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

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ACRONYMS AND FOREIGN TERMS

AIP	AIDS Intervention Project
AMI	Asia Market Intelligence (local research agency)
ANC	Antenatal care
ANE	Asia/Near East Bureau
APBD	Anggaran Pendapatan dan Belanja Daerah (Regional Income and Expenditure Budget Plan)
AZT	Azidothymidine (zidovudine)
ARO/Bangkok	Family Health International/Asia Regional Office, Bangkok
AusAID	Australian Agency for International Development
BCC	Behavior change communication
BKKBN	Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Coordinating Board)
BSS	Behavior surveillance survey
CA	Cooperative agreement
CDC	Centers for Disease Control and Prevention
CHN-3	Community Health Nutrition (3)
CPO	Contract performance objective
CS	Office of Health and Nutrition, Division of Child Survival
CSM	Condom social marketing
CSW	Commercial sex worker
DepKes	Departemen Kesehatan (Ministry of Health)
DKT	DKT International
FHI	Family Health International
FHI/Arlington	Family Health International Headquarters in Arlington, Virginia
FHI/Jakarta	Family Health International in Jakarta
FP	Family planning
FY	Fiscal year
GFS	Global Field Support
GOI	Government of Indonesia
G/PHN/HN/ HIV–AIDS	Bureau for Global Programs, Field Support and Research, Center for Population, Health and Nutrition, Office of Health and Nutrition, HIV–AIDS Division
HAPP	HIV/AIDS Prevention Project
Health Tech	Technologies for Child Health, a PATH project
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IA	Implementing agency
IAKMI	Local Indonesian NGO
IDU	Injecting drug user
IEC	Information, education, and communication
IMPACT	Implementing AIDS Prevention and Control Activities
IR	Intermediate Result
KAP	Knowledge, attitudes, and practice
KfW	Kreditans Talt fur Wiederaufbau (German donor bank)
KPAD	Komisi Penanggulangan AIDS Daerah (Provincial AIDS Commission)
krismon	Economic crisis
Labkes	Laboratorium Kesehatan
Litbangkes	Penelitian dan Pengembangan Kesehatan (National Institute for Health

	Research and Development)
lokalisasi	Local brothel area
MCH	Maternal and child health
Menko Kesra	Menteri Koordinator Kesejahteraan Rakyat (Coordinating Minister/Ministry for People's Welfare at the National Level)
MOH	Ministry of Health
NAMRU-2	Naval Medical Research Unit (2)
NGO	Nongovernmental organization
NIHRD	National Institute for Health Research and Development
PACD	Project Activity Completion Date
PACT	Private Agencies Collaborating Together, Inc. (PVO)
PASA	Participating agency service agreement
PATH	Program for Appropriate Technology in Health (PVO)
PBC	Performance-based contract
PCI	Project Concern International
PIL	Project implementation letter
PNG	Papua New Guinea
puskesma	Local health clinic
PVO	Private Voluntary Organization
repelita	Rencana Pembangunan Lima Tahun (five−year development plan)
RP	Results Package
RTI	Reproductive tract infection
SO	Strategic Objective
SOMARC	Social Marketing for Contraceptives Project
SOAG	Strategic Objective Agreement
SpO	Special Objective
SRI	Survey Research Indonesia (local research agency)
STD	Sexually transmitted disease
TFG	The Futures Group International
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USAID/Indonesia	United States Agency for International Development, Indonesia
USAID/Washington	United States Agency for International Development, Washington
waria	Wanita pria (male transvestite)
WB	World Bank
WHO	World Health Organization
YKB	Yayasan Kusuma Buana
YIK	Yayasan Investasi Kemanusiaan

ASSESSMENT TEAM MEMBERS

A six-person assessment team visited Indonesia from February 8–26, 1999. The team was composed of the following individuals:

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- **Nuning M.K. Masjkuri, Ph.D.,** Department of Epidemiology, University of Indonesia, Jakarta, Indonesia: epidemiology and sexually transmitted disease (STD) control;

- **Firman Lubis, M.D., M.P.H.,** Yayasan Kusuma Buana, Jakarta, Indonesia: HIV/AIDS prevention program strategy; information, education, and communication (IEC); and, epidemiology/STD control;

- **Endang Sedyaningsih, M.D., Ph.D.,** Ministry of Health, Jakarta, Indonesia: government of Indonesia/Ministry of Health (GOI/MOH) strategy/program and STD/HIV/AIDS prevention program strategy;

- **Waliur Rahman, M.Sc.,** Managing Director, Social Marketing Company, Dhaka, Bangladesh: condom social marketing; and,

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CONTENTS

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 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 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, 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.

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 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.

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.

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.

I. BACKGROUND

PURPOSE OF VISIT

The U.S. Agency for International Development (USAID)/Indonesia requested the assistance of an external team to visit Indonesia to assist USAID/Indonesia in assessing: (a) the general human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) situation in the country, (b) government of Indonesia (GOI) and donor commitment/funding for HIV/AIDS and related activities, and (c) 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. Additionally, it is anticipated that the findings and recommendations of the assessment team will be useful to USAID/Indonesia in the refinement of its population, health, and nutrition (PHN) strategy, especially the HIV/AIDS Results Package. As a starting point, the assessment team reviewed a number of key documents. (See annex A, Statement of Work, for a listing of these documents.)

METHODS/ACTIVITIES

During its 3–week stay, the assessment team met with a wide array of GOI representatives (National AIDS Commission and Department of Health, 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 (i.e., USAID "customers"). The assessment team, which split into three subteams, also conducted site visits to the three HAPP field sites in Jakarta, Surabaya, and Manado, as well as PATH field sites in Irian Jaya. At the provincial level (in North Jakarta; Surabaya, East Java; Manado, North Sulawesi; and, Merauke and Jayapura, Irian Jaya), the team systematically met with the National AIDS Commission, KPAD, Departments of Health, Family Health International/Jakarta (FHI/Jakarta), PATH/Jakarta staff and HAPP/PATH partner implementing NGOs, and commercial condom marketing companies and outlets (e.g., pharmacies, drug sellers, other product outlets). The team also visited areas of high-risk behavior (e.g., ports, transportation hubs, and brothel areas) to talk with beneficiaries and to assess the overall situation. (See annex B, Discussion Guides.)

During the final week of the assessment, the team met separately and sequentially with colleagues from each of the key organizations—USAID/Indonesia, FHI/Jakarta, and the Ministry of Health—and held a special briefing for the Minister of Health and his staff. The purpose was to debrief counterparts and share relevant sections of the report, especially the findings and recommendations. (See annexes C, Schedule for HIV/AIDS External Assessment Team; D, Persons Contacted; and E, Meeting Participants.)

USAID/INDONESIA'S STRATEGY

USAID/Indonesia's "Crisis and Recovery: Strategy for Indonesia Fiscal Year (FY) 1999–2000" is composed of six interlinked strategic objectives:

- Democratic transition strengthened,
- Health of the most vulnerable women and children protected,
- Improved food security for the most vulnerable groups,
- Increased employment for targeted communities,
- Recovery of economic and financial systems, and
- Strengthened environmental management.

The five–year PHN strategy is divided into two phases: Phase I: 1999–2000: response to immediate crisis; and, Phase II: 2000–2003: emphasis on recovery. This two-phase strategy responds to immediate needs of the crisis while building foundations for long-term sustainable development. The PHN strategic objective, **"Health of the most vulnerable women and children protected,"** is supported by three Intermediate Results (IRs):

IR1: Effective crisis monitoring and disease/nutritional surveillance established,

IR2: Essential health services preserved (this is the cornerstone of the PHN strategy), and

IR3: Appropriate health behavior and services promoted.

PHN's response within the sector is comprised of four Results Packages (RPs), or components, as follows:

RP1: Family Planning,
RP2: Maternal and Child Health/Nutrition,
RP3: HIV/AIDs and STDs, and
RP4: Surveillance and Monitoring.

PROBLEM ANALYSIS

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. As of January 1999, a cumulative total of 832 individuals with HIV has been reported from 15 provinces. The epidemic has not yet penetrated the general population of Indonesia. HIV screening of more than 500,000 blood donations over each of the past five years shows rates of 0.74, 0.56, 2.03, 3.01, and 1.54 per 100,000. 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). Thirty-six percent of the HIV cases in Irian Jaya (56/155) are documented as being fishermen working for Thai fishing companies who have likely played a central role in the introduction and spread of HIV in some parts of Indonesia.

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. Numerous USAID–and European Commission–supported studies performed by diverse organizations in widely scattered parts of Indonesia have consistently shown that among female CSWs, the prevalence of Chlamydia Trachomatis, Neisseria Gonorrhoea, or both, is as high as anywhere in the world, from 15 to 50 percent. Acute syphilis, though, is relatively rare (less than 10 percent). According to preliminary data from HAPP's longitudinal surveillance of N. gonorrhoea and C. trachomatis among CSWs in Jakarta, Surabaya and Manado, rates for both infections have increased over the last two years. Among women in the general population, Chlamydia Trachomatis is the most important STD, found among 5–10 percent of asymptomatic family planning and antenatal clinic attenders in most studies. (See annex F, Epidemiological Data of HIV and STDs in Indonesia.)

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 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. Over the last five years, there have been regular quarterly donor coordinating meetings chaired by the World Health Organization/Joint United Nations Programme on HIV/AIDS (WHO/UNAIDS), as well as smaller network working meetings. These meetings have been especially significant when the GOI has taken the lead in coordination. 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. The best example is the effective teamwork between USAID's HAPP and Australian Agency for International Development (AusAID) HIV/STD Prevention and Care Project. This cooperation operates at many levels and means that the two 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 PHN Transition Plan, approved by USAID/Washington in April 1997, emphasized the development and implementation of sustainable models and systems prior to cessation of USAID–funded

Strategic Objective 5[1] (SO5) activities in 2000. However, the economic/political crisis has affected Indonesia since July 1997. After the change of governments in May 1998, the crisis has deepened and spread throughout the country with some 30 million people identified by a recent World Bank study as currently below the poverty line. While the data are still incomplete on the scope of the economic crisis, there is concern by USAID that the devaluation of the Indonesian rupiah, inflation, unemployment, and continuing political instability will have an impact, especially in hard-hit urban areas, on household income, unemployment, and health-seeking behaviors, thereby slowing progress toward achievement of SO5. In particular, USAID anticipates a decrease in utilization of private sector health and family planning services as household incomes fall.

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. However, donor support is welcomed in helping the GOI mobilize a proactive response to the monetary crisis. Many donors are adjusting their programs and the existing donor network has been very effective.

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. An SO5/PHN strategy revision, which occurred in late 1998, assessed the scope, magnitude and duration for continued USAID assistance to the Indonesian PHN sector and revised the SO5 results framework accordingly.

[1] Strategic Objective 5: Sustained improvements in health and reduced fertility.

II. KEY ASSUMPTIONS

The following assumptions were made by the assessment team concerning the government of Indonesia (GOI), USAID, and other organizations, including donors, commercial companies, and consumers.

GOVERNMENT OF INDONESIA (GOI)

- GOI, in the June 1999 elections, continues its move towards national stability and democratic governance.

- GOI continues to support an expanded role for international PVOs/NGOs, particularly local NGOs and the commercial sector in HIV/AIDS interventions.

- GOI supports and facilitates commercial and/or generic condom promotion and behavior change messages to be freely broadcast and/or disseminated. GOI also allows social marketing organizations/NGOs/commercial sector to set appropriate prices for condoms, products, and drugs for STD management, and does not intervene in pricing policies, distribution methods and mechanisms.

- The current severe economic crisis (krismon) will lessen and a gradual return to pre–1997 economic vitality will occur.

- Menko Kesra, KPAD, and Ministry of Health leadership remains strong and committed to addressing the HIV/AIDS situation in Indonesia. As part of this commitment, it is important that Indonesia's National AIDS Strategy, adopted in 1994, be periodically reviewed and updated as required.

USAID

- USAID/Indonesia and other donors and organizations working in HIV/AIDS prevention continue their commitment and funding to the implementation of the National AIDS Strategy.

- Public sector and NGO capacities are either very weak and/or stretched to the limit. Thus, the continued refinement, testing, and implementation of USAID/Indonesia's HIV/AIDS Results Package indicators will take patience and time.

- USAID/Indonesia and its implementing agency partners (Family Health International [FHI], Program for Appropriate Technology in Health [PATH], Private Agencies Collaborating Together, Inc. [PACT], Project Concern International [PCI], The Futures Group International [TFG], DKT International [DKT]) assume that the *partnership* is tripartite and includes the public sector

(GOI entities—Menko Kesra, KPAD, MOH), the international PVO/NGO sector (international PVOs/NGOs and local NGOs) and the commercial sector (e.g., advertising/social marketing companies, pharmacies, drug sellers, and private providers/clinics).

- USAID/Washington will provide an adequate and appropriate mix of sectoral funding from the accounts of population, child survival, and HIV–AIDS to USAID/Indonesia in a timely manner in order for the Mission to implement its approved Strategic Plan (multiple strategic and special objectives) over the five–year period.

OTHERS

- Other donors and international PVOs continue to provide complementary inputs/resources and strive for an improved communication and coordination environment within the STD/HIV/AIDS sectoral environment.

- Other donors or commercial companies continue to provide an adequate supply of condoms and appropriate drugs for STD management in a timely manner.

- Consumers (i.e., end beneficiaries/high-risk behavior populations) are willing to pay for quality services and products that have been carefully positioned and priced. For segments of society which cannot pay, freely distributed condoms are not easily available, either because of poor distribution or targeting to these populations.

III. USAID/INDONESIA'S HIV/AIDS RESULTS PACKAGE STRATEGY

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. Based on a number of discussions with various officials from the GOI/MOH, donors, and other organizations, USAID/Indonesia should consider expanding its geographic coverage to other provinces or areas where high-risk behaviors occur, for example, Riau or Maluku. Expansion, however, does **not** necessarily imply a replication of additional demonstration or static sites. Rather, different options should be carefully reviewed considering impact on the epidemic, effort involved, and cost benefit.

The three GOI/HAPP **demonstration** areas were selected on the basis of PATH's "Rapid Assessment of Five Cities in Indonesia," USAID/Indonesia's evolving response to the situation under its "Crisis and Recovery Strategy," and the potential for the introduction and/or spread of HIV/AIDS in these areas. Also, a relatively high number of cases of HIV/AIDS has been reported from Jakarta and East Java, and North Sulawesi is at risk of having a high number of HIV/AIDS cases. 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. This consideration is based on the prevalence of STDs and the number of HIV–positive persons identified in these provinces, known risk factors, and limited resources. The eight urban areas of high risk are in:

1. Irian Jaya, currently assisted by PATH,
2. Riau, formerly assisted by the World Bank,
3. Maluku,
4. West Java,
5. North Sumatera,
6. South Sumatera,
7. Central Java, and
8. 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.

There are compelling reasons for USAID/Indonesia to consider an expanded role regarding the STD and HIV/AIDS situation in Indonesia, including:

- The decrease in donor funding for HIV/AIDS (i.e., the World Bank's [WB] reduction from $25 million to $5 million). The GOI/WB loan mechanisms have constrained the use of these HIV/AIDS funds. The WB's remaining $20 million is still with the GOI for reprogramming, but not necessarily for HIV/AIDS. Apart from USAID, few donors/organizations are working in these provinces, thereby giving USAID/Indonesia new and unique strategic and programmatic advantages under its new five–year strategy.

- The ongoing economic crisis (krismon) and the GOI's current inability to provide adequate counterpart funds.

- Eroding economic conditions of the poorest sectors of society, especially in urban areas, have caused economic stress 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.

- 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 (i.e., roads, transportation links, markets, communications, and accessibility) 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 (doctors, nurses, and midwives).

GEOGRAPHIC PHASING

As noted above, USAID/Indonesia's geographic focus until 2000 is on four specific provinces—three **demonstration** areas under HAPP in North Jakarta; Surabaya, East Java; and Manado/Bitung, North Sulawesi; and, in Irian Jaya with PATH. During Phase II (2000–2003) of USAID/Indonesia assistance, USAID/Indonesia and its partner

organizations should consider expanding geographic coverage to other provinces or areas of high prevalence and where high-risk behaviors occur.

At present, the eight provinces listed above should be considered as new or expansion areas either under HAPP or with coordinated GOI and other donor assistance. However, as stated above, expansion does **not** necessarily imply a replication of additional demonstration or static sites. Rather, different options should be carefully reviewed considering impact on the epidemic, effort involved, and cost benefit. A follow-on "refinement team" should visit several of these provinces to determine the most logical provinces or sites for possible expansion.

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.

IV. USAID/INDONESIA'S HIV/AIDS PREVENTION PROJECT (HAPP)

FAMILY HEALTH INTERNATIONAL'S ROLES AND RESPONSIBILITIES [2]

The following brief descriptions outline the roles and responsibilities of FHI headquarters in Arlington (FHI/Arlington), FHI's Asia Regional Office in Bangkok (ARO/Bangkok) and, FHI in Jakarta (FHI/Jakarta) in the management of HAPP in Indonesia.

FHI/Arlington

FHI's HIV/AIDS activities in Asia are substantially decentralized, with the major design and implementation decisions related to HAPP originating in the country office but subject to review at ARO/Bangkok and FHI/Arlington. Assistance awards, for example, are executed by FHI/Arlington following their development by FHI/Jakarta and both technical and financial review by ARO/Bangkok.

In addition to authorizing the assistance awards (subagreements, letters of agreement and cost amendments greater than $5,000), FHI/Arlington's role in Indonesia includes providing management and technical backup at the request of ARO/Bangkok, approving annual budgets, and managing audits.

FHI/Arlington also maintains program staff members who remain current on activities in Asia in order to provide information to G/HIV–AIDS and the ANE Bureau on the Indonesia program and other programs in Asia.

FHI/Asia Regional Office, Bangkok (ARO/Bangkok)

The FHI/Asia Regional Office, Bangkok (ARO/Bangkok), is responsible for providing management and technical support to FHI/Jakarta. ARO/Bangkok provides specialized technical assistance to FHI/Jakarta by providing onsite technical assistance in-country with FHI/Arlington or ARO/Bangkok staff in addition to local and international consultants. Technical support also is provided by ARO/Bangkok in response to specific queries and through the review of plans and agreements.

A second responsibility of ARO/Bangkok is management support. ARO/Bangkok staff provide onsite management support in addition to reviewing annual work plans, subagreements (with the exception of Rapid Response Funds activities less than $10,000),

[2] For purposes of clarity in distinguishing between the corporate entity FHI and the USAID/Indonesia–assisted HAPP, this report refers to FHI and its affiliates in Bangkok and Jakarta as FHI/Arlington, ARO/Bangkok, and FHI/Jakarta, respectively. Similarly, this report refers to HAPP as the HIV/AIDS Prevention Project working with GOI and other partners rather than HAPP being FHI.

international travel, large procurements (over $5,000), amendments to subagreements, implementing agencies' (IA) monthly financial reports, and new staff positions.

FHI/Jakarta

The primary responsibility for managing HAPP, a bilateral project funded by USAID/Indonesia, rests with the FHI country office in Jakarta (FHI/Jakarta). FHI/Jakarta is responsible for designing and implementing program activities that fulfill the requirements of the HAPP contract. FHI/Jakarta is the primary liaison for USAID/Indonesia and responds to Mission needs and ad hoc requests for information. The country office also is responsible for maintaining contact with the government of Indonesia (GOI), both at the central and provincial levels. FHI/Jakarta develops work plans in consultation with provincial and national health offices of GOI which are, in turn, approved by USAID/Indonesia. The country director reports to and is directly supervised by the Asia Regional Director.

Implementing agencies (IAs), both international PVOs and local NGOs, are selected to carry out activities listed in the work plan. Subagreements with IAs are developed by FHI/Jakarta in conjunction with the IAs. The country office is responsible for ensuring the performance of the IAs, including monitoring through financial and program reports, and supporting them with technical assistance and advancing funds. In-country travel for HAPP is managed by FHI/Jakarta.

FHI/Jakarta is also responsible for programmatic reporting to USAID/Indonesia; quarterly reports are submitted to the Mission and to FHI's other offices. As with all FHI projects, financial reporting to USAID is shared by the country office and FHI/Arlington.

TECHNICAL STRATEGIES

Current HAPP technical strategies include:

- Strategic planning and policy support:
  - Knowledge- and skill-building activities and
  - Strategic process;

- Information, education, and communications for behavior change:
  - Mass media, interpersonal communication, and counseling;

- Sexually transmitted disease diagnosis and treatment; and,

- Expanded access to and promotion of condoms:
  - Social marketing of condoms (see annex G, Assessment of HAPP Indonesia Social Marketing Component).

