demonstrable increase in the quality of services to key populations, or both. The number of people reached by services and program coverage (the number of people reached over the number in the population) are outcomes of the national program that are measured as key output indicators in the national

monitoring and evaluation plan. There are four behavioral outcome indicators in the Indonesia Monitoring and Evaluation Plan for HIV and AIDS 2010 - 2014 that are used to measure changes in behavior:

- Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months
- Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse
- Percentage of female and male sex workers reporting the use of a condom with their most recent client
- Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

Evaluation team members interviewed SUM II, selected supported CSOs, and selected TA providers in Jakarta, East Java, and Papua.

In East Java, it was challenging for most of the CSOs to rapidly and simply present a summary of the outputs and outcomes of their work. With respect to increasing reach among female sex workers, the CSO Genta increased its outreach target over two years and over-achieved its targets. Paramitra had a smaller outreach target and under-achieved it in the second funding cycle. Both organizations achieved similar results with respect to HIV testing. There is an issue with target setting when most women sex workers work in brothel areas. The maximum size of the population of women who work in any one brothel area is fixed and brothel closures can rapidly decrease the size of the population that can be reached. So there is a maximum to outreach capacity and limited scope to demonstrate such capacity. Both organizations work with the gatekeepers of sex workers to ensure compliance with both HIV testing and sexually transmitted infection care. They are unsure about whether female sex workers who are found to be living with HIV received care.

For men who have sex with men, Gaya Nusantara and Igama increased their targets and increased their reach in the second funding cycle. Gaya Nusantara staff note that they have had challenges reaching younger gay men who are at very high risk of infection; only one of their eight outreach workers is under twenty-five years of age. Four hundred and fifty men received voluntary counselling and testing in the second funding cycle and thirty-four were found to be seropositive. Only seventeen or half of them received a CD4 cell count and all of them are on treatment. This organization receives co-funding from a range of organizations. Out of eighty men who received voluntary counselling and testing through Igama activities, forty were positive and twenty-nine are currently receiving antiretroviral treatment. It is clear that Igama is encouraging testing among men who are at higher risk of HIV than those reached by Gaya Nusantara. Limited co-funding of about $3,000 annually has been raised from a tobacco company for Igama.

For *waria*, Perwakos met outreach targets but did not increase its outreach target for the second year of funding. It doubled and then met its target for voluntary counselling and testing. This demonstrates a major increase in capacity. It is also remarkable that this organization has an informal working policy of having no secrets about serostatus so knowledge about serostatus is

open among all members. Of the one hundred and thirty-two transgendered women known to be living with HIV, over eighty are on antiretroviral treatment and the others have CD4 cell counts above the treatment threshold. The CSO Wamarapa has just recently begun to access funding. Twenty-one of the twenty-six people known to their staff to be living with the virus are on antiretroviral treatment. Both organizations note a major increase in the number of *waria* in their communities on treatment.

Orbit is an organization that serves people who use drugs in the city. They have incorporated HIV prevention messages into their harm reduction work that is co-funded with resources from the Global Fund. The meeting room and the outdoor verandah of the Orbit office have up to twenty large cardboard cartons filled with condoms.

Most of these CSOs note that sustainability is an issue for them. They agree that registration is only a first step to ensuring a sustainable response and that investments in HIV prevention by authorities in the cities of Malang and Surabaya are needed. Perwakos recognises that data quality continues to be a concern for them but that improved financial reporting capacity has led to more timely receiving and spending of funds. At the Perwakos office, it was noted that while there is still room for improvement in data quality, the organization demonstrated significant improvement in their recording and management of routine data on EpiInfo compared to the last data quality assessment conducted in June 2012. Surabaya civil society organizations working in HIV actively participated in the final drafting of the local government regulation on HIV called a perdah. They are pleased with the result. Their next step is to convince the local government to allocate financial resources to several non-health government departments in the city.

Staff at the district health office noted that they have no plan for providing HIV prevention services to female sex workers who will be affected by brothel closures. Puskesmas Perak Timur has increased the number of condoms distributed by putting them in a publicly accessible place and Puskesmas Semami provides high quality sexually transmitted infection care for sex workers in two brothel areas. Puskesmas Dinoyo has publicly accessible condoms and has increased the number of members of key populations that they serve.

Communication and media activities in Surabaya are conducted by a journalist associated with the journalists' association. It was unclear to the evaluators what the goals, outcomes, and outputs of this activity were.

It is challenging to determine whether increased capacity for outreach and HIV testing by civil society organizations in Papua can be demonstrated. There is a reluctance to talk about sex and condoms among some staff and community members that the evaluation team met. All CSOs met their targets in the first funding cycle but results have not yet been reported for the second funding cycle. The figures for outreach to the general population are so large that increases in numbers reached or overachievement of targets may reflect an increase in the number of people who come to large group sessions rather than an increase in the capacity of the organization to deliver effective prevention services to those at risk. Graphs of aggregate figures for SUM II in Papua for both outreach and HIV testing clearly show that neither has greatly increased in the last year. Late funding is one reason for this.

Yayasan Caritas Timika Papua (YCTP) is a CSO working with both key populations and the general population. The evaluators recognized the effective leadership and active outreach workers staffing this organization. Papuan street based sex workers are one of the populations served by prevention activities. Two sections - one governmental and one co-funded by the private sector - of the puskesmas in Timika city serve hundreds of brothel based and hospitality venue based sex workers, most of whom are not Papuan. This puskesmas also serves street based Papuan sex workers. The outcome of HIV testing is not known and the number of female sex workers who test positive is not known by the staff. Puskesmas staff note an increase in the number of street-based and hospitality venue based sex workers that they serve in the last year.