STRENGTHS OF HAPP

The strengths of the project include:

- Has been a catalyst for action to several provincial KPADs and appears to have excellent relationships with the KPAD and the GOI;

- Provides expertise in epidemiology and STD surveillance through a participating agency service agreement (PASA) with the Centers for Disease Control and Prevention (CDC), Atlanta, Georgia; and,

- Has demonstrated commitment to improving project management and coordination.

ISSUES/CONCERNS

Areas of concern that need to be addressed include the following:

- FHI/Jakarta administration, management, and responsiveness (see section VII, Recommendations).

- FHI/Jakarta staffing in Jakarta and provinces: since the internal FHI review in August 1998, staffing has improved and turnover has been reduced. This staffing should be maintained for the duration of Phase I.

- Limited delegation of authority, responsibility, and accountability to provincial level HAPP offices. Local NGOs should have responsibility and accountability (see section VII, Recommendations).

- Centralized and lengthy process/decision-making (e.g., expansion of the NGO network in all HAPP demonstration areas from the current three subagreement NGOs per area to other new NGOs which receive Rapid Response Funds).

V. USAID/INDONESIA'S AIDS INTERVENTION PROJECT II (IRIAN JAYA)

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. The underlying philosophies of this project are: (1) community-based local NGOs are well suited to the task of reaching people at risk of HIV infection with meaningful messages, (2) interpersonal communication delivered using community outreach and counseling can be a highly-effective tool in achieving behavior change, (3) awareness of AIDS is no guarantee of behavior change—information is an essential tool in the behavior change process, (4) frequent and widespread exposure to AIDS prevention messages delivered through multiple channels can make a significant contribution in the effort to convince people that they need to change their behavior, and (5) behavior change is a gradual process that can be negotiated and rewarded. (See annexes H and I for discussions of the HIV/AIDS situation in Irian Jaya and Merauke, respectively.)

OBJECTIVES OF AIP PHASE II

Besides strengthening local capacity for HIV/AIDS prevention, objectives of the second phase of the project also include:

- Studying, monitoring, and evaluating AIDS initiatives in Irian Jaya;
- Determining morbidity rates for STDs and AIDS;
- Evaluating the effectiveness of AIDS initiatives activities in detecting STD/HIV/AIDS; and,
- Rationale for treatment and analysis of knowledge, attitudes, and practices (KAP) related to STD/AIDS in high-risk populations.

STRATEGIES

To achieve these objectives, PATH uses the following strategies:

- Indigenous leader outreach;
- IEC and public information;
- Training and seminars;
- Specific technical support; and,

- Drop-in centers for adolescents in suburban areas and for CSWs in the local brothel areas (lokalisasi).

CURRENT ACTIVITIES

Activities for Phase II (October 1997–September 2000) include:

- Baseline KAP survey training in Jayapura for NGOs from Jayapura and Merauke;
- Training on HIV/AIDS basic information in Jayapura, Merauke, and Nabire;
- Reproductive health dissemination program targeted to adolescents/students in five high schools in Jayapura;
- Data collection on STD/HIV prevalence among high-risk communities in seven cities of Irian Jaya;
- STD diagnosis and reproductive health information dissemination program through the establishment of drop-in centers in Sentani, Jayapura, and Malanu, Sorong;
- Baseline KAP among entertainment industry workers and the general population in Jayapura;
- HIV/AIDS prevention program aimed at high-risk behavior group in entertainment establishments in Jayapura;
- A baseline KAP survey among male clients and CSWs in Merauke and Nabire;
- Information dissemination for male clients and CSWs in Merauke;
- Rapid ethnographic assessment on KAP regarding STD and sexual behavior in Sarmi and Sentani tribes; and,
- Monitoring and evaluation to measure progress and achievement.

STRENGTHS OF AIP II (IRIAN JAYA)

The strengths of AIP II in Irian Jaya include:

- 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 (there were no complaints from the collaborating NGOs); and,

- Local GOI representatives (e.g., health office, education office, and religious office) are very receptive to AIP and supportive of its programs.

ISSUES/PROBLEMS

Issues and problems that need to be addressed include:

- The KPADs (provincial and districts) expressed a need for a full-time secretary and operational budget (e.g., for developing an AIDS newsletter);

- There is a need for NGO capacity building in several key areas as 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 (i.e., correct diagnosis and treatment for STDs) 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; developing or refining prevention messages for a variety of subpopulations (i.e., bar girls, indirect sex workers, high-school students, and youth); and, persuading bar managers to put STD/AIDS IEC materials in their bars;

- There are no specific fora for the NGOs to exchange information about program activities with each other;

- There is a need to finalize the scope of work for staff in the drop-in center at Tanjung Elmo, Jayapura; and,

- The beneficiary groups need to be reconsidered—not all high-risk groups are covered by PATH programs, while some low risk groups are. For example, currently no NGOs are working with transvestites and street-based sex workers in Jayapura.

VI. USAID/INDONESIA'S BUDGETED, EXPENDED, AND PROJECTED COSTS

COST CONSIDERATIONS

A major consideration for the assessment team is the cost benefit of USAID/Indonesia's HIV/AIDS portfolio (FHI and international PVOs, PATH, the CDC PASA) and how effectively development funds are reaching indigenous implementing agencies and end beneficiaries, that is, USAID's customers. USAID/Indonesia's current portfolio is funded bilaterally (MOH/GOI, FHI, CDC) through Mission Field Support to PATH under the Child Survival Division's (G/PHN/HN/CS) Technologies for Child Health (Health Tech) project and funds via ANE for specific activities. Given the vastness of the country, the size and population density of many of its provinces, the sophistication of program implementers and commercial firms, and the multiplicity of USAID/Indonesia–funded implementing partners, Indonesia can certainly absorb infinite amounts of HIV/AIDS funding. The question that USAID/Indonesia and its local Indonesian partners need to carefully address is: **"What is an appropriate level of HIV/AIDS funding given the current nature of the epidemic and the Mission's evolving PHN strategy?"** Similarly, USAID/Washington will need to carefully consider USAID/Indonesia's potential requirements for new HIV/AIDS funding given the STD/HIV/AIDS situation in Indonesia and the funding requirements of other needy countries in South or Southeast Asia and Africa.

While the assessment team had limited opportunity to review the total costs of USAID/Indonesia's HIV/AIDS portfolio, it examined in some detail the funding information supplied by USAID/Indonesia, FHI/Jakarta and ARO/Bangkok, and the MOH regarding HAPP. As indicated in the following two tables, the portfolio is funded from multiple sources: bilaterally (FHI and its partners under HAPP and a PASA with CDC); Mission Field Support (PATH through Health Tech, FHI's Implementing AIDS Prevention and Control Activities Project (IMPACT), and G/HIV–AIDS' DMELLD); and, ANE (FHI's IMPACT to PATH/Indonesia). Specifically, two sources of financial information were reviewed: (1) USAID/Indonesia's analysis of all projects dated February 2, 1999, and (2) financial data for both the HAPP activities under the performance-based contract (PBC) and the project implementation letter (PIL) funds to the GOI/MOH.

Two main concerns regarding the Indonesia portfolio are: (1) the PHN Transition Plan (see section I, Background) emphasizes the development and implementation of sustainable models and systems, but a particularly small proportion of funds actually is being used to support local NGOs in their field-based activities and new initiatives (see table 1, p. 19); and, (2) the total amount of funding for Indonesia, still a low prevalence country, is high compared to total funding available to other countries in South or Southeast Asia or Africa. For example, including all funds and sources, the total funding level for the period is approximately $24.7 million to achieve USAID/Indonesia's overall goal of reducing the

rate of HIV/AIDS, including STD transmission, in order to promote the general health and well-being of the people of Indonesia. HAPP, at $21 million over the life of the project (March 1995 to April 2000), is the largest component and includes funds to FHI, the GOI/MOH, and a PASA with CDC (see table 1). PATH funding for the life of the project is $1.3 million. Other activities are funded through both USAID/Indonesia Field Support and the ANE Bureau, totaling $.525 million (see table 2, p. 20).

The assessment team believes that the primary purpose of USAID resources should be the application of those resources on development within the local/country context, especially organizational development and capacity building of local institutions and NGOs. In the case of Indonesia, especially as outlined below, there is a striking difference and an inverse proportion of funds allocated to U.S. organizations (FHI, its international PVO partners, and CDC). While it is acknowledged that implementation under the PBC did not start until mid−1998, it will be important to track this critical issue of proportionality over time. Two issues/questions are immediately apparent: (1) will there be a shift over time in the proportion of funding to FHI and its international PVO partners versus local entities; and, (2) while both the HAPP agreement and FHI's PBC explicitly state that building local capacity is one of HAPP's fundamental objectives, neither the technical components nor any of the seven contract performance objectives (CPOs) include language to this effect. If building capacity of local institutions and NGOs is to be achieved in the future, these concepts must be explicitly included in performance measures and carefully monitored by USAID/Indonesia and the MOH. The following discussions are based on the review of available financial information and tables 1 and 2.

BILATERAL COST CONSIDERATIONS—FHI AND ITS PARTNERS

Based on discussions with FHI/Jakarta, ARO/Bangkok, and FHI/Arlington, and through a review of financial information provided by them, FHI divides HAPP funding into two major categories: program costs and management costs. The total FHI budget for the HAPP project is $9,153,889, which includes a base fee of $258,686 and the possible award fee of $272,329. The contract period is from September 1997 to April 2000.

In dividing the HAPP budget into the two major categories, FHI uses the following definitions:

- **Program costs**, which are required to implement or support program activities, include line items for:

  - program implementation agreements with local agencies—NGOs, rapid response, KPADs;
  - technical assistance and program implementation agreements with partner international PVOs;
  - technical assistance (salaries/benefits)—ARO/Bangkok and FHI/Arlington;
  - travel/per diem;
  - materials/media/workshops; and
  - HIV and STD test kits/freight; and,

- **Management costs**, which are required to provide management and administrative oversight of HAPP, include line items for:

  - FHI/Jakarta field salaries/benefits;
  - ARO/Bangkok and FHI/Arlington office expenses;
  - FHI/Jakarta office expenses; and,
  - general and administrative costs, base fees and award fees.

Using the above definitions, FHI's allocation of program and management costs, in keeping with the PBC budget, are:

Type of Cost	Costs	Percent of Total
▪ Program	$5,054,535	55
▪ Management	$3,084,581	34
▪ Procurement (HIV, STD test kits/freight)	$1,014,773	11
TOTAL COSTS	$ 9,153,889	

Since the HIV/STD test kits are, in fact, a program cost, when these costs are added to the program costs, the total would be $6,069,308, or 66 percent of the total costs. By using FHI's definitions and cost principles, as well as what is stated in the PBC, the above analysis illustrates that a higher percentage of the project budget is used for program costs.

The above definitions place all partner international PVO costs into the program budget, which somewhat exaggerates the program estimate (since international PVO management costs are included in these agreements). However, it should also be pointed out that all FHI/Jakarta personnel costs have been allocated to management costs, although some staff members are entirely program focused (e.g., the IEC adviser) and many staff members perform both program (e.g., technical implementation and capacity-building advice and support) as well as management oversight.

It is important to note that of the $5,054,535 program cost funds cited in the "HAPP Actual and Projected Expenses" report provided by ARO/Bangkok, $1,545,973 (16.9 percent) is intended for agreements with local agencies (i.e., NGOs, rapid response, and KPADs.) As of January 1999, halfway through the contract period, only $394,873, or 25 percent of the intended amount, had been actually used by these local agencies.
From the observations made and discussions in the field, especially with local NGOs, and after reviewing FHI's actual and projected expenses, it is clear that there have been problems with either getting appropriate funding levels to the field or the capacity of local NGOs to utilize or account for these funds. In either case, implementation and performance of community-based activities have been negatively affected.

USAID/Indonesia needs to critically review partnership requirements and overall funding for activities beyond April 2000. First, there should be clear and compelling technical or programmatic reasons for multiple international PVOs under the HAPP umbrella. At the onset, each partner should be responsible for clearly defined roles and specific contributions to the HAPP strategic objectives and results. Otherwise, the overabundance

of partners as well as the overlap of effort is neither managerially efficient nor cost-effective to reach local beneficiaries. This review should be a fundamental task for a refinement team later in the fall, as outlined below. Second, USAID/Indonesia and FHI should critically review FHI's institutional policies and procedures with a view toward streamlining them, thus providing local organizations and NGOs with the authority and funding required to implement their programs.

The following tables, supplied by USAID/Indonesia, provide a clear picture of the overall funding situation.

TABLE 1
HIV/AIDS Prevention Project (HAPP) Bilateral Funds/SOAG

Items/Descriptions	Life of Project Funding	Planned (1)	Actual Obligated (2)	Actual Committed (3)	Balance Funds Now (2–3)
All Components	21,000,000				
FHI Contracts		15,450,000	15,450,000	5,948,897 4,337,540	5,163,563
Project Level Eval./ Audit		450,000	450,000	9,677	440,323
PASA–CDC		1,900,000	1,900,000	1,673,308	226,692
GOI–managed PILs		3,200,000	3,200,000	526,466	2,673,534
TOTAL	21,000,000	21,000,000	21,000,000	12,495,888	8,504,112

Notes: Data from FHI cost analysis (averages are rounded)

Actual expenditures (9/1/97–6/30/98): 10–month period	1,295,741	Ave./month:	129,574
Actual expenditures (7/1/98–12/31/98): 6–month period	1,986,644	Ave./month:	331,107
Subtotal: 16–month period	3,282,385	Ave./month:	205,149
Est. expenditures (1/1/99–3/31/99): 3-month period	1,055,155	Ave./month:	351,718
Subtotal: 19–month period	4,337,540	Ave./month:	228,292
Plan for second increment (4/99–4/00): 13–month period	4,816,349	Ave./month:	370,488
TOTAL FHI PHASE II CONTRACT	**9,153,889**	Ave./month:	286,059

The assessment team did not review the cost benefit of this activity. However, for Phase II (beyond April 2000), FHI should explore options to include the technical assistance activities and costs under HAPP rather than renew/extend its PASA with CDC.

TABLE 2
Outside of HAPP: Global Field Support (GFS) and ANE Funds

Elem. No.	Funds Awarded	Funds Reserved (1)	Earmark/ Plan to Use (2)	Commit./ Contract Awarded (3)	Expend. to Date (4)	Costs (1–4)

	GFS Funds					
1	IMPACT: Bali AIDS Prevention Yayasan Kerti Praja: $ 40,576 Yayasan UPLEG: $ 38,678	100,000	100,000	0	0	100,000
2	Irian Jaya AIDS Initiative Project (PATH)*	800,000	800,000	800,000	343,628	456,372
3	MEDS: AIDS External Assessment	102,000	102,000	102,000	0	102,000
4	DMELLD	198,000	198,000	0	0	0
	ANE Funds					
5	Cross Border Initiative Project (PATH)	125,000	125,000	0	0	125,000
	TOTAL	1,325,000	1,325,000	902,000	343,628	783,372

*According to PATH, the total cooperative agreement for Indonesia is $1,300,064.

In the above table, the term Global Field Support (GFS) is used. In actuality, with the exception of ANE funds to PATH for cross-border activities, all other funds are Mission Field Support funds which are administered through central projects in G/PHN/HN, such as FHI's IMPACT, PATH's Health Tech, and G/HIV–AIDS' Design, Monitoring, Evaluation, Lessons Learned, and Dissemination (DMELLD) contract.

While directly supportive of USAID/Indonesia's overall portfolio, these activities should also be considered for programmatic value and cost benefit during the follow-up refinement exercise recommended for early fall 1999.

To reiterate, the question that both USAID/Indonesia and its local Indonesian partners and USAID/Washington must carefully address during the refinement exercise is, "What is an appropriate level of funding given the current nature of the epidemic and the Mission's evolving PHN strategy?" Elements to consider are: (a) activities and/or interventions and geographic locality, (b) role and number of partners required, (c) cost benefit and cost-effectiveness of interventions and partnerships, (d) local organization capacity building and long term competency, and (e) more appropriate or up-to-date performance indicators than currently exist.

VII. RECOMMENDATIONS

INTRODUCTION

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 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. These delays and the complexity of design reinforce one of the major recommendations of this assessment—change the procurement mechanism from the PBC to a CA for Phase II, April 2000–2003.

The recommendations that follow are separated into two parts: Phase I, March 1995 to April 2000 (short term and HAPP I contract end date); and, Phase II, April 2000-2003 (long term). It will be extremely important to ensure a seamless transition from the current phase to the next phase to ensure that information and services are not disrupted and that there is no demobilization of organizational partner NGOs.

The assessment team concurs with FHI's findings/recommendations as presented in their draft, "Critique of the Performance-Based Contract," which emerged from FHI's internal review of FHI/Jakarta's administration and management of HAPP activities.

With certain modifications to the original FHI/Jakarta recommendations from the "Critique," the assessment team agrees that:

- There should be no further changes of FHI's PBC though April 2000.

- Any alterations or refinements should be made with the assistance of a follow-on team in the near future so that a seamless transition (bridge) occurs between Phase I and Phase II.

- 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. However, multiple partners (GOI, FHI, USAID, and international PVOs and local NGOs) should assist with this selection process.

- 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.

GOVERNMENT OF INDONESIA (GOI)

Menko Kesra (Coordinating Minister/Ministry for People's Welfare at the National Level)

- Review/update the Indonesian National AIDS Strategy (dated June 16, 1994) to be in accordance with emerging HIV/AIDS strategies and Indonesia's next five−year plan (repelita).

- Consider a mechanism or guidelines that would allow local NGOs to sell the condoms they had received at no cost from the MOH and the National Family Planning Coordinating Board (BKKBN). Prior to establishing such a mechanism or guidelines, a study to quantify whether to supply free condoms or subsidize condoms for the lower socioeconomic (D and E) segments of the market should be conducted. Based on the study, guidelines for the establishment of revolving funds, similar to those used in essential drug programs, could be established and followed by the NGOs. This would assist NGOs in their efforts to increase their self-sufficiency.

- Explore the public acceptability of repositioning condoms in the public eye to cover both family planning/contraception and disease prevention more broadly defined (hepatitis viruses, STDs, HIV/AIDS) and cervical cancer. Undertake systematic acceptability research with the assistance of Litbangkes, National Institute for Health Research and Development (NIHRD).

- Resolve to work toward a consensus with all ministries to actively support the 100 percent condom promotion policy in commercial sex establishments.

- Increase access to mass media communications for HIV/AIDS/STD prevention and treatment messages.

- Future observation tours should be conducted in countries other than Thailand. For example, Bangladesh would make an excellent site due to its sociocultural, religious, and geographic similarities with Indonesia. Also beneficial would be field visits to Merauke or Bali to observe the local response to the HIV/AIDS epidemic.

KPAD (Provincial AIDS Commission)

- Strengthen communication/coordination between/among all partner organizations (e.g., GOI [all related government institutions—health, population, religion, social], HAPP/partners [PATH, PACT, PCI, TFG, DKT], but especially local/indigenous NGOs) by providing funding for permanent secretaries for KPAD in high priority provinces.

- Strengthen the management skills of provincial KPADs. Empower them by increasing their skills in planning, monitoring, and evaluating programs, and assist in securing funding for program implementation.

- KPAD, in cooperation with the local NGOs, should consider holding periodic partnership meetings in brothel areas of Jakarta, Surabaya, Irian Jaya (e.g., Kramat Tunggak in Jakarta, Dolly/Jarak in Surabaya, Yobar in Merauke, and Tanjung Elmo in Jayapura) to make KPAD representatives sensitive to the goals and objectives of USAID/Indonesia–funded activities, and to maintain KPAD's focus/attention on end users/beneficiaries. KPAD should also consider including representatives from high-risk groups on the KPAD.

- KPAD's technical committees should consider additional data for decision-making requirements which would assist them in monitoring and responding to the STD and HIV/AIDS situation.

- In line with KPAD's current planning, all observation/study tours should include representatives from NGOs and, if possible, representatives from high-risk groups. Tour participants should provide to HAPP/USAID/Indonesia a plan for implementation of "lessons learned" to their own area of work soon after a tour's completion.

- Future observation tours should be conducted in countries other than Thailand. For example, Bangladesh would make an excellent site due to its sociocultural, religious, and geographic similarities with Indonesia. In addition, field visits to Merauke or Bali to observe the local response to the HIV/AIDS epidemic would be beneficial.

Ministry of Health (MOH/Dinas/Kanwil Kesehatan Provinces)

- Continue to strengthen and reinvigorate STD treatment and services to prevent HIV/AIDS and continue to disseminate IEC in accordance with the new health paradigm for Indonesia.
- Strengthen the dual approach of IEC and service delivery.

- Initiate the development of provincial and district master plans for STD/HIV/AIDS prevention and control programs. This master plan should focus on areas with the potential for high-risk behavior and should be driven by the local epidemiological condition in each area.