In Wamena, there are three CSOs working on HIV prevention. Tali serves both the general population and occupational categories of men who are thought to be at high risk of infection. In one activity for high risk men they mobilized the entire community where a stonebreakers' yard is located to undergo HIV testing. Two hundred and fifty men and women were tested and the testing results were given to the head man to inform the people who were seropositive. Four of the ten people found to be positive began antiretroviral treatment. The Kalveri Clinic serves the general population with HIV prevention education, care for sexually transmitted infections, HIV counselling and testing, and antiretroviral treatment. Yukemdi serves over four hundred and fifty female sex workers in massage parlors, at small cafes, and on the streets and Yukemdi staff over-achieved their target for this population. Yukemdi has on several occasions suffered from condom stockouts. They also serve members of the general population in rural areas. In one rural community visited, eighty-eight of approximately four hundred village residents of reproductive age were tested. No one was found to be seropositive.

The puskesmas in the city of Wamena conducts HIV testing on about four hundred people a month with about a ten per cent positivity rate. On one month recently the staff began twenty-seven out of thirty five seropositive people on antiretroviral treatment. The breakdown of the CD4 cell count equipment made no difference to the number of people beginning treatment. Only those who did not adhere to a two week trial of daily cotrimoxazole prophylaxis did not begin treatment. When one of the evaluators visited this puskesmas four years ago, antiretroviral treatment was only available at the general hospital across the street from the health center and far fewer people living with HIV were begun on treatment.

Of all the key populations and communities served by SUM II activities, it is only the general population in Papua that could realistically be reached with communication messages about partner reduction. None of the communication activities in Papua had any partner reduction messages.

It was noted by the evaluation team that it was an easier task for CSOs in Jakarta to answer the evaluators' questions about data and achievements.

Among the two CSOs that serve female sex workers in DKI Jakarta, one is a true community based organization that is run by and serves sex workers. Bandung Wangi staff noted that they benefited greatly from the organizational capacity building activities. And although they almost doubled their target for outreach in the second funding cycle, they were only able to reach slightly more women than they did in the first cycle. For HIV testing the organization decreased

its target in the second cycle but then doubled the number of women who tested. This is a remarkable achievement for a community-operated organization working with a population of women outside of a brothel setting. It is to be commended.

Performance was mixed so it is difficult to determine if capacity was increased for the two CSOs that work with men who have sex with men in Jakarta. YIM increased their outreach target for the second funding cycle but only slightly increased the number of men who received services. It decreased both its target and the number of men who tested in the second year of funding. LPA decreased both its target and services for outreach but increased its target and doubled its achievement in the second year.

As in the other two provinces, civil society organizations in Jakarta noted that they greatly benefited from the technical assistance in organizational development. Financial management improvement was noted by most of them to be the most challenging and the most useful.

Finding 1. The strategy of SUM II to work with CSOs to increase their capacity to deliver HIV prevention and entry to care services is a sound strategy. It was possible for the evaluation team to confirm that most of the CSOs increased their capacity to deliver these services over the two funding cycles. There were characteristics of the CSOs that the evaluation team associated with success – effective leadership, in-depth knowledge of the local environment for key populations, sound technical focus, and flexibility to change programs to meet the needs of key populations.

Finding 2. There are several challenges in increasing the reach of prevention services among key populations that must be faced by the CSO partners. The first is the nature of the epidemic among the populations themselves. In order to achieve maximum impact it is necessary to reach the maximum number of people who are at the highest risk. Further elaborated below are findings for the following key populations: female sex workers, men who have sex with men, *waria*, people who inject drugs, people living in Papua, and "high risk men."

1. Female sex workers. This includes women in brothel areas who have the most partners or street based sex workers who have little control of their working conditions. All of these women in the geographic sites covered by the CSOs should receive services. It is not always possible for program managers to determine how many of the women reached are reached for the first time or are reached several times.

2. MSM and *Waria*. Among men who have sex with men and *waria*, it is already well known that there is an expanding epidemic among young men who have sex with men and that the members of these two communities who are at greatest risk are those with the most sexual partners or those who practice the most unprotected sex. It is necessary to greatly expand reach of effective prevention services for young men who have sex with men and any *waria* who are not yet reached by prevention activities.

3. PWID. The prevention of sexual transmission among people who use drugs or people who inject drugs is an activity that is simply added to the list of harm reduction activities by organizations that serve these populations. As the level of risk of these beneficiaries is

not clear, the potential benefit of the activities is not known. The marginal cost of adding sexual transmission prevention activities for these organizations is low but so is the value.

4. Papua. It is in Papua that it is a challenge to reach the greatest number of people at the greatest risk. Almost nothing is known by HIV professionals about sexuality and sexual practices among Papuans. And much of what is discussed about sexuality is colored by consideration of Papuans as poorly comprehended 'others' by both foreigners and non Papuan Indonesians. For instance it is not known which Papuan men or women have the greatest number of sexual partners, levels of sexual concurrency, sexual networking patterns, and the proportion of sex between Papuans and non Papuans in the sex industry.