- Establish a national STD referral laboratory. This can be accomplished by supporting an existing laboratory in Jakarta. The MOH can form a small team to assess the capabilities and interests of prominent laboratories in Jakarta and decide which one

can be assigned as the reference laboratory.

- Provide resources and infrastructure to the NIHRD to become a clearinghouse for STD/HIV/AIDS studies in Indonesia.

- Reactivate the national working group for HIV/AIDS so that it can provide analytic support for the KPA and the MOH. This group could assist in evaluating the applicability/appropriateness of the syndromic approach to STDs management as proposed by WHO, as well as other methods.

- Conduct national mapping to characterize the HIV/AIDS epidemic, variations in ethnic sexual behavior, high-risk communities and gonorrhea susceptibility so that resources can be focused on the most needy provinces.

- Include HIV/AIDS/STD prevention in maternal and child health (MCH) and family planning (FP) services, where appropriate.

- Decentralize the planning and execution of surveillance activities by strengthening surveillance capability and the provincial laboratories, especially in high-risk provinces.

- 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. Care must be taken to obtain consent at both the community and individual levels for all epidemiological and behavioral studies.

- Update all health care provider education and training to include current knowledge and management of STD/HIV/AIDS, universal precautions, and patient counseling techniques. Continue to improve the supply of necessary medical materials and instruments to the neediest districts.

- Consider expansion to new geographic areas or opportunities, where appropriate.

- Work in equal partnership with local NGOs working with high-risk groups.
- Work toward a consensus with all ministries to actively support the 100 percent condom promotion strategy in the sex industry.

USAID/INDONESIA

Primary Recommendations for Phase I (Through April 2000)

8. USAID/Indonesia should seriously consider switching from the current procurement mechanism, the performance-based contract (PBC) to a stand-alone cooperative 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 (**not** deobligated/ reobligated).

A switch in procurement mechanism from a PBC to a CA is strongly recommended for the following reasons:

- Because HIV/AIDS is both a public health issue and a development issue, a contract in the context of trying to respond to an epidemic is antithetical to both the public health aspects of HIV/AIDS and general development. HIV/AIDS work requires a flexible, opportunistic, and often rapid response to the evolving epidemiological and geographic situation.

- The HAPP–supported NGOs are confused with and constrained by the complexity of the design and subgrantee mechanism.

- A CA still provides substantial involvement on the part of USAID but does not require the type of intense oversight, monitoring, and programmatic inflexibility required by a contract.

- Since Phase I has already produced an excellent Strategic Framework, Intermediate Results and indicators, and an annual work plan, very little work remains for a contract to be changed into a CA.

The effort required would well serve the goals and objectives of USAID/Indonesia's HIV/AIDS Results Package and those of the GOI and its local partner NGOs.

9. 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. As part of a 3–4 week visit, USAID/Indonesia should consider conducting a

7–10–day facilitated workshop to assist in this exercise. For continuity of understanding, effort, and technical assistance requirements, participants at the workshop would include a small "external" team—ANE, G/HIV–AIDS, and DMELLD technical assistance, and all relevant local HAPP partners—such as MOH, KPAD, and NGOs. It is extremely important that a participatory, bottom-up approach be used to complete Phase II to ensure maximum participation of stakeholders and recipients.

Suggested timing: (1) USAID/Indonesia invites a follow-up visit by a DMELLD–ANE–G/HIV–AIDS team to work with local partners for Phase II planning for a 3–4 week visit by August–September 1999; (2) USAID/Indonesia makes the strategy final by November 1999; and, (3) since April 2000 is PACD for HAPP, but most subgrants only operate until December 1999, FHI/Jakarta should extend subgrants with designated international PVOs/NGOs through April 2000 while noncontinuation international PVO/NGO grants should be allowed to terminate according to current agreements. This timing will ensure ongoing implementation of Phase I activities and a seamless transition to Phase II.

10. USAID/Indonesia should carefully review HAPP's current model of using fixed demonstration areas for the following reasons: while it may be useful to have a few model projects or demonstration areas, activities/programs designed for rapid response and flexibility to pursue the epidemic epidemiologically and geographically are also necessary; and, the costs of fixed demonstration sites require indepth review, given questions of replicability and sustainability as well as GOI commitment and budgets.

11. 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).

12. Adequate, reliable, and valid epidemiological data are needed to be able to efficiently design, target, prioritize, and evaluate disease prevention programs. The value of the limited HIV/STD data available in Indonesia will be enhanced when data are comparable and analyzed together so that patterns can be detected and outliers identified. Therefore, USAID/Indonesia should continue to foster communication among organizations it supports 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.

13. Since G/HIV–AIDS and its U.S.–based Strategic Objective 4 partners (G/PHN Strategic Plan, January 1999) have devoted considerable effort to the development of a *Handbook of Indicators for USAID HIV/AIDS/STD Programs*, this handbook should be used in the process of review and refinement of the Indonesian strategy and the Results Package.

14. Since USAID/Indonesia puts field support funding into the centrally managed PATH grant, the Mission should include/require that PATH activities be incorporated within

the Mission's Strategy and PHN Results Packages, especially the HIV/AIDS Results Package.

15. 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 partners required for Results Package 2.

16. The HAPP STD adviser should be relocated to the MOH's/CDC offices to improve communication and accessibility. The adviser should proactively engage in training and technology transfer to MOH personnel as needs are determined by MOH.

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.

   However, to ensure adequacy of planning and a seamless transition from Phase I to Phase II, all subgrants should be extended to approximately April 2000, in accordance with the prime contract.

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 in potential expansion provinces (urban areas and high-risk behavior groups) to be included as part of the Phase II strategy and work plan. 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.

   However, for the remainder of Phase I, FHI/Jakarta should continue to strengthen its relationships, communication, coordination between/among its international PVO partner organizations (PATH, PACT, TFG, PCI, DKT) and award all subgrants.

3. FHI/Jakarta should delegate true authority, responsibility, and accountability to its HAPP provincial offices and the HAPP–funded NGOs. In this regard, and in spite of the PBC mechanism, FHI/Jakarta should stress partnership and collegiality rather than acting as prime contractor with subgrantees, a relationship which is too hierarchical.

Under the PBC, FHI/Jakarta's emphasis as prime contractor appears to take precedence over and be detrimental to local partner collaboration, participation, responsibility for implementation, and capacity building (see section VI on cost considerations).

FHI/Jakarta's (and perhaps FHI/Arlington's) commitment and attention appear to be overly aligned with central and provincial GOI counterparts rather than on the end beneficiaries (USAID's "customers") and building the capacity of local NGOs. While it is important to have strong, collegial relationships with the GOI, ultimate results in the achievement of indicators reside at both the community and individual levels. FHI/Jakarta should review its philosophy and program to ensure that customers/end beneficiaries are the ultimate recipients of information and services, and that capacity building occurs.

4. If given the opportunity by USAID, a different, more flexible procurement mechanism should be utilized. Under the current PBC, FHI/Jakarta and its partners cannot flexibly, opportunistically, or rapidly respond to the epidemic. Far too often, administrative, bureaucratic, and funding constraints have been encountered. The primary focus should be on the facilitation of implementation rather than too strict adherence to procedure, process, or central control.

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 for the following reasons: (1) in a low prevalence country, such as Indonesia, it may be appropriate to have a few model projects or demonstration areas; and, activities/programs designed for rapid response and flexibility to respond to the epidemic epidemiologically and geographically are also necessary; and, (2) the costs of fixed demonstration sites requires indepth review given questions of replicability and sustainability as well as GOI commitment and budgetary requirements to continue and/or expand without heavy reliance on donor assistance.

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. The value of the limited HIV/STD data available in Indonesia will be enhanced when data are comparable and analyzed together so that patterns can be detected and outliers identified. 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. Furthermore, HAPP, as part of its support to the GOI, should assist Litbangkes in revising the HIV/STD Working Group, comprised of all GOI, NGO, academic, and donor organizations working in HIV/STD

prevention, with the objective of facilitating communications for the purposes listed above.

8. The Rapid Response Fund mechanism is critical to the expansion of the NGO network and this mechanism should continue through Phase I. However, the proposal development and concurrence process should be streamlined and time sensitive. The process should be transparent—guidelines for proposal content should be clearly stated. Firm submission and approval schedules should be established, that is, submitted proposals will be reviewed and receive final approval within 90 days. The number of signatures needed for approval oversight should be reduced by half from the current 13. Each proposal should include a section for evaluating the intervention outcome or data collected and suggest implications of findings in terms of future activities or interventions.

9. Given the difficulties in ensuring STD drug availability and supply to NGOs, FHI/Jakarta should work with a consortium of capable NGOs and DepKes to study options for implementing a revolving essential drug scheme in sites capable of managing such schemes, for example, Surabaya's STD Putat Jaya Clinic and Yayasan Prospectiv. Rather than depending on DepKes for such drugs, private pharmaceutical companies could be approached to provide essential drugs to this consortium at a wholesale price.

10. If not already the practice, FHI/Jakarta should consider instituting a rolling advance and reimbursement system with its local NGOs. For example, the NGOs would initially develop an illustrative annual budget broken into quarters. FHI/Jakarta would advance the first quarter budget. For each successive quarter, but at the end of the second month, the NGO would submit its financial/actual expenditure report to FHI. To maintain quarterly replenishment of funds, FHI/Jakarta would have a maximum of one month to process and reimburse the NGO for the next quarter. Such a system would prevent gaps in funding and the need for NGOs to use other funds, if available, to keep activities ongoing.

11. 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. Training must be provided to partner NGOs and local health departments to assure that consent at both the community and individual levels is obtained for all epidemiological and behavioral studies.

12. To build long-term capacity for IEC, especially in Manado where there was an expressed need and interest from all sectors, an IEC/BCC consultant (ideally an Indonesian) should be sent for a 3–6 month period to work with interested government and NGO staffs by providing training/capacity building for the development, pre-testing, production, and evaluation of STD/HIV/AIDS materials for future sustainability.

13. FHI/Jakarta must review the organizational structure and lines of communication and authority between MOH, international PVOs and NGO partners. Improved

communications are clearly needed among all participants.

14. Current HAPP communication strategies (varied channels for information dissemination, such as interpersonal, peer or skill building) are sound, but strategies do not explain the causal links between exposure to BCC and behavior change. A theoretical framework on which communication and intervention strategies are based needs to be articulated. While the BSS is a useful instrument with which to compare sociodemographic and endpoint behavioral variable rates or percentages cross-nationally, it does not provide information on how behavior change occurs in the high-risk groups being surveyed. It is possible that the impact of project interventions are not fully appreciated (especially in the early stages of the projects when sustained endpoint behavior changes, i.e., consistent condom use will have occurred in very few individuals) because the processes that influence and support behavior change are inadequately specified by the BSS. If it is possible, logistically and financially, HAPP should use a theoretical framework to specify how and which main and intervening variables will affect behavior change and collect longitudinal data (with NGO partners) to assess fully the impact of these variables on their interventions.

15. FHI/Arlington should increase the country director's delegation of authority from its current low level to $50,000 for both procurement, subawards/amendments, and international travel.

16. FHI/Arlington should increase ARO/Bangkok's delegation of authority to the maximum allowable under FHI's policies/regulations for both procurement and subawards.

17. FHI/Arlington should review its current requirements to which subgrantees, especially local NGOs, must adhere (e.g., monthly and quarterly reporting schedules, work plan concurrence). Programmatic and financial reporting is necessary and useful. However, excessive reporting requirements, especially at the NGO level, are administratively burdensome and take valuable time away from implementation. Thus, capacity-building efforts should be intensified by FHI and its partners, and FHI/Arlington should consider adjustable, flexible subrecipient reporting requirements.

Secondary Recommendations for Phase I (Present - April 2000)

1. FHI/Jakarta needs to work more closely with KPAD and its partner organizations than it has been to initiate and implement the goals and objectives of the national programs and activities as outlined in the master plan.

2. USAID/Indonesia, in coordination with FHI/Jakarta and 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).

3. FHI/Jakarta, with support and assistance from USAID/Indonesia, should encourage collaboration of effort between TFG and DKT. There are appropriate niches for each social marketing partner. For example, an expanded niche for KfW/DKT might be in the provision of technical assistance to the GOI in the areas of procurement and

distribution. This would allow the commercial sector to flourish. The current economic crisis requires, in the short term, that DKT continue to make condoms available to the lower socioeconomic strata (D and E) of society.

4. FHI/Jakarta and its partners should encourage local NGOs (Surabaya, for example) to set up revolving funds for condoms. In regard to free MOH and BKKBN condoms, if transportation is an issue, the NGOs might be willing to pick up supplies from provincial warehouse(s).

5. FHI/Jakarta should continue to support NGO staff in conducting cross-training with more experienced NGOs to observe financial, management and training activities to build capacity with the goal of long-term NGO sustainability.

6. FHI/Jakarta, in collaboration with partners such as TFG or the University of Indonesia, should undertake a national probability sample survey of adults to assess the social acceptability of a wide media campaign (including radio and television) to increase awareness about STD/HIV/AIDS. While there has been concern expressed about the acceptability of such a campaign, recent publicity and newspaper advertisements about HIV/AIDS created for World AIDS Day garnered no negative responses. Empirical data should be used to support policy and inform future sensitive and culturally appropriate public information campaigns.

Primary Recommendation for Phase II (April 2000 - 2003)

For Phase II planning and in accordance with the USAID/Indonesia timeframe, between March and November 1999, a second external team should visit Indonesia to assist in an indepth review and refinement of both PHN's and HAPP's strategies, work plans, and indicators. As part of a 3–4 week visit, USAID/Indonesia should consider conducting a 7–10–day facilitated workshop to assist in this exercise. For continuity of understanding, effort, and technical assistance requirements, participants at the workshop would include the external team—ANE, G/HIV–AIDS, and DMELLD technical assistance, and all relevant local HAPP partners—such as MOH, KPAD, and NGOs. It is extremely important that a participatory, bottom-up approach be used to complete Phase II to ensure maximum participation of stakeholders and recipients.

Suggested timing: (1) USAID/Indonesia invites a follow-up visit by a DMELLD–ANE–G/HIV–AIDS team to work with local partners for Phase II planning for a 3–4 week visit by August–September 1999; (2) USAID/Indonesia makes the strategy final by November 1999; and, (3) since April 2000 is PACD for HAPP, but most subgrants only operate until December 1999, FHI/Jakarta should extend subgrants with designated international PVOs/NGOs through April 2000 while noncontinuation international PVO/NGO grants should be allowed to terminate according to current agreements. This timing will ensure ongoing implementation of Phase I activities and a seamless transition to Phase II.

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. The value of the limited HIV/STD data available in Indonesia will be enhanced when data are comparable and analyzed together so that patterns can be detected and outliers identified. 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. Current PATH communication strategies (varied channels for information dissemination such as interpersonal, peer, or skill building) are sound, but strategies do not explain the causal links between exposure to BCC and behavior change. A theoretical framework on which communication and intervention strategies are based needs to be articulated. It is possible that the impact of project interventions are not fully appreciated (especially in the early stages of the projects when sustained endpoint behavior changes, that is, consistent condom use, will have occurred in very few individuals) because the processes that influence and support behavior change are inadequately specified. PATH should use a theoretical framework to specify how and which main and intervening variables will affect behavior change and collect data (with NGO partners) to assess fully the impact of these variables on their interventions.

3. 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.

4. To strengthen local NGO capacity, PATH should provide organizational and management training to improve the skills of outreach workers, especially in approaching indirect sex workers (e.g., bar girls and at-risk youths); improve staff skills in evaluation (i.e., methodology, data management and analysis, and report writing); and, provide feedback to NGOs on their organizational and/or program progress.

Long-term Strategies

1. Set up priorities using mapping. Important areas to map out are STD/HIV/AIDS prevalence, ethnic sexual behaviors, high-risk groups, and gonorrhea susceptibility.

2. Provide funding to support capacity building in new NGOs.

3. The HIV/AIDS epidemic in some places in Irian Jaya is one step ahead of other areas of Indonesia. Hence, it is advisable to expand the STD/HIV/AIDS program to include

home-based care for AIDS patients through NGO outreach activities and community involvement.

4. Provide training and initial supplies to NGOs with medical capacity to provide STD and other opportunistic infection treatments for high-risk groups or develop a referral system with the health facilities. Provide training and supplies for universal precautions.

5. Continue to provide drugs for STD syndromic management, for opportunistic infections and antiviral treatment.

6. Support one laboratory in Jakarta to become a national STD/HIV/AIDS referral laboratory.

7. Focus intervention activities on the most vulnerable groups such as street CSWs, transvestites, pregnant teenagers, and tuberculosis patients.

8. Incorporate STD/HIV/AIDS messages in broader reproductive health issues/programs. (See annexes G and H.)

OTHER DONORS

Within the current Indonesian context, it is important that all population/health-related donors strive for increased donor coordination and communication and coordinated programmatic support to assist in the achievement of the goals and objectives of Indonesia's National HIV/AIDS program. While some of these recommendations are organizationally specific, it is hoped that they will be broadly useful within the donor context.

1. All donors should work cooperatively to achieve the National AIDS programmatic goals and objectives as outlined in the Master Plan. There is a real need to reduce isolationism between donors and their projects.

2. Donors should actively engage their MOH counterparts to make STD/HIV/AIDS projects and activities a priority.

3. Donors should work within the provincial structure. Refinements and capacity building are needed at the KPAD level that can be supported by donors.

4. An integrated approach should be promoted, where appropriate and feasible, to include HIV/AIDS into MCH and FP programs.

5. A complete package of services is needed: surveillance, detection, treatment, counseling and care, universal precautions, reducing stigmatization, and voluntary participation by high-risk communities in studies.

6. Capacity building is needed at the provincial level.

7. A proactive role should be taken with the GOI in terms of policy and implementation and to encourage a continued GOI budget for HIV/AIDS activities.

8. Given the inherent high cost of imported technologies and the low probability of developing new technologies in Indonesia, as well as to assist in long-term funding sustainability, donors should collectively coordinate funding for procurement of respiratory tract infection (RTI), STD, and HIV diagnostic test kits and reagents (at least until the economy demonstrates recovery). They should also lobby manufacturers of test kits to lower their prices for the duration of the economic crisis, as some pharmaceutical companies have done for azidothymidine (AZT).

9. Donors should continue to lobby pharmaceutical manufacturers to provide locally affordable AZT and antiretroviral medications to prevent vertical transmission of HIV.

USAID/WASHINGTON

1. ANE and G/HIV–AIDS will continue to support USAID/Indonesia with technical assistance and programmatic advice on both HIV/AIDS and tuberculosis, as required, since the division is tasked under the G/PHN Strategic Plan in this regard.

2. USAID/Washington, that is, ANE and G/HIV–AIDS, will need to carefully consider USAID/Indonesia's potential requirements for new HIV/AIDS funding, either bilaterally (FHI and CDC) or through central projects such as Health Tech (PATH), given the HIV/AIDS situation and funding requirements of other countries.

3. Explore programming possibilities for USAID/Indonesia assistance in Batam Islands, Riau, given the current geographic code prohibition on such assistance (duty free zone).

ANNEXES

ANNEX A

STATEMENT OF WORK

(provided by USAID/Indonesia)

STATEMENT OF WORK
AN ASSESSMENT OF USAID/INDONESIA'S HIV/AIDS RESULTS PACKAGE

I. BACKGROUND

Indonesia first reported an individual with Acquired Immune Deficiency Syndrome (AIDS) in 1987. Since then, a cumulative total of 622 individuals with Human Immune-deficiency Virus (HIV) and AIDS (468 HIV, 153 AIDS) have been reported from fifteen provinces as of February 1998. The epidemic is evolving slowly. Based on more than 500,000 blood donations tested for HIV over each of the past five years, HIV infection rates have been 0.74, 0.56, 2.03, 3.01, and 1.54 per 100,000. Although these numbers are low, the trend, though fluctuating, is increasing. Based on sero-surveillance among more than 600 Jakarta area male transvestite sex workers, who have been tested for HIV over each of the past four years, the rates of 0.0, 0.16, 0.31, and 1.39 percent, again show an increasing prevalence of infection. The number of new cases of HIV infection/AIDS reported annually in the Jakarta area since 1987 continue to increase and have been 2/1, 2/1, 2/1, 3/4, 2/6, 10/8, 13/10, 20/9, 10/21, and 22/7 respectively for both reported HIV infections and reported AIDS cases.

Indonesia's general population of 130 million adults may be at lower potential risk of HIV than the general population in Thailand and India. However, there is accumulating evidence that the risk may be significantly higher for the 1.8 million persons living in Irian Jaya who are culturally distinct from the rest of the Indonesian population. Reported HIV/AIDS cases in remote Irian Jaya have increased from 0 in 1991 to 155 by February 1998. 56 of these cases are documented as being Thai Fisherman who have likely played a central role in the introduction and spread of HIV in Indonesia. A sero-survey of 1297 high risk adults was carried out in Irian Jaya in January 1997 and showed 10 HIV positives, the highest sub-population prevalence to date, 0.8%.

Since 1993, HIV/AIDS has received growing attention from the Government of Indonesia (GOI) and the international donor community. The GOI established an inter-sectoral 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% 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. Over the last five years, there have been regular quarterly donor coordinating meetings chaired by WHO/UNAIDS. These have some value enabling the network to share information where UNAIDS has facilitated small working meetings. These has been very useful, where the GOI has taken the lead, the coordination has been more significant. Donors have regularly been included in GOI planning and NGO meetings with much evidence of genuine partnerships.

Donors have worked hard together in the design of their activities to minimize duplication and overlap. The best example is the effective team work between USAID's HAPP and AUSAID's HIV/STD Prevention and Care Project. This operates at many levels and means that the two projects benefit from lessons learned and ongoing strategic planning.

II. USAID/INDONESIA'S CURRENT HIV/AIDS RESULT PACKAGE

1. HIV/AIDS PREVENTION PROJECT (HAPP) (1995-2000)

In 1995, USAID/Jakarta assisted the GOI in launching its National AIDS Prevention Program through the five-year bilateral HIV/AIDS Prevention Project (HAPP). HAPP was designed in response to the GOI's request to enhance its capacity to respond to the need for HIV/AIDS prevention policies and programs.

HAPP is a $27 million, five year effort, jointly funded by USAID ($21 million) and the GOI ($7 million). The USAID grant funds are channeled through:

- a FHI/AIDSCAP buy-in delivery order (1995-97) and a FHI performance based contract with USAID/Jakarta (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 STI technical assistance in preventing and managing sexually transmitted infections (STIs);

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

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

HAPP is being implemented in three demonstration areas: North Jakarta, Surabaya and Manado. In these three demonstration areas, HAPP is working with national and local governments, universities, and non-governmental organizations (NGOs).

HAPP is an integrated project comprised of four primary technical components. In the implementation of the project, activities and interventions developed as part of these four components will be combined to interact and support each other. These technical components include: **Policy Support and Dissemination** 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; **Information, education and communication (IEC) for behavior change** to increase public awareness of transmission and prevention of HIV/AIDS and motivate people to reduce high risk behaviors; **Improved Management and Control of HIV and other sexually transmitted infections (STIs)** to improve access to appropriate quality diagnostic and treatment services; and **Expanded Access to and Promotion of Condoms** to prevent the transmission of HIV/STIs for persons at risk through collaboration with the private sector.

The GOI supports and facilitates the implementation of HAPP activities that can be

sustained and replicated in the longer term. HAPP is seen by the GOI as one of the most successful donor initiatives in HIV/AIDS prevention.

2. AIDS Initiatives Project (AIP) (1993-1997, 1997-2000)

Phase I of AIP was a three year cooperative agreement awarded to PATH in 1993 through the Strengthening Institutional Development PVO Co-financing II Project to strengthen the capacity of local NGOs to organize and implement HIV/AIDS prevention activities in seven locations in Indonesia, including Irian Jaya. The target audiences were commercial sex workers (CSWs), young persons at immediate risk, and indigenous NGO staff, STI clinics, medical and para medical staff and young factory workers, especially those living in dormitories. Phase I of AIP implementation was completed in September 1997.

Phase II of AIP focuses solely on extending and strengthening interventions in Irian Jaya with primary target groups (CSWs, adolescents, and fishermen) in Jayapura, Sorong, Waimena and Merauke, and expansion of interventions to additional groups not yet reached in these four primary cities. PATH implements this project using Mission Field Support funds through the HealthTech Project. This project started implementation in December 1997 and is funded through 2000.

Major program elements are outreach and interpersonal interventions for high-risk individuals and groups; responsible sexual decision-making programs for sexually-active youth, including self-esteem and self-control for adolescents, young adults and CSWs; STI service strengthening, and inclusion of a referral system into counseling and STI service delivery.

III. ACHIEVEMENTS TO DATE

1. HAPP

Progress toward achievement of HAPP objectives is good. Of the eight performance indicators used to monitor progress toward achievement, 63% met or exceeded planned targets in 1997.

Three HAPP offices in Jakarta, Surabaya and Manado have been established and staffed. More than 25 local and international NGOs implement various outreach activities targeted to female commercial sex workers, male client groups, and youth at risk.

Advocacy, capacity and policy support were built through provision of study tours to Thailand and Malaysia for Provincial AIDS Commission members, policy makers and religious leaders. These study tours allowed Indonesian leaders to observe and discuss HIV prevention activities that have worked in the region. HAPP has established critically important linkages with the Provincial AIDS Commissions (KPADs) in all three demonstration areas, which has greatly facilitated implementation of activities.

GOI commitment to HIV/AIDS prevention remains high and is evident in the steady increase in national AIDS policies developed, from 1 in 1994 to 8 by 1997. The two new

policies issued in 1997 support 100% condom use in brothel complexes, and provide guidelines on the role and responsibility of Islamic leaders in supporting HIV/AIDS prevention. Both policies represent strong GOI action in politically sensitive areas and important support for HIV/AIDS prevention activities.

Good progress is being made in donor coordination in demonstration areas, particularly in implementing a joint donor model for STI syndromic approach guidelines, and in use and replication of HAPP's behavioral research methodologies for facilitation of nationwide data comparison. HAPP is providing technical assistance and some operating costs in collaboration with other donors.

A variety of capacity building activities for Implementing Agencies (IAs) and local governments have been implemented. NGOs work with peer educators to improve condom negotiation and interpersonal communication skills among CSWs. With technical assistance from CDC/Atlanta, 15 health facilities were upgraded and nine STI training activities completed, enabling doctors, paramedics and laboratory workers to more effectively use national guidelines for the syndromic approach to diagnosis and treatment of STIs. As a result, the percentage of people at high risk correctly diagnosed and treated by STI clinics in demonstration areas is ahead of the planned target.

Condom use by those at risk in demonstration areas increased slightly among CSWs in 1997, but decreased slightly among CSW male clients. This may be due to the fact that there is high mobility of male clients, making it extremely difficult to have contact with prevention activities, such as condom promotion. Knowledge of acceptable ways to prevent HIV transmission among CSWs and non-CSW females increased in 1997, but decreased slightly among high-risk males. It is probable that start-up activities placed insufficient emphasis on male clients of CSWs.

2. AIP

Under the Cooperative Agreement between PATH and USAID/Jakarta, PATH focused activities on empowering local NGOs in planning and managing HIV/AIDS prevention and STI prevention and treatment.

A variety of capacity building activities for NGOs were implemented. Twelve NGOs in Irian Jaya and twelve NGOs in Jakarta, Semarang, Bandung, Bali, Manado, Kupang, Ujung Pandang completed their various outreach activities among high risk groups.

With technical assistance from PATH, several NGOs developed, pretested and distributed various IEC materials (posters, leaflets, stickers, comic books) for each target group (CSWs, youth, male at risk and health providers).

A two-week study tour to Thailand on HIV/AIDS prevention programs was arranged for local NGOs. The purpose of this study tour was to learn from the experiences of Thailand in developing and implementing HIV/AIDS prevention programs.
A National Donor Coordinating meeting in Jakarta was conducted in September 1997 to finalize the overall plan for STI/HIV intervention programs in Irian Jaya, and to discuss the

possible role of donor agencies in supporting the intervention programs. The participants were from the National as well as Provincial AIDS Commissions, Ministry of Health/Jakarta and Irian Jaya, donor agencies, local and international NGOs. Based on these results, PATH developed phase II of AIP in Irian Jaya.

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IV. ECONOMIC CRISIS AND POSTPONEMENT OF THE TRANSITION PLAN

The PHN Transition Plan, approved by USAID/Washington in April 1997, emphasized the development and implementation of sustainable models and systems prior to cessation of USAID-funded SO5/PHN activities in 2000.

However, a devastating economic/political crisis has affected Indonesia since July 1997. After the change of governments in May 1998, this crisis has deepened and spread throughout the country with some 80-100 million people expected to fall below the poverty line. The devaluation of the Indonesian rupiah, inflation, political instability leading to a change in government, and severe droughts are having direct impacts on greatly reduced household income, unemployment, agricultural production failures, and especially on health seeking behavior, and thereby on the progress toward achievement of SO5 "Sustained Improvements in Health and Reduced Fertility". In particular, USAID/PHN anticipates a decrease in utilization of private sector health and family planning services as household incomes fall.

The changes in 1998 have meant that Indonesian government leaders are preoccupied with many pressing issues. This has meant that it is difficult to make such headway with HIV/AIDS issues in general government departments at present. However, donor support is welcomed in helping the GOI to mobilize a more proactive response to the monetary crisis. Many donors are adjusting their programs and the existing network has been very effective. A good example is the procurement of the HIV test kits by HAPP/FHI for the GOI, where there has been extensive collaboration between GOI, WHO, USAID/FHI/CDC-Atlanta, and others.

Therefore, USAID/W and USAID/Jakarta have re-visited 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. A SO 5/PHN strategy revision, currently scheduled for October 15-30, 1998, will assess the scope, magnitude and duration for continued USAID assistance in the PHN sector and revise the SO 5 results framework accordingly.

USAID/HAPP'S RESPONSE TO THE ECONOMIC CRISIS

Without changing the objective of HAPP, but to prevent accelerated transmission of HIV/STIs as an impact of the economic crisis in Indonesia, some HAPP activities are refocusing to better respond to the crisis. The following are three examples:

1. Procurement of additional medical supplies needed for STI/HIV/AIDS prevention efforts during the crisis period, including but not limited to ELISA tests, disposable syringes and surgical gloves. This is to address growing concern about shortage of medical supplies and equipment necessary to support HIV/AIDS/STI prevention and control activities.

2. Increased support for social marketing of locally manufactured condom brands. This is needed in an effort to keep the private sector market for condoms from collapsing during the economic crisis. At present, successful commercial companies are competing for the upper-end of the market and allowing a subsidized product to dominate the low end. If this continues, several inexpensive, locally manufactured condoms may disappear altogether, leaving much of the consumer market largely dependent on government supported or donor subsidized condoms. Increased USAID support for social marketing of local condom brands will encourage commercial market development and avoid over-reliance on subsidized and free commodities, neither of which is sustainable over time.

3. Conducting monitoring surveys to accelerate the data collection and analysis, so that the impact of the economic crisis on STI/HIV transmission associated with the sex industry can be assessed and used for planning and modifying interventions in three demonstration areas. The Behavior Surveillance Survey includes additional specific questions to assess the impact of the economic crisis on any changes in the turnover, overall number and mobility of sex workers, in the average number of customers reported by each sex worker per day, and proportion of sex acts protected by condoms. The STI prevalence among female CSWs survey by JEN includes additional questions to assess the impact of economic crisis on the STI transmission associated with the sex industry.

V. STATEMENT OF WORK:

A. Purpose of this assessment:

1. Assess the current HIV/AIDS situation in Indonesia from a epidemiological, demographic, and geographic perspective to best determine USAID/Jakarta's comparative advantage and kinds and levels of assistance. This will be accomplished through the review of key documents; meetings with GOI, donor, and NGO officials; and selected field visits

2. To review the current funding situation, including GOI and donor support to the HIV/AIDS sector.

3. To assess and highlight accomplishments under HAPP and AIP/II. This will complement FHI'S internal assessment of HAPP conducted in July 27 to August 7,

1998.

4. To assess appropriateness of HAPP and AIP/II program interventions;

5. To assess contractor management under HAPP and AIP/II;

6. To make recommendations for redirecting or better directing HAPP and AIP/II remaining resources and/or geographic focus through 2000;

7. To provide recommendations for continued support to STI/HIV/AIDS activities for consideration during the Mission's PHN Strategy revision currently scheduled for o/a October 15-30, 1998.

B. The Assessment Team will undertake the following tasks:

1. Assess the general HIV/AIDS situation in Indonesia, what has been achieved to date under HAPP and AIP/II, and the degree of progress based on the Strategic Objective Agreement, results framework indicators and the project implementation workplans; specifically the:

   - adequacy of progress against indicators,
   - appropriateness of indicators, data collection and progress monitoring,

2. Assess whether the current strategy includes activities and interventions that are best suited to meeting the current epidemiological, demographic, geographic, and behavioral pattern of HIV/AIDS spread in light of:

   - progress to date against indicators/targets;
   - the present state of the HIV/AIDS epidemic in Indonesia;
   - the current economic crisis;
   - other donor-assisted activities;
   - prospects for sustainable impacts;
   - USAID/Jakarta's comparative advantage in the sector.

3. A management review of contractor/CA management practices to look at and consider:

   - the appropriateness of various management mechanisms for carrying out HIV/AIDS results package activities (i.e., AIDSCAP buy-in, biateral **performance-based contract**, PASA, global field support mechanisms, etc),

- the roles, responsibilities and authorities of the Ministry of Health, FHI, PATH and USAID/Jakarta,

- the extent to which authority is delegated within the contractor's (FHI's and PATH's): Jakarta office and to the field offices,

- effectiveness of communication and cooperation/coordination among contractors, project staff, MOH, USAID, other donors, provincial and national AIDS commissions, NGOs, etc.,

- the "value added" in having a HIV/AIDS bilateral project in addition to central programs.

4. Assess the need to redirect or better direct remaining resources under HAPP and AIP/II with particular focus on:

   - sufficiency of focus and funding on mass media and male clients,

   - the appropriateness of the existing balance of expatriate and local technical advisors,

   - technical adjustments needed in the HIV/AIDS portfolio given the current economic crisis in Indonesia.

5. Recommendations concerning the direction and magnitude which USAID assistance might take beyond 2000 for consideration during the Mission's upcoming PHN Strategy Revision particularly considering:

   - the seriousness of the HIV/AIDS epidemic as reported in Jakarta 006576, November 7,1997,

   - the need or desirability of integrating STI/HIV/AIDS services into a bilateral Integrated Reproductive Health activity versus continued support for a vertical HIV/AIDS activity,

   - appropriate resource levels, geographic coverage, interventions, management mechanisms, and

   - GOI and USAID priority for allocating additional resources to STI/HIV/AIDS prevention activities.

C. CONSULTANT REQUIREMENTS AND LEVEL OF EFFORT:

The Assessment Team consists of three expatriates and two Indonesians. All five members are required for up to 30 work days of effort starting January 30, 1999. Team member roles and names are as follows:

- One senior USDH from G/PHN/HIV, preferably with previous Indonesia experience and facility with Bahasa Indonesia. Mission requests that this person's expenses be covered by G/PHN. [David L. Piet, G/PHN/HN/HIV-AIDS]

- One senior USDH/fellow from ANE, preferably with HIV/AIDS prevention program experience. Mission requests that her/his expenses be covered by ANE. This "fellow" will also serve as the Information, Education and Communication (IEC) for behavior change expert in STI/HIV/AIDS programs. Previous experience in Indonesia and facility with Bahasa Indonesia desirable. [Dr. Kai Spratt, ANE]

- One Indonesian consultant with expertise in STI/epidemiology, preferably with previous Indonesia experience and/or facility with Bahasa Indonesia. [Dr. Firman Lubis, YKB, Jakarta, Indonesia]

- One Asian consultant with expertise in condom social marketing, preferably in Indonesia or Asia countries. [Mr. Waliur Rahman, Social Marketing Company, Dhaka, Bangladesh]

- One Indonesian consultant who is familiar with Indonesia's HIV/AIDS prevention program strategy or has expertise in IEC or epidemiology/STI control. [Dr. Nuning Masjkuri, University of Indonesia, Jakarta, Indonesia]

The Team will be assisted also by one or two MOH staff who are familiar with STI/HIV/AIDS prevention program activities in Indonesia, and one expatriate consultant with expertise in STI/HIV/AIDS from CDC/Atlanta. The contractor will not provide salaries/incentives for the MOH staff, however their per-diem and in-country airfares/local transportation will be covered by the contractor. The CDC/Atlanta consultant's expenses will be covered under the Mission's CDC/PASA budget.

Mission will cost-share G/PHN/HIV's and ANE's per-diem and in-country airfares/local transport during the assessment in Indonesia.

D. REPORTS AND PROCEDURES:

Work on the above tasks can begin as soon as qualified individuals are identified and fielded by the contractor. Mission requests that G/PHN/HIV-AIDS/USAID Washington will take on this role and work with the Mission on putting together the team. G/PHN/HIV-AIDS/USAID Washington will then work with the contractor on the administrative/logistics issues. After that the contractor will provide resumes for the consultant candidates as soon as possible for review and approval by the Ministry of Health and USAID Mission.

The contractor will provide all logistical support for the consultants while they are in country including funds for translating appropriate documents, in-country travel, typing and photocopying services. Consultants will be required to submit a draft of their report and brief Ministry of Health (MOH) and USAID officials on evaluation findings and recommendations, before leaving the country. The final report should include a three-five page Executive Summary which summarizes the most important findings and recommendations. The final report should be submitted by the contractor within 30 days after the Team departs Indonesia. No reports should be finalized or distributed in Indonesia or the U.S. prior to obtaining the written approval of the MOH and USAID.

E. KEY PEOPLE TO CONTACT:

1. USAID/PHN staff
2. HAPP staff in Jakarta, Surabaya and Manado, including all advisors
3. Ministry of Health (MOH): CDC&EH, Center for Health Education, Center for Communicable Disease research
4. National AIDS Commission
5. Provincial AIDS Commission for Jakarta, Surabaya and Manado, and Irian Jaya
6. PATH, PCI, PACT, The Futures Group
7. Other donors: UNAIDS, WHO, AusAID, World Bank, etc.

F. DOCUMENTS FOR REVIEW:

NOTE: Since the documents are essentially in chronological order and are grouped into three categories from the general to the specific, team members should: (1) read the documents in the order presented below; i.e., from the general HIV/AIDS situation to specific documents on various organizations and projects; (2) that team members, based on role within the team, focus on their area of expertise; i.e., STD/epidemiologists review more fully those sections of the key documents related to your area, or for social marketing review those areas most germane to that area of expertise; etc.

A. <u>National level</u>:

Key documents, strategic plans, other donor and GOI materials/data that would assist the team assess the current HIV/AIDS situation in Indonesia from a epidemiological, demographic, and geographic perspective:

1. "Indonesian National AIDS Strategy [Translation of the official strategy], dated June 16, 1994
2. John Moran's tables on "Sexual Behaviors.... [by category]", dated October 1998
3. HAPP PowerPoint presentation "The Evolution of the HIV Epidemic in Indonesia," dated September 1998

B. USAID/Indonesia and Other Donor Documents:

1. Cable Jakarta 006576, November 7, 1997
2. "Strategic Objective Grant Agreement,", dated August 26, 1997
3. "Strategic Objective Grant Agreement, Amendment No. 1," dated August 19, 1998
4. "Results Review and Resource Request" (R4), dated April 1998
5. USAID/Indonesia "Crisis and Recovery: Strategy for Indonesia 9FY 1999 - FY 2003," dated November 2, 1998.

C. Family Health International [FHI/HAPP] and Program for Appropriate Technology in Health [PATH] Documents:

1. PATH "Rapid Ethnography Assessment: Strategic Planning for AIDS Prevention in Five Indonesian Cities: Phase I in Five Cities in Indonesia", dated September 1995
2. PATH "Rapid Assessment of HIV Transmission Risk in North Jakarta and Surabaya for the HIV/AIDS Prevention Project [HAPP]," dated December 1996
3. FHI Contract for HAPP
4. Sub-agreement with implementing agencies
5. HAPP Management Plan dated October 15, 1997
6. HAPP Evaluation Framework dated 27 March 1998
7. FHI's "Terms of Reference for FHI Internal Review of HAPP"
8. "FHI Internal Review of HAPP," dated August 31, 1998
9. HAPP/FHI "Third Quarterly Report [Period April 1 - June 30, 1998]," dated July 1998
10. HAPP "Discussion Guide ... [by various categories]", Wilson-Spaid cover letter dated July 24, 1998
11. HAPP "Annual Work Plan and Contract Performance Monitoring Plan--September 1997-December 1998"
12. PATH Cooperative Agreements for AIP (phase I and II)
13. PATH/AIP quarterly and Phase I Final Reports
14. The Futures Group [FHI] sub-contract on Condom Social Marketing

D. Other Important Documents:

USAID/Washington "Integration of Family Planning/MCH with HIV/STD Prevention, Programmatic Technical Guidance" dated December 23, 1998 [copy transmitted to all Missions via email attachment]

Many other documents were reviewed in-country

G. TENTATIVE SCHEDULE

First Week - Jakarta

- Meeting with USAID/PHN
- Meeting with FHI/HAPP staff, including CDC/PASA STD advisor
- Meeting with MOH related staff
- Meeting with TFG, PCI and PACT staff
- Meeting with National AIDS Commission
- Meeting with HAPP implementing agencies (NGOs), including JEN and University of Indonesia (Puska-UI) staff
- Meeting with other donor agencies on HIV/AIDS programs

Second Week

- Field visits to Surabaya, Manado/Bitung and Irian Jaya to meet with HAPP and AIP provincial staff, and local NGOs; team will likely split into two or three groups to adequately cover field sites.