   Although prevalence of HIV is higher in the general population in Tanah Papua than in the general population on other islands in the country – between one and three per cent - it is still much lower than the prevalence among female sex workers in Papua, and probably lower than among *waria* and men who have sex with men there. All of the members of the general population of Papua are not at equal risk. In order to make an impact on sexual transmission among Papuans, it is necessary to provide HIV prevention services for Papuans in the general population who have the most unprotected sexual partners. There is no indication that this targeting has taken place.

5. High risk men. Finally, the use of the term 'high risk men' continues to obscure rather than clarify sexual transmission risk among men. There is no evidence that a large proportion of the men who have the greatest number of sexual partners or have the greatest risk are among the many occupational categories that are used for 'high risk men'. 'High risk men' are not a proxy group for the clients of sex workers. 'High risk men' who are clients of sex workers had lower seroprevalence than nonclients in an informal analysis of unweighted data from the 2011 round of integrated biobehavioral surveillance. It is defined differently in different program sites. 'High risk men' was a nebulous construct when it was first proposed several years ago and it has not become better defined as a key population since then.

Finding 3. If the goal of SUM II is only to prevent sexual transmission then there is no need to include HIV testing in the activities. It is not always possible for program managers to determine how many people reached are reached for the first time or are reached several times. Studies show that members of key populations who test negative do not change their behavior so those who demonstrated repeated negative tests are less likely to test positive than those who have never been tested.

However, if the goal is to increase the continuum of care then there is sound reason to increase access to HIV testing as the gateway to care. There is a major new opportunity to increase the number of members of key populations who begin antiretroviral treatment in Indonesia. The Minister of Health has recently signed a circular encouraging the early use of antiretroviral treatment of members of key populations who are found to be living with HIV without the use of CD4 cell testing for to determine whether they meet the threshold criteria for entry to care. This initiative is being called 'Strategic Use of Antiretrovirals' or SUAV by some development partners. A more accurate term is 'Test and Treat'. It is not related to 'Treatment as Prevention'.

The circular is appended to this report.[7] It encourages immediate antiretroviral treatment of seropositive female sex workers, men who have sex with men, and people who inject drugs. *Waria* are not specifically mentioned in the circular. This is a major opportunity for members of these four communities to begin to exercise their right to health without the barrier of CD4 testing.

Kinerja

As with SUM I and SUM II, team members met with Kinerja staff in Jakarta before commencing field visits to Kinerja field staff and supported projects in Timika, Wamena, and Jayapura. Interviews with external stakeholders such as district health officials and LMPAK in Timika also informed the progress review.

Kinerja's work in Papua is implemented in four districts. Beginning in 2012, Kinerja works to improve governance of the health system by supporting efforts that strengthen the capacity of the local government to manage and deliver services (supply), and with civil society, including through multi stakeholder fora (MSF), to increase the public awareness, use, and oversight of health services (demand). Key components of Kinerja interventions include management and leadership capacity building for DHO and puskesmas, the creation of and implementation of Action Plans for short, medium, and long term goals, and awareness-raising of community health rights through use of media and MSF engagement. Kinerja's efforts are not intended to increase technical capacity.

In Timika, evaluation team members heard reports of high satisfaction with Kinerja's program from external stakeholders. Officials from the district health office and members of LPMAK offered appreciation in particular for Kinerja's work in management and leadership training at the puskesmas level. This training includes work on the minimum service standards and on standard operating procedures (SOPs), such as those to improve patient flow and display opening hours of the puskesmas.

In Wamena, Kinerja works with three puskesmas, offering technical assistance and management and leadership training for DHO staff online. After the training, the districts put together an action plan that includes short, medium, and long term goals. Short term goals can include plans for construction of new buildings; long term goals may include creating an annual plan so that they can request more budget from the national level.

Kinerja has piloted a client satisfaction survey in the four districts in Papua to establish a baseline understanding of community satisfaction with puskesmas. They plan to follow this with a complaint survey, the results of which can be taken to the puskesmas leadership once complete. Early results of the baseline satisfaction survey suggest communities are highly satisfied with

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services provided; it is widely noted that this likely has less to do with actual satisfaction as with limited understanding of what communities should expect from puskesmas.

At Puskesmas Tanjung Ria in Jayapura, the team saw evidence of Kinerja's management and operational work. Members of the MSF and staff of the puskesmas displayed the patient flow charts and noted that Kinerja had helped them with standard operating procedures (SOPs). The SOPs were a reflection of work the group had already been doing. The MSF is comprised of mostly Papuans, and the group is highly committed to care for pregnant women and children in their community.

Kinerja's achievements include SOP development and implementation in 9 puskesmas in 3 Kinerja-supported districts, the establishment of 4 district and 12 puskesmas level MSF, and 31 DHO level action plans in place.

Finding. Overall, evaluation team members had some difficulty understanding the governance aspect of Kinerja's interventions, as many of the training and management components appeared similar to the organizational development work of SUM II. Further, while the team observed and heard positive feedback of Kinerja at the puskesmas level, the effectiveness of the training at the higher levels of local government was unclear.

Annex 1: Scope of Work

SCOPE OF WORK
EVALUATION FOR HIV/AIDS PROGRAM

I. BACKGROUND INFORMATION

The cumulative number of reported HIV infections in Indonesia has risen sharply from 7,195 in 2006 to 76,879 by 2011 (MOH, Year End Report on Situation of HIV/AIDS in Indonesia, 2006 and 2011). According to the 2009 national estimates of HIV infection about 186,257 people were infected with HIV and 6.4 million people were at risk (MOH, Estimation of at-risk Adult Population, 2009).