Third Week

- Continuation of field visits as necessary
- Mid-point briefing/discussion with USAID/PHN staff
- Continuation of unfinished meetings from week one
- Begin report writing

Fourth Week

- Discussions with USAID/PHN and other related counterparts
- Report writing
- Preliminary presentation of findings and recommendations to USAID/PHN
- Presentation of findings and recommendations to MOH, FHI/HAPP, PATH and USAID representative
- Submission of draft report and de-brief with USAID/PHN

ANNEX B

DISCUSSION GUIDES

FOR PROVINCIAL KPAD AND DINAS KESEHATAN

1. Describe the role of KPAD or Dinas Kesehatan activities with HIV/AIDS activities.
2. How do you see the epidemic developing in your province? Has the krismon had any effect on the HIV/AIDS situation or epidemic?
3. What kind of data would be useful to you to assist you in your duties?
4. Describe your interaction with the HAPP project. [Probe]
5. How does the HAPP project fit in with your activities?
6. What kind of effect, if any, has the HAPP project had on your regular duties/workload?
7. Do you get any technical assistance or support from HAPP?
   —If so, what kind?
   —If not, are there areas of technical assistance or support you would like?
   —What is working well?
   —What is not working so well?
   —Suggestions for improvement
   —Have you experienced any delays/difficulties in receiving funds? Materials?
8. Coordination/communication:
   —with HAPP?
   —with NGOs?
9. Did HAPP/Jakarta do a needs assessment with this office of your needs and capabilities, e.g., training, study tours? Has your training been sufficient to do your work? If not, do you have any suggestions?
10. In your opinion, is the HAPP work specific to local needs? If so, how? If not, why not? [Suggestions for change]
11. How many other organizations in your area, that you know of, are doing HIV/AIDS education and prevention work? Do you coordinate any of your activities with these organizations?
12. What are your greatest challenges? Locally? Other?

FOR HAPP PROVINCIAL STAFF

1. Describe what you do for HAPP. [Probe]
2. How do you work with HAPP–supported NGOs? [Probe]
3. How well do you feel you get technical/administrative/financial support from HAPP/Jakarta?
   —What works well?
   —What is not working so well?
   —Suggestions for improvement?
   —Have you experienced any delays/difficulties in receiving funds? Materials?
4. Coordination/communication:
   —with HAPP/Jakarta?
   —with KPAD and Dinas Kesehatan?
   —with NGOs?
5. Did HAPP/Jakarta do a needs assessment with this office of your needs and capabilities, e.g., training? Has your training been sufficient to do your work? If not, do you have any suggestions?

6. In your opinion, is the HAPP work specific to local needs? If so, how? If not, why not? [Suggestions for change]
7. How many other organizations in your area, that you know of, are doing HIV/AIDS education and prevention work? Do you coordinate any of your activities with these organizations?
8. What are your greatest challenges? Locally? Other?

FOR LOCAL NGOs

1. Describe what your NGO does [activities]. [Probe]
2. How did you get involved with HAPP?
3. From your description of your activities, which of these activities do you do with/for the HAPP project? [Probe]
4. How well do you feel you get technical/administrative/financial support from HAPP?
   —What works well?
   —What is not working so well?
   —Suggestions for improvement?
   —Tell us about your reporting requirements to HAPP.
   —Have you experienced any delays/difficulties in receiving funds? Materials?
5. Coordination/communication:
   —with HAPP?
   —with KPAD and Dinas Kesehatan?
   —with other NGOs?
6. Did HAPP/Jakarta or HAPP/Province do a needs assessment with this NGO of your needs and capabilities, e.g., training? If training was provided:
   —Did you like the training?
   —Was the training participatory?
   —How has the training improved your skills/knowledge? If not, provide suggestions.
7. In your opinion, is the HAPP work specific to local needs? If so, how? If not, why not? [Suggestions for change]
8. How many other organizations in your area, that you know of, are doing HIV/AIDS education and prevention work? Do you coordinate any of your activities with these organizations?
9. What are your greatest challenges? Locally? Other?

FOR HAPP BENEFICIARIES

1. How long have you been living/working/coming to this area?
2. Have you ever heard about HIV/AIDS or STDs? How long ago did you get this information? [Probe: within the last month? Within the last 3–6 months? IF NO: Would you like to get some information on HIV/AIDS/STDs?
3. How did you hear about HIV/AIDS/STDs (e.g., TV, radio, outreach worker, peer counselor, poster, sticker, comic book, coworker, friend, family)? IF HAPP IS NOT MENTIONED: Have you ever heard of HAPP? IF YES: How did you hear about HAPP?
4. What did you learn about HIV/AIDS/STDs?

5. What did you like about the information you got?
6. Was there anything about the information you got that you didn't like or thought should be different?
7. What have you done to protect yourself from HIV/AIDS/STDs since getting information about it? IF NO CHANGE YET: Are you thinking about changing any of your behaviors in the future? IF YES: What do you think you will change?
8. What other kinds of activities would you like to have to get more information about HIV/AIDS/STDs?
9. Have you ever talked to any of your friends or coworkers about the HIV/AIDS/STDs information that you got?

ANNEX C

SCHEDULE FOR HIV/AIDS EXTERNAL ASSESSMENT TEAM

(prepared by Yayasan Kusuma Buana, support contractor in Indonesia)

Schedule for HIV/AIDS External Assessment Team: February 8 - 27, 1999

Date:	Time:	Place:	To meet with - Purpose:	Remarks:
Feb.8 Mon.	08:30-10:00	Borobudur Hotel	Internal team discussion within Team Members	
	10:30 - 14:30	USAID/PHN, American Embassy, Jakarta; Tel:3442211 X2407	Meeting with Ratna Kurniawati & S. Hadianto: - To introduce the team members; - To discuss schedule and overview of statement of work; - Other related issues (in-house briefing)	
	15:00 - 16:00	USAID/DIR	Courtesy to Mr. Terry Myers, USAID Mission Director. Accompany by: Ratna Kurniawati and Sebastian Hadianto.	
Feb.9 Tues.	Picked up at 08.00 09:00 - 10:30	CDC&EH, MOH Jl.Percetakan Negara #29, Jkt Tel:4209930	Meeting with Dr. Achmad Suyudi, Director General CDC&EH, MOH, including Prof. Dr. Umar Fahmi, Head of LitBangKes and Health Education Staff (PKM). Accompany by Dr.Indriyono, Dr.Arwati, Ms. Jane Wilson, Dr. Runizar, Sebastian and Ratna .	Arrange by HAPP
	10:30 - 11:30	MOH, DirGen.Mtg Rm. Jl.Percetakan Negara #29, Jakarta	Meeting with KfW (Germany donor agency) and IBRD (World Bank). Accompanied by Sebastian and Ratna	Arranged by Maria, HAPP
	11:30 - 16:00	HAPP Office; Jl.Percetakan Negara #29,Jkt Tel:4223463, 4223464, 4223465	Meeting with FHI/HAPP Staffs: Ms. Jane Wilson, and HAPP Advisors, including Dr. John Moran, CDC STD Advisor. Accompanied by Sebastian and Ratna	Arranged by Maria, HAPP
Feb.10 Wed.	Picked up at 07.45 08:30 - 11:30	Graphic Mc Can Erricsson Building, Mampang Prapatan	Meeting with Asia Reg. Manager Mr. Anton Schneider: - To discuss HAPP's Condom Social Marketing activities.	Confirmed with Suli, TFG 2/1
	12:00 - 16:30	PATH Office: Tifa Bldg, 11th Flr., Suite 1102 Tel:5200737, 5200065	Meeting with Country Repr. Mr. Don Douglas: - To discuss AIDS Initiative project in Irian Jaya	Confirmed with Ika, PATH 2/1

Date:	Time:	Place:	To meet with - Purpose:	Remarks:
Feb.11 Thurs.	Picked up at 08:30 09:00 – 12:30	Acasia Hotel, Kramat Raya	Meeting with PVOs: PATH, PACT, PCI, DKT - To discuss HAPP activities.	Arranged by HAPP, Maria
	13:30-16:30 pm	DKT Office in Pasar Minggu and YKB Office	Mr.Walliur Rachman will visit DKT Office while the rest of the team will work in YKB Office	Arranged by HAPP, Maria
Feb.12 Fri.	Picked up at 08:15 09:00 – 12:00	DKI-Jakarta Provincial AIDS Commission (KPAD) Jl. Kesehatan Jakarta	Meeting with DKI-Jakarta AIDS Provincial Commission (KPAD): - To discuss KPAD's AIDS Programs and other related STD/HIV/AIDS issues	Arrange by HAPP, Maria
	13:30-16:00 pm	Klinik Keluarga Yayasan Kusuma Buana (YKB): Jl. Edam II No. 36 Tamjung Priok, Jakarta Utara Tel: 493-102	Meeting with HAPP IAs (NGOs): To discuss NGOs activities funded under HAPP - Yayasan Kusuma Buana (YKB);	Arrange by HAPP, Maria
	17:00 – 19:00	Kramat Tunggak area	Site visit to Kramat Tunggak prostitution area	Arranged by YKB
Feb.13 Sat.			Individual work	
Feb.15 Mon.	Picked up at 09:15 10:00 - 13:00	Menko Kesra. Office Jl.Merdeka Barat #3 Jkt, Tel:351-1854	Participation in Quarterly Donor Meeting, chaired by Mr. Haryono Suyono. Accompanied by Sebastian and Ratna	
	13:30 - 16:00	YIK Office: Jl. Tanjung Lengkong #4, Jakarta Timur Tel: 856-7022	Meeting with HAPP IAs (NGOs): - Yayasan Investasi Kemanusiaan (YIK) Proj. Director Mr. Paulus Madur Proj. Manager Mr. Jacob Kedang.	Arrange by HAPP, Maria
GROUP A: TO SURABAYA			Suggested Participants: - Mr. Waliur Rahman - Mr. David Piet - Ms. Ratna Kurniawati, USAID/Jkt Accompanied by Dr. Arwati (covered by PIL)	

Date:	Time:	Place:	To meet with - Purpose:	Remarks:
Feb. 16	08.30 – 09.45	Kanwil Depkes office	Meeting with Kanwil Depkes (HAPP GOI/PILL); Dinkes Dati I (PPM and PA KPAD)	
	10.00 – 11.00	HAPP Prov. Office	Meeting with HAPP/FHI; PPM, DPPM, AFA	
	11.30 – 13.30	KPAD/Governor Office	Meeting with KPAD Chairman, Core Team, Program Advisor	
	13.30 – 14.30	Lunch		
	15.00 – 17.00	YAA Office	Meeting with YAA, discussion with CSW clients	
	20.00 – 22.00	Dolly/Putat Jaya brothel Complex	Field visit to Dolly/ Putat Jaya brothel Complex	
Feb. 17	08.30 – 10.30	Balai Labkes Office	Meeting with Balai Laboratorium Kesehatan (Labkes)	
	10.30 – 12.30	Putata Jaya Clinic	Meeting with STD Clinic Putat Jaya; clinic visit; puskesmas, Kanwil Depkes/DKK staffs	
	12.30 – 13.30	Lunch		
	13.30 – 16.00	STD Clinic & Counselling Room	Meeting with PKBI and field visit	
	19.30 – 21.00	Mirah Harbour, Tanjung Perak	Field visit with Y. Prospective Staff: street CSW & street transvestite	
Feb. 18	08.30 – 10.30	Y Pros Office, Y. Pros Clinic, Harbour area	Meeting with Y. Prospective Staff and field visit	
	11.00 – 13.00	HAPP Office	Meeting with HAPP Sby Staff; PPM, DPPM, AFA, Dr. Arwati, and Dr. Ratna	
	13.00 – 14.00	Lunch		
	14.00 – 16.00	HAPP Office	Meeting with “RRF” NGOs; Dr. Arwati, Dr. Ratna, PPM, DPPM	
	20.00 – 21.00	Dolly/Putat Jaya brothel complex	Field visit to Dolly/Putat Jaya brothel complex with YAA staff	

Date:	Time:	Place:	To meet with - Purpose:	Remarks:
GROUP B: TO MANADO			Suggested Participants: - Ms. Kai Spratt - Dr. Firman Lubis Accompanied by Dr. Daryono (covered by PIL), and Sebastianus Hadianto (covered by USAID/Jkt)	
Feb 16	14.30 – 16.30	HAPP office	Presentation: HAP Project (HAPP, PIL, KPAD): Bpk. Lapadengan, Dr. Slamet Sunarno Hardjosuwarno, and Dr. Jopie Manoy Activities in Manado: * Meet with HAPP Provincial and staff; KPAD, Health Provincial Office	Arrange by HAPP office, Maria
Feb 17	08.00 – 09.00	Labkes DT I Sulawesi Utara	Visit Laboratorium Kesehatan Daerah Tk. I Sulut with Dr. Demas Waas	
	09.15 – 10.15		Meeting with Vice Governor (Audiency)	
	10.45 – 11.45	YBHK Clinic	Visit YBHK Clinic with Dr. Nina Runtupalit	
	12.00 – 13.00		Lunch	
	13.30 – 16.00	Maumbi	Field Visit YMM Camping Activity with Ir. Johny Nanna	
Feb. 18	10.30 – 13.00	Bitung Harbor	Visit YBHK field activities–collecting sample among sailors on the boat (Dr. Nina Runtupalit)	
	13.00 – 14.00	Lunch		
	14.30 – 15.30		Visit to YPeka field activities: PT Sinar Pure food " Pendampingan" Program to Factory Workers (Th. Adiloekito, SH)	
	16.00 – 18.00		Visit to Drop in Centre–Attend CSW Meeting (Th. Adiloekito, SH)	
Feb 19	08.00 – 09.30		Wrap-up Meeting with Vice Governor	
	10.00 – 11.30		Meeting with prospective RRF NGO (Theo Lumenon, SH [ZPG])	

Date:	Time:	Place:	To meet with - Purpose:	Remarks:
GROUP C: TO JAYAPURA			Suggested Participants: - Dr. Nuning Masjkuri, Dr. Endang Sedyaningsih Accompanied by Dr. John Moran and Dr.Anton Wijaya	Travel & accommodation arrange by Sani, PATH
Feb. 18	13.30	Kanwil Office	Meeting with Kakanwil DepKes and Prov. Team	
	14.30 – 17.00	PATH-Irja Office	Presentation of PATH Irja	
	17.30 – 18.30	Bethesda Office	Meeting with Bethesda	
	18.30 – 21.00	Mandala Restaurant	Dinner with Kanwil DepKes (Dr. Gunawan, Dr. Budi, Dr Tigor, Dr. Krisman, Pejabat Kakanwil, PKBI, Yasmad, Bethesda	
Feb. 19	07.30 – 08.30		Depart Jayapura, arrive Merauke	
	10.00 – 11.00	District Health office, Comp. RS Kusta	Meeting with Kakandep, KaDinkes, RS Kusta and Yasanto	
	12.00 – 13.00	Lunch		
	13.30 – 15.30	Yasanto Office	Yasanto presentation on AIP program	
	17.00 – 19.00	Sasate, Dep Tran, Belrusuk	Field visit (PSKJ) Yasanto Project	
	19.00 – 21.00		Dinner with Kakandep, KaDinkes, KRSU and Yasanto	
Feb. 20	08.30 – 10.30	RSU Merauke	Visit to KRSU Merauke	
	11.00 – 12.00	Yasanto Office	Discuss the field result with Yasanto	
	12.30 – 13.30	Lunch		
	16.00 – 19.00	Belrusak, Bilyard Primadona	Field visit to male at risk, Yasanto Project	
Feb 21	10.00 – 11.30		Depart Merauke, arrive Jayapura	
	12.00	Lunch at Yoga Resto	Visit Mc Arthur Monumen	
	16.30 – 19.00		Visit Base G. Beach and Hamadi souvenir shop	

Date:	Time:	Place:	To meet with - Purpose:	Remarks:
	21.00 – 23.00	Atlanta and Kharisma	Visit 2 Bars, Yasanto project	
Feb.22	09.00 – 09.30		Visit Laboratory BLK, Jayapura	
	10.00 – 12.00	Double six Bar	Yasmad presentation	
	12.30 – 13.30	Lunch		
	14.00 – 17.00	Sentani The Turki Brothel	Visit Tanjung Elmo Drop-in center PKBI Project Presentation SLTP, SLTA Abepura	
	21.00 – 23.00	Romantika, Ramon	Visit two bars, Yasmad Project	
Feb.22 Mon.	picked up at 08:30 09:00 - 12:00	IAKMI Jl. RS Paru, Ancol Selatan,Jkt Tel: 3145583	Visit IAKMI: To discuss NGOs activities funded under HAPP	Arrange by HAPP office, Maria
	13:00 – 16:00	JEN Office: c/o MOH Negara Tel: 4266063	Meeting with Jaringan Epidemiology Nasional (JEN) + Behavioral Surveillance Survey (BSS-UI) staffs	JEN (Dini)
Feb.23 Tues.	Picked up at 08:00 08:30 – 09:30	UNAIDS Office at UN Building, Jl.Thamrin	Meeting with Dr.George Loth to discuss HIV/AIDS programs in Indonesia	
	10:30 – 12:30	Acasia Hotel	Meeting with US-AID Cas (PopCon, AVSC, PCS, and others)	
	14:00 – 16:00	USAID	Briefing from PHN Director, Leslie Curtin for: - PHN Strategy and Program Planning, Other related issues Accompany by Ratna Kurniawati and S. Hadianto.	
Feb.24 Wed.	Picked up at 08:30 09.00 – 11.00	Minister Meeting Room MOH Jl.Rasuna Said Kav. 3-5, Kuningan Jakarta	Meeting with the Minister of Health (Dr.Farid Moeloek) and National AIDS Commission	Arranged by HAPP, Maria
	12:00 – 16.00	YKB Office/Borobudur Hotel	Team work	

Date:	Time:	Place:	To meet with - Purpose:	Remarks:
Feb. 25 Thurs.	Picked up at 07:30 08:00 - 10:00	USAID	Discussion with Ratna & S. Hadianto: - Incorporate USAID/PHN	
	10:30 - 12:30	Borobudur Hotel	Meeting with HAPP (debriefing)	
	13:00 - 14:00	USAID	Presentation of findings and recommendations to USAID/PHN	
	14:30 - 17:30	Borobudur Hotel	Team work	
Feb. 26 Fri.	Picked up at 08:15 09:00 – 11:30	MOH Office Gedung B Percetakan Negara 29, Jakarta	Presentation of findings and recommendations to MOH, USAID, FHI, HAPP, PATH.	
	14:00 - 16:00	USAID	Submission of draft report & de-brief USAID/PHN staffs.	
	16:30 - 17:30	Borobudur Hotel	Farewell party (Team, US-AID, HAPP, and related NGOs)	
Feb. 27 Sat.			Team leaving Jakarta/Indonesia	

ANNEX D

PERSONS CONTACTED

(provided by Yayasan Kusuma Buana, support contractor in Indonesia)