The United States Government and the U.S. Agency for International Development (USAID) play a major role in the response to HIV/AIDS in Indonesia. Since 1993, USAID has provided assistance to Indonesia for a comprehensive HIV/AIDS response program. At present USAID/Indonesia is planning to develop a new design for USAID-funded HIV/AIDS Program. The PEPFAR strategy in Indonesia supports the Government of Indonesia (GOI) achieving its goals to prevent and reduce the transmission of HIV infection; improve the quality of life for people living with HIV; and reduce the socio-economic impact of the AIDS epidemic on individuals, families and society. The current USAID-funded activities focus on reducing sexual transmission of HIV/AIDS by accelerating condom availability and use among high risk groups (MSM, high-risk men, sex workers, transgender people), building the capacity of civil society organizations and government counterparts to provide appropriate prevention services, technical assistance to support MOH and National AIDS Commission efforts to expand coverage and improve the quality of prevention and treatment, and expanding access to HIV services in Papua and West Papua.

II. SCOPE OF WORK

This scope of work has two components: (1) the evaluation of selected USAID HIV/AIDS activities in Indonesia; and (2) technical support for the development of follow-on HIV/AIDS and infectious disease programs.

COMPONENT 1: EVALUATION OF HIV/AIDS PROGRAMS

OBJECTIVES

This evaluation will provide valuable in-sight information regarding the impact and performance of HIV/AIDS prevention and control in the context of technical, social, economic, cultural, and governmental systems of Indonesia. The evaluation will be a review of USAID Indonesia's efforts to prevent and control HIV/AIDS program in Indonesia from FY 2010-current (2013), to assess the progress and impact of the USAID HIV/AIDS programs, and recommend appropriate measures towards revision of interventions and strategies.

Projects to be Evaluated	Prime Implementing Partner
Scaling Up for Most at Risk Population I: Technical Assistance (SUM I)	**FHI 360**
Scaling Up for Most at Risk Population II: Organizational Performance (SUM II)	**TRG**
Kinerja Expansion in Papua	**RTI**

METHODOLOGY

The purpose this evaluation is to assess the project performance and its impact from 2010 to date and provide insights and important feedback to each of the partners and stakeholders that should assist them to understand both the strengths and areas where technical, administrative and management efforts could be improved. It will also provide evidence and learning for improving USAID/Indonesia program designs, strategies and policies, specifically:

- Provide information on the impact made by each component of program to prevent and control HIV/AIDS program in Indonesia including relevant issues, sustainability, and cost effectiveness;
- Assess how well various components work together and foster multi-sector engagement
- Determine to what extent the USAID HIV/AIDS Program is meeting the objectives and what challenges, weakness, and lessons learned can be drawn from implementation of this program;
- Examine whether programs contribute as intended to the goals of the Indonesian government's response to the epidemic; and
- Provide recommendations for USAID to better target efforts, audiences and resource investment

The evaluation team will include the following: Team Lead, external HIV/AIDS expert, and USAID HIV experts, and undertake the evaluation during October 2013.

Prior to the start of data collection, the evaluation team will develop and present, for USAID review and approval as part of the work plan, a data collection plan that details how secondary and primary data will be analyzed; and how the evaluation will weigh and integrate qualitative data from these sources with project performing monitoring records to reach conclusions about the effectiveness and efficiency of the HIV/AIDS projects.

The evaluation team will apply a range of data collection and analysis methods, including:

1. Review all relevant background materials, including country planning and program document. USAID/Indonesia will provide the evaluation team with a package of briefing materials for each project including:
    - Program background documents, including contracts, co-operative agreements and other key design and implementation guidance documents;
    - Performance Management Plans;
    - Annual work plans;

- Quarterly/Annual Reports;
- Assessments, Studies and Reviews related to these projects.

2. Conduct in-depth interviews and focus group discussions, at a minimum, with the following organizations:
    - Ministry of Health, Directorate of Communicable Diseases
    - International Development Partners: UNAIDS, WHO, AusAID, CHAI, and HCPI,
    - Implementing partners: FHI 360, TRG, NAC and RTI
    - Province and District Health Office
    - Provincial and District AIDS Commission
    - Health Facilities
    - Civil Society Organizations
    - Technical Assistance Providers
3. Conduct field visits to program implementation site in Jakarta, East Java and Papua. The Evaluation Team may be accompanied by a staff member from USAID/Indonesia, as appropriate, to observe interviews and field visits.

The evaluation design should specifically address the following questions:

1. To what extent have the program activities made an impact to mitigate the risks of sexual transmission for HIV/AIDS?
2. To what extent have the program activities made an impact to improve technical and organizational capacities for Civil Society Organizations Indonesia in reducing the transmission of HIV/AIDS in Indonesia?
3. To what extent have the program activities made an impact to improve the capacity of the health service in preventing and controlling HIV/AIDS in Indonesia?
4. To what extent have the program activity strengthen capacity of the national and sub-national (province and district) government, private sector, community, and other stakeholders?
5. What is the contribution of each project to the overall HIV/AIDS program at national and provincial level?
6. How replicable, adaptable/adoptable, sustainable are the programs/program components?
7. How effective has the collaboration/coordination among the programs been in maximizing efforts and achieving greater results?
8. Have program interventions effectively enhanced local and national ownership and future commitment to continued implementation of good practices/lesson learned be enhanced?

As part of the overall evaluation process, the evaluation team, led by the Team Lead will undertake the following:

(a) Team Planning Meeting: A Team Planning Meeting will be held Jakarta and will be organized and led by the Team Lead. This meeting will allow USAID/Indonesia to discuss the purpose, expectations, and agenda of the assignment with the team.

(b) In-briefing with USAID: The Evaluation Team is expected to schedule and facilitate an in-briefing with USAID. At the in-brief, the Evaluation Team should have the list of interviewees and schedule prepared, along with the detailed chart mapping out the evaluation through the report drafting, feedback and final submission periods.

(c) Discussion of Preliminary Draft Evaluation Report: The Evaluation Team will submit a preliminary outline and plan to finalize the assessment report to the USAID Health Office prior to final Mission debriefing. The final draft report must be completed by January 2014.

(d) Debriefing with USAID: The team will present the major findings of the evaluation to USAID Indonesia, respectively, through a PowerPoint presentation after submission of the draft report or outline and plan and before the team's departure from country. The debriefing will include a discussion of achievements and issues as well as recommendations for the future activities designs and implementation. The team will consider USAID comments and revise the draft report accordingly, as appropriate.

REPORT FORMAT

The Final evaluation report will include the following:

- Expanded Executive Summary: The team will submit an expanded executive summary to accompany the final report that will include a background summary on the evaluation purpose and methodology, and an overview of the main data points, findings, and conclusions. The expanded executive summary should be easy to read for wide distribution to local audiences and the partners are encouraged to look for creative presentation styles, formatting and means of dissemination. The expanded executive summary will be submitted in English.
- Detail and describe results, effects, constraints, and lessons learned from USAID HIV/AIDS partners and other stakeholder-supported activities.
- Review current USAID-funded programs' goals and objectives and their applicability in the context of host government and other stakeholder objectives and activities.
- Evaluate level of coordination among USAID partners, host governments, and other stakeholders.
- Evaluate level of sustainability/replication/adaptation of USAID-funded activities.
- Provide recommendations and lessons on aspects related to factors that contributed to or hindered: attainment of program objectives, sustainability of program results, innovation, and replication.

The report shall follow USAID branding procedures. An acceptable report will meet the following requirements as per USAID policy (please see: the USAID Evaluation Policy):

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- The evaluation report should address all evaluation questions included in the scope of work.

- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex to the final report.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions.
- Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an Annex, including a list of all individuals interviewed.
- Recommendations need to be supported by a specific set of findings. Recommendations should be action-oriented, practical and specific.

The annexes to the report shall include:

- The Scope of Work
- All tools used in conducting the evaluation, such as questionnaires, checklists, survey instruments
- List of Sources of information
- Disclosure of conflicts of interest forms for all evaluation team members, either attesting to a lack of conflict of interest or describing existing conflict of interest.

III. LEVEL OF EFFORT

The evaluation for HIV/AIDS Program will begin in October 2013 with level of effort as detailed below, which may extend through the end of December 2014.

Activity	**Estimated LOE**
Desk review	5 days
Evaluation Design document draft preparation	5 days
Assessment and field visits	15 days
Finalize evaluation report	10 days
Prepare ID PAD documents	15 days

IV. DELIVERABLES

1. Evaluation Design and Work Plan: A Work Plan and Evaluation Design for the evaluation shall be completed by the Team Leader within two weeks of the contract and presented to USAID/Indonesia. The evaluation design will include a detailed evaluation design matrix, draft questionnaires and other data collection instruments, and known limitations to the evaluation design. The final design requires USAID/Indonesia approval.

2. List of Interviewees and Schedule: USAID/Indonesia will provide the Evaluation Team with a stakeholder analysis that includes an initial list of interviewees, from which the Evaluation Team can work to create a more comprehensive list. Prior to starting data collection, the Evaluation Team will provide USAID with a list of interviewees and a schedule for conducting the interviews. The Evaluation Team will continue to share updated lists of interviewees and schedules as meetings/interviews take place and informants are added to/deleted from the schedule.

3. Draft evaluation report: A draft report of the findings and recommendations should be submitted to the USAID Health Office. The written report should clearly describe findings and conclusions. USAID will provide written comments on the draft report within 10 working days of receiving the document.

4. Final Report: The Evaluation Team will produce an evaluation report including executive summary, expanded executive summary, and final report, will be provided to USAID. The evaluation will provide important feedback to each of the partners and information both their strengths and weakness on the technical, administrative and management aspects. USAID Indonesia will integrate the evaluations recommendations to the future HIV/AIDS activities and share lesson learned and best practices especially to implementing partners and related stakeholders. The final report should incorporates responses to Mission comments and suggestions following the format described above, no later than five working days after USAID/Indonesia, respectively, provides written comments on the Team's draft evaluation report (see above). This report should not exceed 50 pages in length (not including appendices, lists of contacts, etc.). The report will be submitted in electronically in English to USAID/Indonesia for final approval.