NO	CONTACT PERSON	ORGANIZATION	ADDRESS
		JAKARTA	
1.	Terry Myers Leslie Curtin Ratna Kurniawati Sebastian Hadiyanto	USAID/PHN	American Embassy, Jakarta Tel : (021) 3442211 Fax : (021) 380 6694
2.	Jane Wilson Dr. John Moran Dian Rosdian	HAPP	Jl. Percetakan Negara No. 29 Jakarta Tel : (21) 422-3463, 4223464, 4223465 Fax : (21) 422-3455 Email: dianr@fhi.or.id
3.	Don Douglas Dr. A. Anton Julie Marsaban Yanti Triwan	PATH	Tifa Building , 11 th floor Suite 1102 Jl. Kuningan Barat No 26 Jakarta 12710 Tel : (21)520-0737, 520-0065 Fax : 520-0621 Email: don@pathjkt.or.id
4.	Russell Vogel Dr. Bimo	JHPIEGO	Tel : (21) 315-3788 Fax : (21) 310-6723 Email: jhpindo@indosatnet.id
5.	Fitri Putjuk	JHU/PCS	Tifa Building Suite 502 Jl. Kuningan Barat No 26 Jakarta 12710 Tel : (21) 525-2174, 525-2183 Fax : (21) 525- 1548 Email:
6.	Heather Bull Dr. Endang L. Achadi	Mother Care	Gedung Petrosia Jl. Taman Kemang 32 B Jakarta 12730 Tel : (21) 797-5081, 797-5031 Fax : (21) 717-92182 Email: meindo@indo net.id
7.	Dr. Does Sampurna Sumengen Sutomo Lynnette Johnson	PATHFINDER	Permata Plaza , 10 th Floor Jl. MH Thamrin57 Jakarta 10350 Tel : (21) 390-3304, 390-3302 Fax : (21) 390-3302 E-mail : information@pathfind.org
8.	Debra Hull Ch. Shinta Widimulyani Imam Mulyadi	PACT	Jl. Tebet Barat I no. 8 Jakarta Selatan 12810 Tel : (21) 829-3156 Fax : (21) 829-0482 E-mail: pactaids @ rad.net.id
9.	Carol Carp Alex H. Sumarauw	PCI	Jl. Ciasem I No. 32 Kebayoran Baru Jakarta 12180 Tel : (21) 739-4267,7229731 Fax : (21) 722-9731 Email: pcijkt@rad.net..id

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11.	Dr. Meiwita Iskandar	Pop. Council	Mega Kuningan Barat Kav. EY.3 No.1 Jakarta, 12950, Indonesia Tel ; (21)576-1011/12 Fax : (21)576-1013 Email**:** **pc-jkt@rad.net.id** http://www.popcouncil.org
12.	Dr. Trish McDonad Patrice White	PRIME	Jl. Kramat sentiong 49. Jakarta Tel : (21) 230-5236 Fax: (21)390 1883 Email: **eoctrain@indosat.net.id**
13.	Anton Schneider	TFG	Tifa Building 2nd floor Jl. Kuningan Barat No 26 Jakarta 12710 Tel : (21) 520-0596 Fax : (21) 522-1324 Email : **antonsch@dnet.net id**
14.	Ratna Kurniawati	USAID	American Embassy, Jakarta Tel : (21) 344-2211 Fax : (21) 380-6694 Email:
15.	Craig Darden Christine Claypoole	DKT Indonesia	Graha Sucofindo lt 12 Jl. Raya Pasar Minggu Kav. 34 Jakarta 12780 Tel : (21) 798-6569/71 Fax : (21) 798-6570 Email: **dktindo@rad net.id**
16.	Leny E. Tanod	IPM Public Relations	Komplek Golen Plaza (Golden truly) Blok G/10. Jl. Fatmaati No, 15 Jakarta 12420 Tel ;(21) 765- 8451 HP. : 0816-909622 Fax ; (21) 765-9281,765-7963 Email : **ipmprc@indosat.net.id**
17.	Robby Susatyo	AMI (Asia market Intelligence) Indonesia	Plaza Chase Podium 6th Floor Jl Jendral Sudirman Kav.21 Jakarta 12920 Indonesia Tel : 521-3420 Fax : 521-3424 Email **: ami indonesia@ami-group.com** Website **http://www.ami.group.com**

NO	CONTACT PERSON	ORGANIZATION	ADDRESS
18.	Rocky Menayang Venessa Williams	Grafik McCann-Ericson (PT. Tiara Alam Grafika)	Graha Mobisel Lt. 3 Jl. Mampang Prapatan Raya No. 139, Jakarta 12740 Indonesia PO BOX 3022, Jakarta 10030 Tel ; 790-2405 Fax : 798-2816 Email : **grafmce@rad net.id**
19.	Rita Kusriastuti, MSc.	KPAD/ Unit Pelaksana Proyek P2M HIV/AIDS & PMS Dinkes DKI-Jakarta	Jl. Kesehatan No. 10 Gedung B, lantai 1V Jakarta Pusat Tel/Fax: 350-9455, 3518102 Email : **ritakus@dnet net.id**
20.	Iwan J. Sabirin,	KPAD	Jl. Ahmad yani Kav. 64 By Pass Cempaka Putih, Jakarta Pusat 10510 Tel : 424-6470, 421-6805
21.	Dr. Firman Lubis Dr. Joedo Prihartono	Yayasan Kusuma Buana (YKB) Jakarta	Jl. Asem Baris Raya B/III Tebet Jakarta selatan Tel : 829-6337 Tel/Fax : 831 4764 Email : **ykb-jkt@idola net.id**
22.	Joko Suharno Lenny	Menko Kesra /KPA Pusat	Jl. Merdeka barat #3 Jakarta Pusat10110 Tel : 351-1854, 350-5561, 376-215 Fax : 345-3055
23.	Paulus Madur Jacob Kedang	Yayasan Investasi Kemanusiaan (YIK)	Jl. Tanjung Lengkong # 4, Jakarta Timur Tel : 856-7022
24.	Dr. Komala	IAKMI	Mochtar Building 2nd Floor Jl. Pegangsaan Timur #16 Jakarta Tel. : 314-5583
25.	Dr. Satoto	Jariangan Epidemiologi Nasional (JEN)	c/o MOH, BaLitBang, P4K Percetakan Negara Tel. : 426-6063
		MENADO	
26.	Theo Lumenon	Zero Population Grouth	Jl. Ahmad Yani No.43 Serio- Manado Tel: 0431- 852614
27.	Th. Adiloekito	Yayasan pelita Kasih Abadi	JL Arnold Mononutu No. 605 Lingkungan V Pakowa – Manado Tel/Fax : 0431- 863662

28.	Max Pangkey Didi	PT. Sinar Pure Food Drop in Center	Jl. Raya Madidir – Bitung Tel : 0438-21500 Kompleks Sari Intan Kelapa Lingkungan III Bitung Tel : 0438-31536

NO	CONTACT PERSON	ORGANIZATION	ADDRESS
29.	Jonny Nana	Yayasan Mia Masyarakat YMM Camping Activity	Jl. Bethel I No. 7 lingkungan II Karombasan Manado Tel/Fax : 0431-860652 Bumi Perkemahan Pramuka Maumbi Manado
30.	Dr. Nina Runtupalit	Klinik Spesialis Yayasan Bahagia Harapan Kita Pelabuhan Bitung Dr. Purwanto	Jl. Panjaitan No. 64 Manado Tel : 0431-864303 Fax :0431-855949 Kantor Kesehatan Pelabuhan Bitung Kompleks Pelabuhan Bitung Tel. : 0438-21076
31.	Dr. Demas Waas	Laboratorium Kesehatan Daerah Tingkat I Propinsi, Sulawesi Utara	Dinas Kesehatan Dati I silawesi Utara Jl. 17 Agustus Manado Tel : 0431-862522
32.	Drs. A.K . Lapadengan Governor Assisstant for social Welfare	Governor Offoce	Jl. 17 agustus Manado Tel : 0431- 867834
33.	Dr. JopieManoy	HAPP Manado	Kanwil Depkes Jl. 17 Agustus, Manado Tel. 0431- 867834 Fax:
		SURABAYA	
34.	Dr. Bambang Soetjipto	HAPP Surabaya	Jl. Kaeangan Menjangan 22, surabaya Tel. (031) – 5031 413 Fax. (031) – 503 1415
35.	Dr. Tuti	Balai Labkes	Jl. Karang Menjangan 18 Surabaya Tel. (031) 502 1718
36.	Dr. Arya	Kanwil Depkes Office	Jl. Karang Menjangan 12, surabaya Tel. (031) 502 1277
37.	Dr. Priyono	KPAD Office	Jl. Pahlawan 110,5th floor, surabaya Tel. (031) 357 5478
38.	Dr. Adi Widodo	PKBI- Surabaya	Jl. Indragiri no 24 Surabaya 60241 Tel : (031) 5675594.5687308 Fax : (031)5664901
39.	Ms. Liliek Sulistyowati	Yayaan abdi Asih Project Manager	Jl. Dukuh Kupang Timur XII/No.22 Surabaya, 60256 Tel. (031) 563 0862 Fax. (031)563 0862
40.	Dr. Murphy Sembiring	Yayasan Perspektiv	Jl. Teluk Kumai Timur 137, Surabaya Tel. (031) 329 1107 Fax. (031) 329 1107
41.	Dr. Rahmat	STD Clinic Putat Jaya	Jl. Kupang Gunung 5 Raya no 16 Surabaya Tep (031) 5687637

42.	Dr. Willy Kalallo Dr. Budi Subianto Dr. Gunawan Ingko K.	Regional MOH Office of Irian Jaya Province	Jl. Raya Sentani Kotaraja, Kotak Pos 1797 Jayapura 99017- Irian Jaya Tel. (0967) 581990-5811065 Fax : (0967) 581990 - 581798

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43.	Dr. Riby	CDC Office (Kanwil)	Jl. Raya Sentani Kotaraja, Kotak Pos 1797 Jayapura 99017- Irian Jaya Tel. (0967) 581 059
44.	Dr. Lana	Yayasan Kesehatan Bethesda	Jl. Pembangunan no. 3 – 5 Jayapura 99019- Irian Jaya Tel : (0967) 531 785 Fax: (0967) 531 785
45.	Sofia S. Merauje Fred Imbiri	Yayasan Maytresamad	Jl. Batu Karang no. 46, Ardipura II Jayapura 99223- Irian Jaya Tel : (0967) 532 849
46.	Dr. Gunawan Ingko-kusumo	PKBI Jayapura	Jl. Raya Sentani no. 87 Waena 99358, Jayapura – Irian Jaya Tel. : (0967) 571 138 – 571 947 Fax : (0967) 581 448
47.	Dr. Nurhasan	NAMRU- Jayapura	Tel : (0967) 531 351
48.	Dr. Yenny	Balai Pelatihan Kesehatan-Jayapura	Tel : (0967) 532 615 – 534304 Fax : (0967) 534 304
		SORONG	
49.	Drs. Victor Matombrie Sr. Fransiska Hadisu-santi	Yayasan Santo Agustinus	Jl. Jend. A. Yani No. 83 Kotak Pos 183 Sorong 98401- Irian Jaya Tel : (0951) 21201, 22020 Fax : (0951) 23794
50.	Dr. Robinson Panja-itan	PMI	Jl. Kesehatan Kompleks RSUD SORONG Tel : (0951) 278 933 Fax : (0951) 24431
51.	Izak Komigi, SH	Yayasan Bina Lestari Bumi Cendrawasih	Jl. Danau Ayamaru No. 17 Sorong 98412 – Irian Jaya Tel : (0951) 26920 Fax : (0951) 23474
		MERAUKE	
52.	Dr. Beni Simatupang	Distict Health Office Merauke	Tel : (0971) 21356

53.	Max Mahuse Sam Oyeb	Yayasan Pengembangan Sosial Ekonomi dan Lingkungan Hidup (YAPSEL)	Jl. Misi Merauke – Irian Jaya Tel : (0971) 21489 Fax : (0971) 21610
54.	Ir. Leo Mahuse Jago Bukit Maria	Yayasan Santo Antonius	Jl. Martadinata P.O. Box 214 Merauke – Irian Jaya Tel : (0971)21845 Fax : (0917) 21554
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WAMENA			
56.	Dr. Budi Subianto	Principal Investigator of Yasukhogo	Jl. SD Percobaan No. 45
57.	Ibu Darmi	WACTH Project	PO Box 195 Wamene 99501 Tel : (0969)31107
TIMIKA			
58.	Steve Wignall MD	Freeport Malaria Contral	Timika Indah C-9 Timika 98663- Irian Jaya Tel : (0901)321542 Fax : (0901) 424117
NABIRE			
59.	Dr. Lingga Wijaya	GENERASI	Jl. Wolter Monginsidi II, PO Box 250 Nabire 98816- Irian Jaya Tel : (0984) 22574, 23005 Fax : (0984)22574
BIAK			
60.	Josua Singgamui	PKBI - Biak	D/a BKKBN Kabupaten Biak Numfor Jl. Mojopait PO BOX 172 Tel/Fax : (0981) 21249

ANNEX E

MEETING PARTICIPANTS

(provided by Yayasan Kusuma Buana, support contractor in Indonesia)

B. Meeting With USAID , February 8, 1999

Name	Position	Organization
1. Terry Myers	Mission Director	USAID
2. Leslie Curtin		USAID
3. Dr. Ratna Kurniawati		USAID
4. Sebastian Hadianto		USAID

B. Meeting With MOH - CDC , February 9, 1999

Name	Position	Organization
1. Dr. Ratna Kurniawati	PHN	USAID
2. Sebastian Hadianto	PHN	USAID
3. Dr. Achmad Sujudi, MHA	Dirjen PPM & PLP	MOH
4. Dr. Abdul Manaf, SKM	Kadit P2ML,Ditjen PPM &PLP	MOH
5. Dr. Indriyono T. MPH	Kasubdit PMS-AIDS & Framb	MOH
6. Dr. Sigit Priohutomo, MPH	ASS. Manajer	HAPP-P2M
7. Berton, SKM	Subdit PMS-AIDS & Framb.	MOH
8. V. Indrawati	Subdit PMS-AIDS & Framb.	MOH
9. Jane Wilson	CD	HAPP - FHI
10. Dian Rosdiana	BCC Advisor	HAPP -FHI
11. Dr. john Moran	STD Adviser	HAPP - CDC
12. Dr. Arwati Soepanto	Manajer	HAPP
13. Djumali	GOI	HAPP
14. Italiana	GOI	HAPP

C. Meeting With HAPP, February 9, 1999

Name	Position	Organization
1. Jane Wilson	CD	HAPP - FHI
2. Dian Rosdiana	BCC Advisor	HAPP -FHI
3. Diah Pertiwi	IEC	HAPP
4. Dr. Arwati Soepanto	Manajer	HAPP
5. Dr. Ratna Kurniawati		USAID
6. Sebastian Hadianto		USAID
7. Lee Rine-Mercier		FHI/DC
8. Doreen B		HAPP
9. Ridwan Joesoef		CDC
10. Dr. john Moran	STD Adviser	HAPP - CDC
11. Ahmad Bahrul	Program Officer	HAPP

D. Meeting With Asia Reg. Manager, February 10, 1999

Name	Position	Organization
1. Anton Schneider	Social marketing Manager	Futures
2. Denny I Yatim	Research Associate	Futures
3. Alex Y. Syfu	Technical adviser	Grafic MCE
4. Juliana HatoSenior	Account executive	Grafic MCE
5. Venessa Williams	Technical adviser	Grafic MCE
6. Rocky Menayang	Group Acc. Director	Grafic MCE
7. Ina Setia Budi	Account Executive	IPM – PR
8. Leny E. Tando	Managing Director	IPM – PR
9. Robby Susatyo	President Director	AMI

E. Meeting With PATH Indonesia, February 10, 1999

Name	Position	Organization
1. Don L Douglas, MBA	Country Director	PATH
2. Julie Marsaban	Prog. Ass. Soc. Marketing	PATH
3. Dr. A. Widjaya	Medical advisor	PATH
4. Yanti Triswan		PATH

F. PVOs Meeting, February 11, 1999

Name	Position	Organization
1. Don L Douglas, MBA	Country Director	PATH
2. Carol Carp M.S	Country Director	PCI
3. Alex H Sumarauw, Bsc,MBA	Capacity Building Specialist	PCI
4. Imam Mulyadi	Project Director	PACT
5. Ch. Shinta Widimulyani	Project Coordinator	PACT
6. Craig Darden	Country Director	DKT
7. Christine Claypoole	Communication Advisor	DKT
8. Dr. Ratna Kurniawati		USAID

G. Meeting With KPAD, February 12, 1999

Name	Position	Organization

Titi Karsita Linggo		Dinkes
R. Walman		Dep. Agama
Erniek Suprapti		Depsos
Asian Lasman		Dinkes
Muhiyat		Kandep. Peneranga
Iwan J. Sabirin		BKKBN-DKI
Herman S		KanwilDepkes
Yuni Syatri		Pariwisata
Dhiani Astuti		Dep. Perhubungan
Tiodor S		Kanwil Perhub.
Rama Chandra		Forum AIDS Jabota
Jacob Kendang	Direktur	YIK
Pane Madur	Wakl direktur	YIK
Ahmad Bahrul		HAPP
Dyah Pertiwi	IEC	HAPP
Dr. Rita Kusriati	Kepala Seksi surveilans	KPAD

H. Meeting With Yayasan Kusuma Buana, February 12, 1999

Name	Position	Organization
1. Dr. Adi Sasongko	Dir. Pelayanan Kesehatan	YKB
2. Jeremias Wutun	Field Staff	YKB
3. Yani Maryani	Koordinator Program	YKB
4. Nitta	Field Staff	YKB
5. Ana	Sekretaris	Bandungwangi
6. Darmi	Ketua	Bandungwangi

I. Donor Informal exchange Meeting on AIDS Menko Kesra Office February 15, 1999

Name	Position	Organization
1. Haryono Suyono	Minister	Menkesra
2. Joko Prayitno	Staf Ahli	Kesra
3. Joko Suharno	Staf ahli	Kesra
4. George Loth	Country Prog. Adviser	UNAIDS
5. Don L Douglas	Country director	PATh
6. Stephen J. Woodhouse	Chair Person	UNAIDS
7. M. Soedarmadi	Secretary	Menkokesra
8. Bing Wibisono		WHO
9. Meiwita B Iskandar	Program asociate II	Pop. Council
10. John Moran	STD Adviser	HAPP - CDC
9. Crhistine Claypoole	Communication Advisor	DKT
11. Joice Jaelani	Staf	PATH

12. Rudi Nuriadi	Staf	UKRIDA
13. Nuraini Kamka	Counselor	YMI
14. Luciana	Counselor	Spiritia
15. Suzana Murni	Director	Spiritia

J. Meeting With Yayasan Investasi Kemanusiaan, February 15, 1999

Name	Position	Organization
1. Jacob Kedang	Director	YIK
2. Pane Madur	Vise Direktor	YIK
3. Richard	Field Staf	YIK
4. Wimpy	Project Coordinator	YIK
5. Lucky	Staf	YIK
6. Putri Mandiri Group Members		

K. Meeting With IAKMI, February 22, 1999

Name	Position	Organization
1. Dr. Toha Muhaimin	Program Direktor	IAKMI
2. Nancy Iskandar	Leader Group	Waria
3. Upi	Field Staff	IAKMI
4. Baby	Project Koordinator	IAKMI

L. Meeting With Indonesian Epidemiology Network JEN Office February 22, 1999

Name	Position	Organization
1. Dr. Nick G Dharmaputra	Researcher	PPK -UI
2. Vera Hakim	Staf	PPK - UI
3. Heru Suparno	Staf	PPK - UI
4. Charles Surjadi		JEN/Atmajaya
5. Ridwan Malik		IDI
6. Clara Ajisukmo	Researcher	Atmajaya
7. Irwanto	Ketua PKPM	Atmajaya
8. Tri Bun W.R		PPK
9. Yvonne		PPK

M. Meeting With USAID Cas, Acacia Hotel February 23, 1999

Name	Position	Organization
1. Bill Emmet		Policy/Futures
2. Sebastian Hadianto		USAID/PHN
3. Anton Schneider	Social mark. Manager	Futures

4. Wilson Sitorus		HAPP
5. Russ Vogel		JHPIEGO
6. Sat Watanabe		USAID/G/PHN
7. Libby Kugler		Policy/Depkes
8. Don Douglas	Country Director	PATH
9. Imam Mulyadi	Project Director	PACT
10. Greg Rooney		PACT
11. Imran Lubis		PACT
12. Ratna Kurniawati		USAID
13. Alex H Sumarauw	Capacity Building	PCI
12. Dian rosdiana	BCC Advisor	HAPP -FHI
14. Jane Wilson	CD	HAPP - FHI

N. Meeting With Ministri Of Health MOH Meeting Room February 24, 1999

Name	Position	Organization
1. Dr. Abdul Muluk	Ministri	MOH
2. Dr. Achmad Sujudi	Dirjen P2MPLP	MOH
3. Dian Rosdiana	BCC	HAPP
4. Dr. Fonny J silfanus	Subdit PMS/AIDS	MOH
5. Dr. Sigit Priyohutomo	Subdit PMS/AIDS	MOH
6. Dr. Abdul Manaf	Dit. P2ML	MOH
7. Dr. Indriyono. T. MPH	Subdit PMS/AIDS	MOH
8. Jane Wilson	CD	HAPP
9. Nindi Pinta, SKM	Subdit PMS/AIDS	MOH
10. Dr. Widisono	Binkesmas	MOH
11. Dr. Ratna Kurniati		USAID
12. Dr. Sunadi G	Staf Puslit Penyakit Menular	MOH
13. Indra Gotama	Staf Balitbang	MOH
14. Fauzan Meirad	Staf Pus. Bid. Kes	MOH
15. Dadi	Staf Kesra	Menkesra
16. Djoko Prayitno	Staf Ahli	Menkesra
17. Terry Mayer		USAID
18. Ms. Leslie Curtin		USAID
19. Dr. Sri Astuti	Staf Dirjen Yanmedik	MOH
20. Dr. Arwati S.	Manager	HAPP
21. Dr. Gita Maya . KS	Staf Ditkes	MOH
22. Harini .S	Staf Dit RSKS	MOH
23. Berton P	Subdit P2PMS-Mas/Framb.	MOH
24. Indrawati	Subdit P2PMS-Mas/Framb.	MOH

O. Meeting With HAPP, February 25, 1999

Name	Position	Organization
1. Jane Wilson	CD	HAPP - FHI
2. Dr. john Moran	STD Adviser	HAPP - CDC
3. Dian Rosdiana	BCC Advisor	HAPP -FHI
4. Dr. Arwati Soepanto	Manajer	HAPP-GOI
5. Edward Hutapea	Finance	HAPP
6. Ciptasari Prabawanti	Program Officer	HAPP
7. Wilson Sitorus	Program Officer	HAPP
8. Ahmad Bahrul	Program Officer	HAPP

P. Presentation of Finding and Recommendations, February 26, 1999

Name	Position	Organization
1. Dr. Ratna Kurniawati	PHN	USAID
2. Don Douglas	Country Director	PATH
3. Dr. Indriyono T. MPH	Kasubdit PMS-AIDS & Framb	MOH
4. Dr. Sigit Priohutomo, MPH	Kasubdit PMS-AIDS & Framb	MOH
5. Nandipinta	Subdit PMS-AIDS & Framb.	MOH
6. Fonny J.S	Subdit PMS-AIDS & Framb.	MOH
7. Berton, SKM	Subdit PMS-AIDS & Framb.	MOH
8. V. Indrawati	Subdit PMS-AIDS & Framb.	MOH
9. Jane Wilson	CD	HAPP - FHI
10. Dian Rosdiana	BCC Advisor	HAPP -FHI
11. Dr. john Moran	STD Adviser	HAPP - CDC
12. Dr. Arwati Soepanto	Manajer	HAPP
13. Ciptasari Prabawanti	Program Officer	HAPP
14. Wilson Sitorus	Program Officer	HAPP
Edward Hutapea	Program Officer	HAPP

ANNEX F

EPIDEMIOLOGICAL DATA OF HIV AND STDs IN INDONESIA

(provided by HIV/AIDS Prevention Project [HAPP])

The Epidemiology of HIV and other STDs in Indonesia

An overview prepared for USAID's External Review Team
February 1999

John S. Moran, MD, MPH
STD Advisor

Summary

Background
HIV data
STD data
Behavioral data
Effects of monetary crisis
Interpretation
Implications

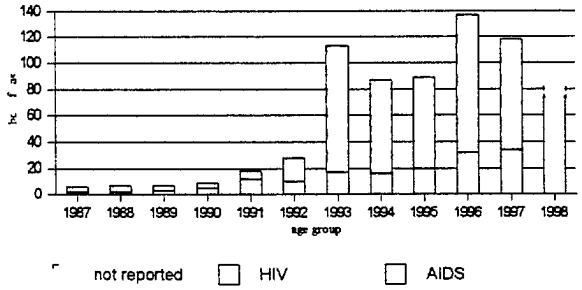
Background

Past estimates and predictions

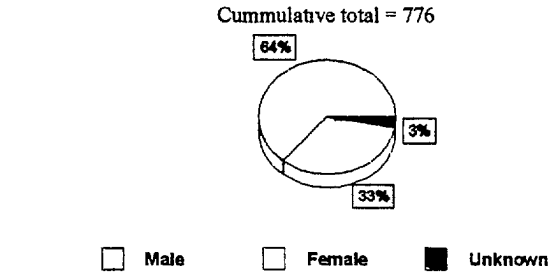
- "There were 40,000 - 50,000 HIV-infected Indonesians" in 1993 (WHO/USAID 1994)
- "There will be 360,000 - 900,000 HIV-infected Indonesians in 2000" (UI/UNICEF 1996)
- "There will be 12,000 - 31,000 AIDS deaths in 2000" (UI/UNICEF 1996)

HIV Incidence and Prevalence Data

HIV and AIDS Incidence

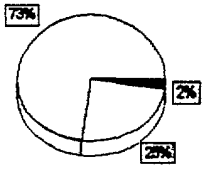


Distribution of HIV Seropositives by Sex



Distribution of HIV Seropositives by Nationality

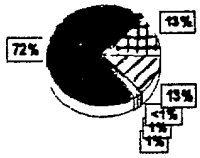
Cummulative total = 776



Indonesian Foreign Unknown

Distribution of HIV Seropositives by Risk Factor

Cummulative total = 776



Homo/bisexual Heterosexual
IDU Maternal-child
Blood/blood product Unknown

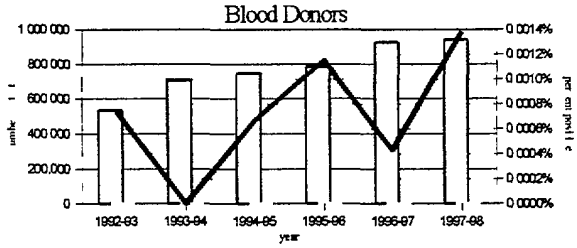
Government HIV and AIDS Incidence Data

Footnotes

- Of cummulative total of 776 HIV seropositives, 111 are reported to have died

HIV Prevalence

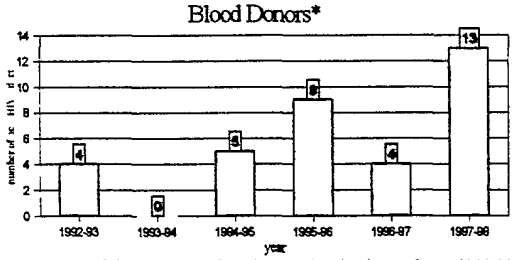
Blood Donors



Neg (Y1) Pos (Y1) % pos (Y2)

HIV Incidence

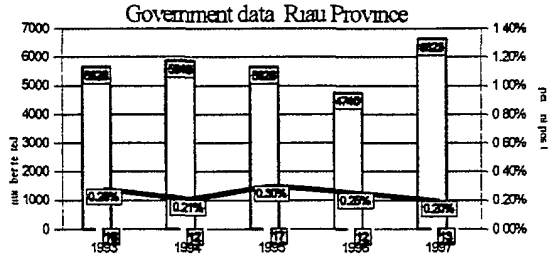
Blood Donors*



*Blood donors may be loosely considered to be a cohort of 300 000 to 500 000 persons who are tested for HIV two to three times each year

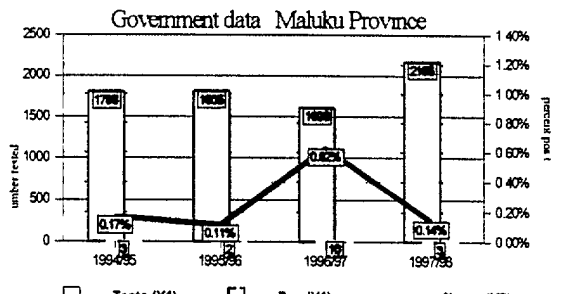
HIV Prevalence

Government data Riau Province

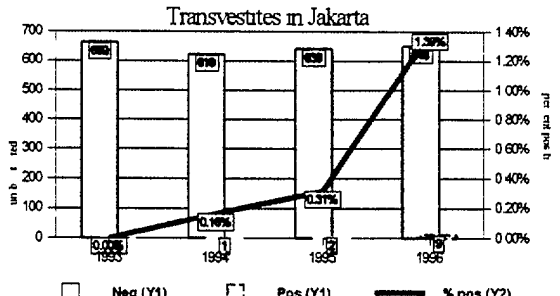


Tested (Y1) Pos (Y1) 0% (Y2)

HIV Prevalence



HIV Prevalence



HIV and AIDS Prevalence Data

- 1992-93 CDC study of brothel-based female CSWs in Surabaya **0 of 693**
- 1992-93 CDC study of streetwalking female CSWs in Surabaya **0 of 178**
- 1992-93 CDC study of non-brothel-based, non-streetwalking female CSWs in Surabaya **0 of 947**
- 1992-93 CDC study of prenatal clinic attenders in Surabavaa **0 of 599**

HIV and AIDS Prevalence Data

- 1995 University of Antwerp study of brothel-based female CSWs in Jakarta **0 of 504**
- 1995 University of Antwerp study of brothel-based female CSWs in Surabava **0 of 614**
- 1995 University of Antwerp study of brothel-based female CSWs in Bandung **0 of 342**

HIV and AIDS Prevalence Data

- 1997-98 University of Michigan-supported study of brothel-based, female CSWs in Bali **1 of 600**
- 1998 USAID-supported study of "high risk" persons in eastern Irian Java (mostly female CSWs from other parts of Indonesia) **2 of 1222** (preliminary result)
- 1998 Brown University-supported study of female prostitutes in Jakarta **0 of about 150**

HIV and AIDS Prevalence Data

Footnotes

- Incidence and prevalence are much lower than was predicted
- Incidence and prevalence are increasing
- 2/3 of infections are in men
- 85% of infections are sexually transmitted

HIV and AIDS Prevalence Data

Footnotes

- Male transvestites in Jakarta, most of whom are said to be low-priced sex workers, have the highest documented HIV prevalence of any Indonesian population

HIV and AIDS Prevalence Data

Unknowns

- Prevalence among injecting drug users
- Number of injecting drug users

Research on Injecting Drug Users in Indonesia

(I Made Setiawan, et al. "Report on intravenous drug use (IVDU) in Bali (Denpasar and Kuta) Results of an interview survey Int J Drug Policy Feb 1999-vol 10

- "We now estimate that there may be up to 1000 regular intravenous drug users (IVDU) in Bali "
- "The target sample was approximately 100 respondents "
- After about 7 months our final sample was about 34 complete questionnaires "

HIV and AIDS Prevalence Data

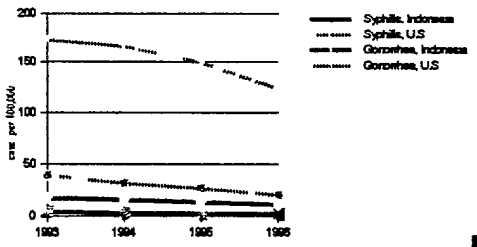
Unknowns

- Prevalence among non-transvestite men who have sex with men
- Number of non-transvestite men who have sex with men

STD Data

STD Incidence: Syphilis and Gonorrhea

Cases reported per 100 000 population, Indonesia and U S

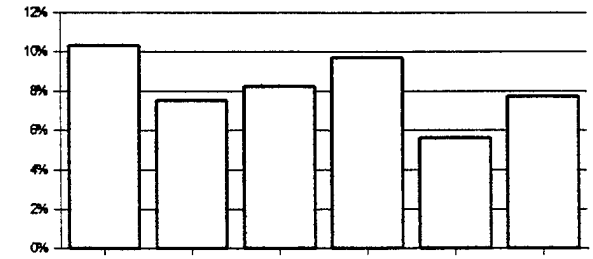


STD Incidence Data

- Incidence data are reliable only when a constant proportion of cases are reported
- In Indonesia, as in other countries, many cases are not reported and the proportion that is reported is unknown and may change as patterns of health care seeking change
- STD incidence data available in Indonesia must interpreted carefully

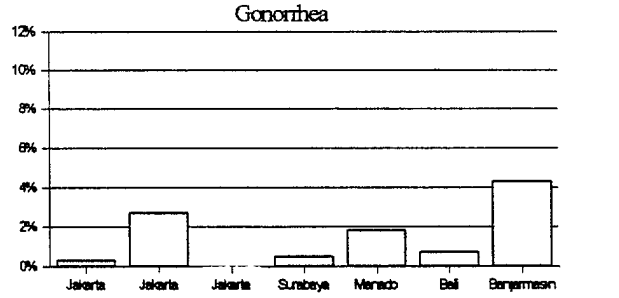
STD Prevalence Among Low Risk Women

Chlamydia trachomatis genitourinary infection



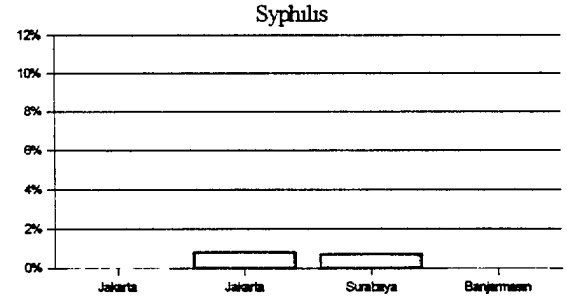
STD Prevalence Among Low Risk Women

Gonorrhea



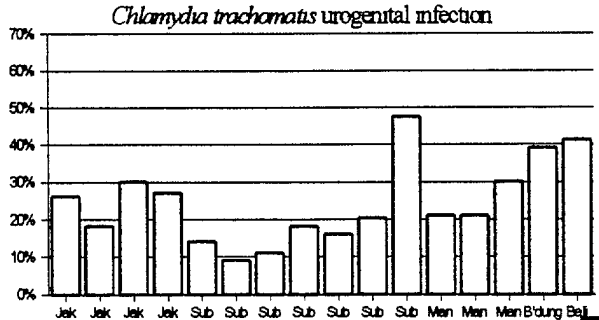
STD Prevalence Among Low Risk Women

Syphilis



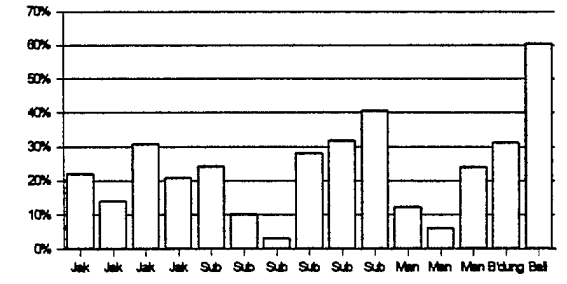
STD Prevalence Among High Risk Women

Chlamydia trachomatis urogenital infection

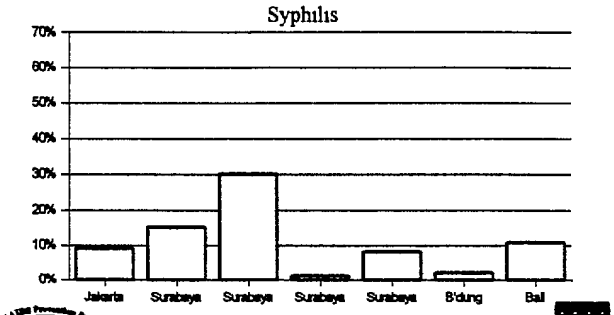


STD Prevalence Among High Risk Women

Gonorrhea

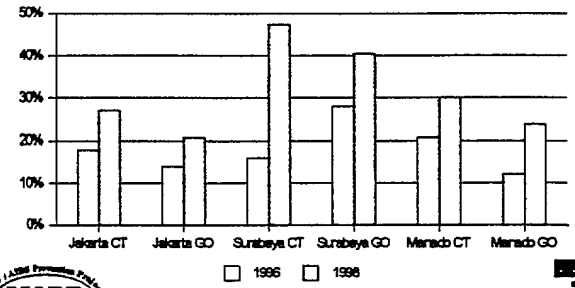


STD Prevalence Among High Risk Women



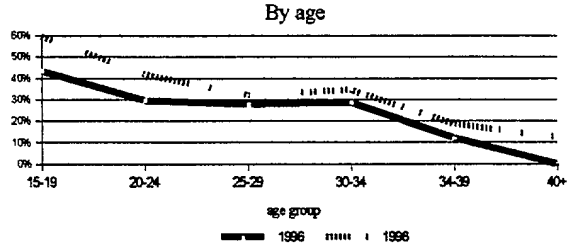
STD Prevalence among CSWs in 1996 and 1998

CT = *Chlamydia trachomatis* GO = *Neisseria gonorrhoeae*



STD* Prevalence among CSWs in 1996 and 1998

By age



*Infection with *N gonorrhoeae C trachomatis* or both

STD Data

- **Hepatitis B** Prevalence of HbsAg among 786 870 blood donations in 1997/98 2 1%
- **Hepatitis C** Prevalence of HCV Ab among 211 890 blood donations in 1997/98 0 73%
- **Human papillomavirus** no data
- **Herpes simplex virus type 2** Prevalence of HSV2 Ab among 599 pregnant women. 9 9%

STD Data

Summary Curable STDs

- In the general population, infection with *Chlamydia trachomatis* is the most important STD, being found among 5-10% of asymptomatic family planning and antenatal clinic attendees
- In the general population, *Chlamydia trachomatis* infection appears to be the only really important STD

STD Data

Summary Curable STDs (continued)

- Among female CSWs, the prevalence of infection with *Chlamydia trachomatis, Neisseria gonorrhoeae*, or both is as high as anywhere in the world, between 15 and 50% in most surveys
- The only available longitudinal data indicate that both chlamydia infection and gonorrhea have become more common among CSWs between the end of 1996 and the end of 1998

STD Data

Summary: Incurable STDs

- In the general population, sexually transmitted hepatitis B and C infection is an important problem
- At the present time, sexually transmitted hepatitis is a much more common cause of sickness and death in Indonesia than is sexually transmitted HIV

Behavioral Data

Ever had sexual intercourse?

- **High school students** in three cities
  - Females 2.9% of 1601 said yes
  - Males 12.8% of 1600 said yes
- **Unmarried factory workers** in Surabaya
  - 2.6% of 420 females said yes
  - 21.2% of 173 males said yes
- **Unmarried sailors, seaport laborers, truck drivers, and truck driver's assistants** in three cities
  - 71.2% of 1291 males said yes

Behavioral Data

Had sex with a CSW in the past year?

- **Male high school students** in three cities
  - 2.6% of 1600 said yes
- **Male factory workers** in Surabaya
  - 6.4% of 801 said yes
- **Sailors, seaport laborers, truck drivers, and truck driver's assistants** in three cities
  - 35.9% of 3602 said yes

Behavioral Data

Mean number of reported CSW contacts in past year

- **Male high school students** in three cities
  - Per CSW patron* 3.6
  - Per respondent 0.10
- **Male factory workers** in Surabaya
  - Per CSW patron. 9.5
  - Per respondent 0.62
- **Sailors, seaport laborers, truck drivers, and truck driver's assistants** in three cities
  - Per CSW patron. 10.8
  - Per respondent 3.88

*per respondent who reported CSW contact in past year

Behavioral Data

Condom knowledge and use

- **Male high school students** in three cities
  - 84.2% of 1600 recognize condom
  - 73.2% of 1599 know that condoms can prevent HIV/AIDS
- **Sexually experienced male high school students** in three cities
  - 91.7% of 204 recognize a condom
  - 5.6% of 177 say it is difficult to get a condom
  - 15.7% of 51 used a condom when they last had sex with a CSW

Behavioral Data

Condom knowledge and use

- **Male factory workers** in Surabaya
  - 93.8% of 801 recognize condom
  - 60.2% of 801 know that condoms can prevent HIV/AIDS
- **Sexually experienced male factory workers** in Surabaya
  - 0 of 545 say it is difficult to get a condom
  - 10.3% of 87 used a condom when they last had sex with a CSW

Behavioral Data

Condom knowledge and use

- **Male sailors, seaport laborers, truck drivers, and truck driver's assistants in three cities**
  - 87 1% of 3602 recognize condom
  - 65 8% of 3602 know that condoms can prevent HIV/AIDS
- **Male sailors, seaport laborers, truck drivers, and truck driver's assistants in three cities who had sex with a CSW in the past year**
  - 10 6% of 1294 say they used a condom when they last had sex with a CSW

Behavioral Data

Condom knowledge and use

- **Female CSWs** in three cities
  - 96 7% of 3003 recognize condom
  - 75 0% of 3003 know that condoms can prevent HIV/AIDS
  - 36 7 % of 3003 reported using a condom with their last client
- **Female CSWs** in three cities who did not use a condom the last time they had sex
  - 1 3% of 1894 say a condoms was difficult to get
  - 6 4% of 1894 say they were out of stock
  - 16 9% of 1894 say condoms are uncomfortable or reduce pleasure
  - 48 3% of 1894 say their partner did not want to use a condom

Behavioral Data

Mean number of clients reported by CSWs in past week

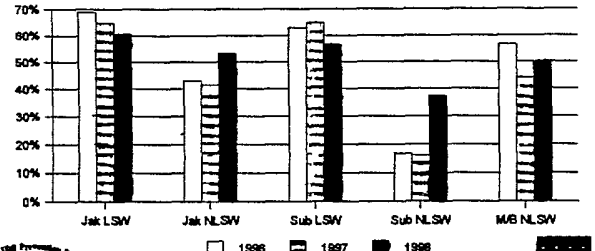
- Jakarta brothel-based (n=590) 6 0
- Jakarta non-brothel-based (n=580) 5 6
- Surabaya brothel-based (n=592) 13 0
- Surabaya non-brothel-based (n=580) 12 0
- Manado/Bitung non-brothel-based (n=584) 4 1

Effect of economic crisis

- Mean number of clients reported by CSWs in past week
  - 1996 (n=966) 8 4
  - 1997 (n=1002) 9 2
  - 1998 (n=958) 6 8
- Reported visits in past year per respondent (sailors seaport laborers, truck drivers, and truck driver s assistants in three cities)
  - 1996 (n=1199) 2 8
  - 1997 (n=1200) 4 5
  - 1998 (n=1203) 4 3

CSW Longevity

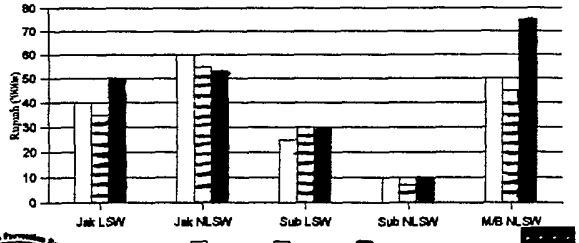
Proportion of respondents reporting ≤ 1 year of work experience



LSW = brothel based, NLSW = non-brothel-based

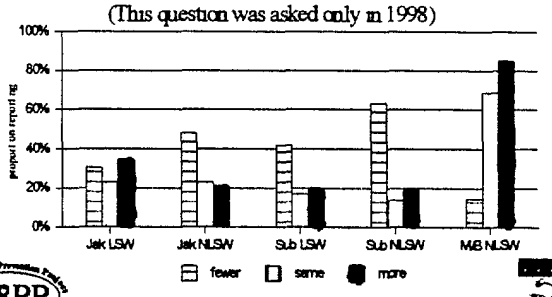
CSW Pay

Median payment received from last client



CSW's Perception of Changes in the Number of CSWs on Site in the Past Year

(This question was asked only in 1998)



Effect of economic crisis

Summary

- There is no evidence that the volume of commercial sex transactions has increased in HAPP cities
- There is some evidence of an influx of new CSWs into the non-*lokalisasi** CSW populations in Jakarta and Surabaya.