5. Drafts of follow-on program activities as requested by the Office of Health

Annex 2: Evaluation Team Schedule of Activities

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES
October 31, 2013	**Jakarta**	07:30-08:30	Meeting with Health Office Director	**USAID Office**	Irene Koek Tetty Rachmawati
		09.00-11.00	Meeting with SUM I	**SUM I Office** Menara Salemba Lt 3, Salemba Raya, No 5, Jakarta Pusat, 10440 Indonesia	USAID team SUM I staff: • Asha Basnyat, • Anton Schneider • Heri Hasyim • Rizky Syafitri • Yunita Wahyuningrum
		11.30-01:30	Meeting with SUM 2	**SUM 2 Office**, Menara Salemba, 7th Floor, Jl. Salemba Raya No. 5, Jakarta Pusat	• USAID Team • Yen Rusalam • Ricky Andriansyah • Fiferi Murni • M. Helmi Prasetyo • Hudallah
		02.30-04.30pm	Meeting with Kinerja		
November, 01, 2013	**MALANG**				
		12:00 – 12:30	Meeting with SUM staff for briefing	Hotel where the team stays	

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES
		01:00 – 02:00pm	Meeting with government officials (SUM 1 and SUM 2)	DHO and DAC of Malang City	• USAID team • SUM1 and SUM2
		02:30 – 03:30pm	Visit to health facilities in Malang District and Municipality that SUM I and SUM II working with	Puskesmas Dinoyo, Kota Malang Jl. MT Haryono IX No. 13, Kota Malang	• USAID team • Drg. Wuryaningsih (6281 3341322971) • Puskesmas Dinoyo staff
		04:00 – 05:30pm	Meeting with Key Affected Populations (KAPs- FSWs)	Paramitra Office	• USAID team • FSWs, • Paramitra Field Staff
		08.00-09.30pm	Meeting with KAPs-MSM	Alun alun	• USAID team • IGAMA Field Staff
November 02, 2013	**MALANG & SURABAYA**	09:00 – 12:00	Meeting Three CSO partners	IGAMA Office	• USAID team • Director, PM, KL, Monev of Paramitra, IGAMA and KK Wamarapa.
		05:00 – 06:00pm	Meeting with SUM staff for briefing	The hotel where the team stays	• USAID team; • SUM1 and SUM2
		06:00 – 09.00pm	Site visit with GN and discuss with KAPs (MSM)	Pattaya and Taman Bungkul, Surabaya	• USAID team; • GN Field Staff
November 03, 2013	**SURABAYA**	09:00 – 12:00	Meeting with SUM II CSO Partners Surabaya	**SUM 2 Regional Office of Surabaya** Jl. Ngagel Jaya Utara No.	• USAID team • Director, PM, KL, Monev of

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES
				33, Surabaya Surabaya	Orbit, Genta, Embun Surabaya(YES), Perwakos, and GN.
		02:00 – 04:00pm	Meeting with KAPs (Transgender)	Shelter/Perwakos Office	• USAID team; • Perwakos
November 04, 2013	**SURABAYA**	09:00 – 11:00	Meeting with Province AIDS Commission	PAC Office	• USAID Team • Secretary PAC
		12:00 – 14:00	Meeting with KAPs (IDUs)	Orbit Office/ rumah pemberdayaan	• USAID team; • Orbit Field Staff
		06.00 – 09.00pm	Visit FSW hotpot in Dolly.	Dolly and Jarak Brothel.	• USAID team; • YES Field Staff
November 05, 2013	**SURABAYA**	09:00 – 11:00	Meeting with SUM I	SUM I Office, Surabaya	SUM 1 staff
		11:30 – 02:00pm	Meeting with SUM II.	**SUM 2 Regional Office of Surabaya** Jl. Ngagel Jaya Utara No. 33, Surabaya Surabaya	• USAID team; • Meytha Nurani; • Mainul Sofyan • Dwi Aris Subakti
		02.30 – 03.30pm	**(Optional) Meeting with selected CSO as it needed**		
November 06, 2013	SURABAYA	09:00 – 10:00	Meeting government officials (Dinas Kesehatan, KPA Kota Surabaya).	DHO Surabaya City	• USAID team; • DHO Staff • DAC Staff
		11:00 – 01.00pm	Visit Menur Hospital.	Menur hospital	• USAID team; • Menur Hospital Staff
		01.30-02.30pm	Visit to Puskesmas Sememi	Puskesmas Sememi, Kota	• USAID team

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES
				Surabaya Jl. Raya Kendung, Kelurahan Sememi, Surabaya	• Dr. Lolita Riamawati (62 81 2301 8996) • Puskesmas Sememi staff
		03.00 – 04.00pm	Visit to Puskesmas Perak Timur	Puskesmas Perak Timur, Kota Surabaya Jl. Jakarta No. 9, Surabaya	• USAID team • Dr. Nurul Hidayah (62 81 2309 8416) • Puskesmas Perak Timur staff
November 06, 2013					
November 07, 2013	**TIMIKA**	09.00-11.00	Meeting with Head of District Health Office and District KPA Secretary	District Health Office, Timika	• USAID team • Head of DHO • Secretary of DAC
		11.30 – 01.00pm	Visit Rumah Sakit Mitra Masyarakat (RSMM), Timika	RSMM Timika	• USAID team • YCTP Director • RSMM Director and Health Staff
		02.00-04.00pm	Meeting with Private Sector, Lembaga Pengembangan Masyarakat Amungme-Kamoro (LPMAK)	LPMAK Office	• USAID team • LPMAK Director and program Manager
		04.30-06.00pm	Meeting with CSO partner (YCTP)	YCTP Office	• USAID team • YCTP Staff
		07.00-09.00pm	Visit non-brothel FSWs in Timika City (optional, if the time still permit)	Timika City	• USAID team • YCTP Field Staff
November 08, 2013	**JAYAWIJAYA**	03.00-05.00pm	Meeting with two CSO partners	Yukemdi Office	• USAID team

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES
					• Yukemdi and Tali Directors, Program Managers, M&E Officers, Field Coordinators
		07.00-09.00pm	Visit FSW Panti an Warung Remang Hotspot	Jl Suci or Hom-Hom	• USAID Team • RCBO • Field cordinator
November 09, 2013	**JAYAWIJAYA**	09.00-11.00	Meeting with District Government of Jayawijaya	District Government Office	• USAID team • Asisten II • District Health Office • District Social Welfare • Secretary of District AIDS Commission • Director of Wamena Hospital
		11.30 – 12.30	Visit Puskesmas Wamena Kota	Puskesmas Wamena Kota	• USAID team • Puskesmas Director and Medical Staff
		02.00-04.00pm	Visit Wamena Hospital, Klinik Anggrek	Wamena City	• USAID team • Hospital/Clinic Director
		07.00-09.00pm	Visit Hotspots non-brothel FSW in Wamena Kota	Wamena City	• USAID team • Yukemdi Field Staff
November 10, 2013	**JAYAWIJAYA**	11.00am – 05.00pm	Visit to community at Walelagama, or Asologama: • Meeting with Faith and Tribal-based Leaders,	Walelagama or Asologama	• USAID team • Faith and Tribal-based Leaders;

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES
			Women and Youth Leaders.		• Women and Youth Leaders.
			Visit Puskesmas Walelagama or Asologama	Walelagama or Asologama	• USAID team • Puskesmas Director and Medical Staff
November 11, 2013					
	JAYAPURA	10.00 – 12.00	Meeting with SUM II	SUM Papua Meeting Room, Gedung PELNI, 2nd Floor, Argapura – Japura (Tel. 0967 – 523 418)	• USAID Team • SUM II
		01.00 – 03.00pm	Meeting with SUM I	SUM Papua Meeting Room, Gedung PELNI, 2nd Floor, Argapura – Japura (Tel. 0967 – 523 418)	• USAID Team • SUM I
		04.00-06.00pm	Meeting with Kinerja		•
		07.00-09.00pm	Visit FSW Hotspot at Karaoke and Massage Parlor Darmo	Entrop	• USAID Team • SUM2 • All Staf Program YHI
13 November	**Jakarta**	Morning	Meeting with National AIDS Commission	NAC Office Wisma Sirca, lantai 2 Jl. Johar No. 18, Menteng Jakarta 10340 Telp : (021) 3905918	• USAID Team • DR. Kemal Siregar, NAC Secretary
			Meeting with Provincial AIDS Commission Jakarta	PAC Office	• USAID Team • Ibu Rohana/PAC Secretary
		Afternoon	Meeting with WHO	WHO office Percetakan Negara	

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES
Thursday **14 November**	**Jakarta**	09.00-10.30	Meeting with SUM 2 CSO Partners DKI Jakarta	**SUM 1 and SUM 2 Meeting Rooms**, Menara Salemba, Jl. Salemba Raya No. 5, Jakarta Pusat	• USAID Team • Director, Program Manager, and M&E Officer of 7 CSOs (YKB, Karisma, YIM, Bandungwangi, YSS, LPA Karya Bhakti, Angsamerah)
		10.30-12.00	Meeting with SUM 2 TA Provider Institutions	**SUM 2 Office**, Menara Salemba, 7th Floor, Jl. Salemba Raya No. 5, Jakarta Pusat	• USAID Team The Team Leader or Program Manager and one mentor to each of 4 TA providers (Penabulu, Circle, SurveyMETER, Satunama)
		02.00-03.30pm 02.00-03.30pm	Visit to Puskesmas Pasar Rebo	Puskesmas Pasar Rebo Jl. Raya Kalisari, Jakarta Timur Dyah (62 85 6117 0543)	• USAID team • Puskesmas Pasar Rebo staff
			Visit Klinik Yayasan Angsamerah	Yayasan Klinik Yayasan Angsamerah	• USAID Team • Staff of Klinik

DATE		TIME	ACTIVITIES	VENUE (ADDRESS)	ATTENDEES
			Jl. Panglima Polim Blok 6K, Kebayoran Baru, Jakarta Selatan		Yayasan Angsamerah •
		**8:00 a.m. Friday morning, Nov 15	Meeting with MOH	MOH Percetakan Negara Gedung D	• Evaluation Team • Dr. Nadia and staff
Friday **November** **15**		**6:00 p.m., Thursday evening, Grand Hyatt	Meeting with Secretary of National AIDS Commission	TBC	• Evaluation Team • Pak Kemal
		10:30-11:30	Meeting with AusAID	Australian AID Office Cyber II	
		12:00-01:30	Meeting with HCPI and CHAI	Australian AID Office Cyber II Building	
November **18**	**Jakarta**	02:00-04:00	Meeting with USAID	USAID Meeting Room	• Ibu Irene • Ibu Mary • Tetty Rachmawati • Evaluation Team
		Morning	Meeting with Mission Director of USAID		

Annex 2: MoH Test and Treat Circular

MENTERI KESEHATAN
REPUBLIK INDONESIA

Yang terhormat,

1. Kepala Dinas Kesehatan Provinsi
2. Kepala Dinas Kesehatan Kabupaten/kota
3. Direktur Rumah Sakit seluruh Indonesia

SURAT EDARAN
NOMOR : 129 Tahun 2013

TENTANG
PELAKSANAAN PENGENDALIAN HIV-AIDS DAN INFEKSI MENULAR SEKSUAL (IMS)

Dalam rangka mencapai tujuan *Millenium Development Goals* (MDG) yang ke-6, terkait dengan pengendalian HIV dan AIDS yaitu mengendalikan penyebaran dan mulai menurunkan jumlah kasus baru HIV dan AIDS serta mewujudkan akses terhadap pengobatan AIDS bagi semua yang membutuhkan pada tahun 2015, maka perlu dilakukan upaya–upaya sebagai berikut:

I. Memperkuat Upaya Promkes Pencegahan

1. Pemerintah Daerah agar meningkatkan dan memperluas promosi kesehatan termasuk melalui Kampanye Aku Bangga Aku Tahu (ABAT) di wilayahnya masing-masing dengan mensinergiskan lintas sektor terkait, sehingga cakupan dapat diperluas.

2. Dinas Kesehatan kabupaten/kota agar meningkatkan layanan Infeksi Menular Seksual di Puskesmas yang dalam wilayah kerjanya terdapat *hotspots* (daerah pelacuran dan atau penggunaan napza), upaya pencegahan HIV melalui transmisi seksual (PMTS), dengan meningkatkan penemuan kasus/skrining rutin, pengobatan IMS dan penggunaan kondom yang konsisten pada setiap hubungan seks berisiko.

3. Agar pemberian kondom sebagai alat pencegahan penularan IMS dan HIV menjadi bagian dari paket pengobatan IMS, ARV, layanan terapi rumatan metadon, dan layanan alat suntik steril

Jl. H.R. Rasuna Said Blok X5, Kav 4-9 Jakarta 12950 Telepon/Faksimile (021) 5201591

II. Upaya Perluasan Konseling dan Tes HIV.

1. Peningkatan diagnosis dini melalui penawaran tes HIV melalui Tes dan Konseling Inisiatif Petugas *(TKIP/PITC)*, sehingga orang yang terinfeksi HIV dapat se gera mendapatkan akses layanan yang dibutuhkan. Setelah mengetahui hasil tes HIV, maka kepada yang bersangkutan dilakukan konseling paska tes oleh konselor untuk mendapatkan akses layanan Perawatan Dukungan dan Pengobatan (PDP).

2. Agar dianjurkan tes HIV kepada semua
   - Ibu hamil di daerah dengan prevalensi HIV tinggi
   - Pasien Infeksi Menular Seksual (IMS)
   - Pasangan ODHA
   - Pasien TB
   - Pasien Hepatitis
   - Warga binaan Lapas/Rutan

3. Pada populasi kunci dan orang yang masih berperilaku berisiko agar dilakukan tes HIV ulang *(retesting)* minimal setiap 6 bulan sekali.

4. Petugas kesehatan atau konselor agar mengaktifkan konseling keluarga (*family counseling*) dan konseling pasangan (*couple counseling*) dari orang yang terinfeksi HIV.

III. Upaya, Perawatan, Dukungan dan Pengobatan:

1. Puskesmas dan Rumah Sakit agar memasukkan layanan terkait HIV dan AIDS ke dalam salah satu layanan pokoknya sebagai bagian dari standar Pelayanan di RS, mengingat layanan HIV-AIDS sudah menjadi salah satu penilaian dalam akreditasi RS.

2. Dinas Kesehatan Provinsi dan Kabupaten/kota agar segera memperluas pelaksanaan Layanan Komprehensif Berkesinambungan (LKB) di kabupaten/kota bersumber dana pemerintah daerah/APBD.

3. Agar segera menerapkan Surat Edaran Menkes Nomor GK/MENKES/001/I/2013 tentang LAYANAN PENCEGAHAN PENULARAN *HUMAN IMMUNODEFICIENCY VIRUS* (HIV) DARI IBU KE ANAK (PPIA).

4. Inisiasi dini ART tanpa melihat nilai CD4, dapat diberikan kepada mereka yang HIV (+) yaitu : Ibu Hamil, pasien koinfeksi TB, Lelaki Seks dengan Lelaki, pasien koinfeksi Hepatitis B dan C, Wanita Pekerja Seks, Pengguna Narkoba Suntik, ODHA yang pasangan tetapnya memiliki status HIV (-) dan tidak menggunakan kondom secara konsisten.

5. Diharapkan Pemerintah Daerah/Rumah Sakit dapat membebaskan biaya untuk pemeriksaan laboratorium seperti pemeriksaan *Rapid Test HIV, Viral Load,* dan pemeriksaan *CD4* guna memudahkan akses ODHA untuk pengobatan ARV.

Atas perhatian dan kerja sama Saudara, kami ucapkan terima kasih.

Ditetapkan di Jakarta
Pada tanggal 13 Maret 2013

MENTERI KESEHATAN
REPUBLIK INDONESIA,

NAFSIAH MBOI

Tembusan:
1. Sekretaris Jenderal Kementerian Kesehatan RI
2. Direktur Jenderal Bina Upaya Kesehatan Kementerian Kesehatan RI
3. Direktur Jenderal PP dan PL Kementerian Kesehatan RI
4. Gubernur seluruh Indonesia
5. Bupati/walikota seluruh Indonesia