**Lokalisasi* are designated brothel areas

Effect of economic crisis

Summary (continued)

- CSWs fees for service have not kept up with inflation in Jakarta or Surabaya but have in Manado/Bitung
- CSWs in Jakarta outside of *lokalisasi* and CSWs in Surabaya perceive a decrease in the numbers of CSWs at their worksite but CSWs at Jakarta *lokalisasi* and CSWs in Manado/Bitung report no change

Interpretation

- Indonesia is a low HIV prevalence country
- HIV incidence is increasing
- The rate at which HIV is spreading is accelerating and is likely to continue to accelerate in the absence of effective interventions
- At present, high risk is limited to injection drug users, men who have sex with men, and CSWs

Interpretation

- CSWs and their clients have a demonstrable, high risk of acquiring and transmitting HIV
- This risk can be reduced by increasing condom use and by improving STD detection and treatment

Implications

- Indonesians' personal experience with HIV is not likely to spur behavior change in the near furture
- Payoff (in terms of HIV infections prevented) will be greatest from focused activities
- Efforts should be made to control STDs among CSWs

ANNEX G

ASSESSMENT OF THE HIV/AIDS PREVENTION PROJECT (HAPP)/INDONESIA SOCIAL MARKETING COMPONENT

BACKGROUND

Social marketing can be broadly defined as marketing for social benefit and not for profit. Essentially, there are two components: (1) bring behavioral change among target group members by providing necessary information and education so as to motivate them for the desired behavior; and, (2) market a product/service at an affordable price so that by using the product or service, the target group can practice the desired behavior.

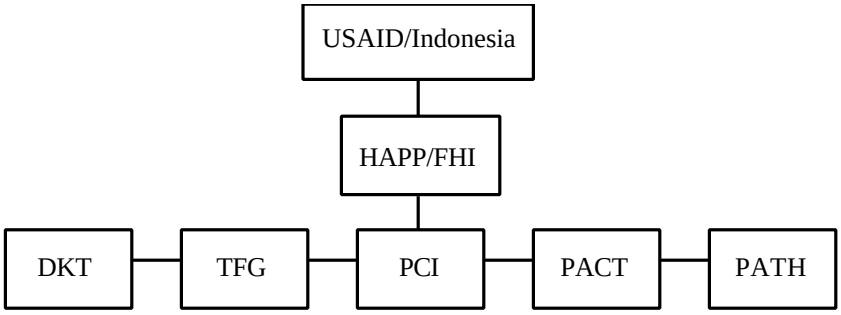
In Indonesia, social marketing of condoms for family planning started by the National Family Planning Coordinating Board (BKKBN) more than a decade ago and it has been highly successful. But social marketing of condoms for sexually transmitted disease/acquired immune deficiency syndrome (STD/AIDS) prevention is a comparatively new activity (since 1993).

In Indonesia, a predominately Moslem country, extramarital sex is considered to be a sin. Until now, the program has not received much support from the Ulamas (religious leaders). For the same reason, the government of Indonesia (GOI) does not want to take the risk of promoting or supporting the program openly at this point in time.

During the early stage of the human immunodeficiency virus (HIV)/AIDS epidemic in 1992, the Social Marketing for Contraceptives project (SOMARC) was asked to develop a condom social marketing pilot project (CSM) in Surabaya/Indonesia that would increase the availability and accessibility of affordable high-quality condoms in brothels by increasing awareness of condoms as protection from HIV/AIDS and encouraging condom use among commercial sex workers (CSWs).

HIV/AIDS PREVENTION PROJECT (HAPP)

USAID funded the HIV/AIDS Prevention Project (HAPP) as a collaborative effort between the GOI, nongovernmental organizations (NGOs), and USAID to reduce the rate of HIV/AIDS transmission in Indonesia. The total funding committed is U.S. $26.7 million, of which about 75 percent (U.S. $20 million) will be provided by USAID and the balance, 25 percent (U.S. $6.7 million), by the government of Indonesia. The present setup of HAPP is shown below.



Note: DKT currently receives funding from three sources: KfW (a German donor bank), DKT/Washington, and USAID/Indonesia.

The strategy for condom promotion for HIV/AIDS prevention is to:

- increase awareness;
- build a positive attitude;
- increase availability/distribution; and,
- increase advertising and promotion.

All of the strategies noted above can be implemented through social marketing and/or NGOs working with social/commercial marketers.

GENERAL OBSERVATIONS (ON SOCIAL MARKETING)

After reviewing the report/papers on condom social marketing for STD/AIDS prevention in Indonesia, listening to the presentations made by the GOI, USAID, other donors, HAPP, NGOs, conducting field trips to the brothels and the market around these places, and talking with distributors, peer educators, and CSWs, the review committee made the following observations.

1. The Indonesian social marketing program for family planning is a success. After reviewing the existing program of CSM for STD/AIDS prevention, it is strongly believed that the program will succeed.

2. There appears to be a lack of coordination between HAPP, NGOs, and other organizations. Improving coordination and cooperation between all partners and avoiding duplication or overlap in activities or territories is recommended.

3. The Futures Group International has developed excellent, high-quality, informative educational materials; supported NGOs with IEC materials; and, supported commercial manufacturers/marketers to increase the availability of condoms to the high-risk group. From the sustainability point, this seems to be very appropriate. However, it seems that until now, IEC for behavioral change has been conducted mostly among the CSWs who are neither the decision-makers nor the buyers.

GENERAL RECOMMENDATIONS FOR SOCIAL MARKETING

1. In social marketing of condoms for STD/AIDS prevention, the major factors to increase usage are **awareness** and **availability** (of any brand) and not subsidized pricing because the cost of the condom is negligible compared to the fee of the CSW. Unless there is a clear-cut correlation between affordable price and usage (i.e., a clear-cut niche in the market for subsidized pricing), there is no point in selling a brand below cost. However, if the price of the lowest commercial brand is a detrimental factor for the end users in the lowest two socioeconomic segments, then these segments should receive subsidized pricing.
   Based on discussions with donors, NGOs, peer educators, and CSWs, it does not seem that price is a hindrance for use (between the range of rupiah [Rp.] 250–1,500 [U.S. $.03–$0.19; 8,000 Rp. = U.S. $1] per piece). If a social marketer sells a brand at a subsidized price through commercial outlets, it must be guaranteed that the end users

(and not the traders) benefit. Otherwise, the purpose of subsidized pricing is lost. If it is difficult to ensure, then the alternative is a noncommercial distribution channel, such as community-based distribution through NGOs, peer educators, brothel managers, and pimps for the lowest two economic segments of the market in selected pockets of the country. There is no point in subsidizing the three highest socioeconomic segments of the market. It was not clear if there is a definite niche for subsidized pricing.

The present coexistence of DKT and commercial marketers should continue until April 2000 and/or until economic conditions improve. After this, the GOI and donors, with the help of research findings, will decide whether subsidized pricing for a brand is necessary or not for the affordability of the two lowest economic segments of the market for STDs/AIDS prevention.

2. IEC activities should be intensified among the clients (because they are the decision-makers) for the use of condoms. Once the demand is increased from the clients' side, usage will increase automatically.

3. The Futures Group in Indonesia should initiate a study to determine if a brand which connotes protection will have a better impact on clients and CSWs on the use of condoms for protecting against STD/AIDS. Many of the existing socially marketed brands of condoms for STD/HIV/AIDS in other countries connote protection. When one of the partners (mostly CSWs) insists on the use of a condom, the other partner may think that she/he is infected. That affects the interaction. In Uganda, the brand name of the social marketed condom for STD/AIDS prevention is called "Protector"; in Nepal, "Dhal" (meaning shield); and, in Bangladesh, the STD/AIDS prevention program of social marketing is called "Surrakah" (meaning well protected).

4. It appears that vendors who sell items such as cigarettes and invigorating drinks inside the brothels are not yet selling condoms. Both DKT and commercial marketers should use them for that purpose.

5. NGOs working in the field should have a revolving fund and, through peer educators, distribute condoms to the CSWs.

6. A story-based videotape on STD/AIDS prevention should be produced and shown during IEC training to the CSWs, pimps, and high-risk clients (i.e., sailors, fishermen, truckers, and laborers). This has been found to be highly effective in Bangladesh. The impact of "education through entertainment" is much more effective than conventional lectures.

7. Transvestites are in the high-risk group. Their way of life and sexual behavior is different from that of normal males. It was reported that there are about 4,000 transvestites in Jakarta alone. On the basis of research findings on their behavior, it is recommended that specific IEC materials be developed for them and distributed by NGOs (e.g., IAKMI) who are working for them. The community-based distribution of condoms is likely to be very effective. HAPP's condom social marketing (CSM) activity is mainly implemented by The Futures Group, which

- initiates research on target groups' knowledge, attitudes, and practices (KAP), markets, and media, mainly through local research agencies such as Survey Research Indonesia (SRI) and Asia Market Intelligence (AMI);

- develops communication (IEC) materials for high-risk groups (awareness, use of condoms, negotiation skills) and for mass media; and,

- supports local condom manufacturers to increase distribution and accessibility at affordable prices and ensures quality.

RECOMMENDATIONS

1. The Futures Group should help commercial marketers to cater to the highest socioeconomic segments of the markets and not the lowest two segments because commercial marketers will not sell a brand without profit. They will sell at the subsidized price only if a donor provides the subsidy. That may not be necessary as long as DKT is there.

2. The Futures Group focuses on demand creation and supports commercial marketers for widespread geographic distribution. Since the current condom prices do not seem to be problematic, the sale of all commercial brands is likely to increase if demand is increased.

DKT: OBSERVATIONS

DKT started social marketing of condoms for STD/AIDS prevention in 1996, mainly with KfW funding. It has its own brand, "sutra" (which means silk) which is distributed at a subsidized price, mainly to the retail outlets (pharmacies and kiosks) near the brothels.

1. DKT is distributing condoms in 8 provinces (out of 27) of the countries. According to DKT, there are about 268 brothels in these areas in which about 42,000 CSWs work. The distribution of sutra to the retail outlets around those brothels was excellent. This is the highest selling brand in those areas, particularly where CSWs' fees are between Rp. 5,000–25,000 (U.S. $0.63–$3.13).

2. DKT's stickers about sutra are widely visible, even in the individual rooms of CSWs, which means that they have really penetrated the brothels.

3. Their 1999 calendars on sutra are highly visible in clinics, training centers, and bars. Their wall clocks are also visible at the clinics and training center.

4. Their comic books on the use of condoms for STD/AIDS prevention seems to be effective, based on discussions with the commercial marketers.

5. By providing sutra at a subsidized price to the traders, it seems that they are eroding the normal commercial market.

6. There are complaints from certain areas that although DKT sells sutra at a subsidized price for the benefit of the low-end users, the traders do not pass on the benefit to the user. They make a large profit by selling these at a price much higher than the recommended price of Rp. 250 per piece (U.S. $0.03).

RECOMMENDATIONS

1. Instead of eroding the commercial market, DKT should create a market niche between commercial market and free distribution. In fact, they should cater to the lowest two socioeconmoic segments and part of the third lowest segment of the market.

2. Their present consumer price of Rp. 250 per piece seems appropriate and affordable to the target group. In view of the present economic situation, they should not consider raising prices now. When the economic situation improves, DKT may raise the price of sutra, even up to Rp. 500 per piece.

3. DKT should increase their distribution network to all of the major towns/areas of high-risk groups in Indonesia. Otherwise, some important high-risk areas will remain unidentified.

SUMMARY OF RECOMMENDATIONS (ON SOCIAL MARKETING)

For the purpose of improving usage of condoms for STD/AIDS prevention:

1. The high-performing areas (such as Jakarta and Surabaya) and low-performing areas (such as Manado) of the country in terms of awareness and availability of condoms and their usage are to be identified.

2. Special effort should be given to improve awareness and availability of condoms in the low-performing areas.

3. It seems that IEC training mostly has been given to the CSWs in the high-performing areas. Intensified IEC should be given to high-risk clients (e.g., sailors, truckers, laborers, youth) both in the high- and low-performing areas because it is the client who is the decision-maker and the buyer of condoms. Once the demand is increased from the clients' side, usage will increase automatically.

4. The necessity of marketing a brand at a subsidized price should be looked into at a later date, about a year from now.

5. Geographic expansion of the activity (both IEC and availability of condoms) in all the high-risk areas of the country is necessary.

6. Mass media (i.e., television, radio, and press) communication on the use of condoms for STD/AIDS prevention should be increased.

ANNEX H

HIV/AIDS SITUATION IN IRIAN JAYA

INTRODUCTION

Human immunodeficiency virus (HIV) infection was found in Irian Jaya in 1992 from the serologic survey in Merauke. Subsequent surveys found that the infection had also penetrated other places, such as Jaya pura (1993), Serui (1994), Timika (1995), Kaimana (1995), Biak (1997), and Sorong (1997). The first acquired immune deficiency syndrome (AIDS) case was found in Merauke hospital in August 1994; beginning in 1996, almost every month, one or more new cases were found in the hospital. So far, 201 cases (out of a population of 2,020,900) consisted of 78 AIDS cases and 123 cases of HIV (October 1998), making it the highest prevalence in the country (0.8 percent among 1,297 high-risk adults). Almost 50 percent of the cases are 15–39 year olds. Even though the prevalence is relatively low, since the sexually transmitted disease (STD) prevalence is high, it has the potential to grow and spread. Among the provinces in Indonesia, Irian Jaya is unique in terms of ethnicity, geography, and economic development, which affected the potential spread of the disease.

The assessment team members who visited the province were Drs. Endang Sedyaningsih, Nuning M. K. Masjkuri, and John Moran. They were accompanied by Dr. Anton Wijaya from Program for Appropriate Technology in Health (PATH). The visit was conducted from February 19 to 23, 1999. The team visited the health office both at the provincial level and the district level and the collaborating nongovernmental organizations (NGOs). Beside Jayapura (the capital city), Merauke was also visited, as it has the highest incidence in the whole province. The assessment included reviewing selected documents, having discussions with key persons (government officials, NGO representatives as well as their beneficiaries), and conducting site visits.

FINDINGS

- The province has had a master plan to control and prevent HIV/AIDS and STD for the years 2000–2003.

- Out of nine districts, only six have developed a provincial AIDS commission (KPAD).

- Although there are approximately 20 NGOs interested in AIDS prevention, only 9 are currently active; the rest are inhibited by lack of funding. Most of the NGOs are weak in the planning and managing of the interventions, especially in monitoring and evaluating the outcomes and impact. Very few NGOs have the medical capacity to help extend treatment to the high-risk population. Many of the NGOs were not aware of the existence of the Master Plan.

- Several donor agencies (such as PATH, the Ford Foundation, Community Health Nutrition (3) [CHN-3]) have assisted in AIDS prevention activities. The Australian Agency for International Development (AusAID) is interested in assisting in an AIDS workshop in Merauke, provided the KPAD submits a sound proposal.
- The high prevalence of AIDS stimulates awareness in the population, reduces the resistance to discuss formerly taboo topics, such as sexual behavior and STDs. Several religious leaders are willing to participate.

- The prevalence of AIDS varies widely. Merauke showed the highest cases, probably because it has extensive hospital surveillance.

- The provincial health laboratory, though small, has experience in collecting and examining specimens for STD as well as HIV/AIDS.

- Economic development opened several previously inaccessible areas. With the industries come migrant workers (mostly men) living away from their families. There is a concern that economic development will be followed by sex industries, with the potential of spreading HIV/AIDS not only to the workers but also to the population surrounding the sites. Kaimana is vulnerable from that aspect. The increased price of kayu gaharu is a magnet for entrepreneurs to visit the area.

- The population (2,020,900) in Irian Jaya consists of 240 different ethnic groups. The illiteracy rate is high. Transportation problems are notorious in Irian Jaya.

- There is a concern about the cessation of funding from donor agencies.

RECOMMENDATIONS

- Strengthen provincial KPAD in management as well as coordination. Empower it by increasing its skills in planning, monitoring, and evaluating the program, and assist in securing funds for implementation.

- Strengthen coordination between Menko Kesra and KPAD, between sectors within the KPAD, between KPAD and NGOs, and between NGOs by meeting and communicating. There is a need for a permanent secretary of KPAD to synchronize capacity and needed service.

- The Master Plan should be focused on the areas suspected of high risk: the original village where the cases were first found, ports visited by Thai fishermen, and the border with Papua New Guinea (PNG), which has a higher incidence of HIV/AIDS. The variability of HIV/AIDS prevalence encourages mapping of the prevalence as well as the sexuality of the tribes and group of communities within the area to determine on which target groups to focus.

- Intervention should include surveillance, counseling, IEC, treatment for STDs as well as for opportunistic infections, antiviral treatment, and condom marketing. Monitor the treatment of STDs to ensure its appropriateness and prevent the resistance of the microbe toward the antibiotics. Collaborate with hospital or puskesmas (local health clinics) for referral treatment. AIDS patients with tuberculosis can be referred to

puskesmas with a tuberculosis program.

- Alleviating condom use as a sign for permissiveness of infidelity, by promoting the benefit of condoms in the prevention of other health problems, such as hepatitis.

- Include the provincial laboratory in planning and executing surveillance activities. Increase the power of the laboratory as a reference laboratory for the province.

- Sustainability of the intervention can be accomplished by fee for service.

ANNEX I

HIV/AIDS SITUATION IN MERAUKE, IRIAN JAYA

BACKGROUND

The acquired immune deficiency syndrome (AIDS) epidemic in Irian Jaya was realized when six human immunodeficiency virus (HIV) positive cases were diagnosed in Merauke in 1992. Until December 1998, the cumulative numbers of HIV positive and AIDS cases in Merauke were 86 and 69, respectively. All of the AIDS cases were detected in Merauke

POTENTIAL IMPROVEMENTS

1. Coordination among the sectors needs to be strengthened, including between KPAD and the NGOs.

2. Techniques in specimen taking and laboratory testing for the STD monitoring system need to be improved.

3. The methods used in sentinel surveillance need to be improved (e.g., sampling methods, recording, and reporting).

4. Confirmation tests for HIV are still conducted in Jakarta, causing delay in informing and counseling the patients.

5. Maintenance of the shelter program needs to be reconsidered and/or replanned.

6. Drug supplies and regimen have not followed the syndromic approach yet.

7. Approaches to indirect CSWs/bar girls need to be improved. Implicit messages will not make these individuals realize that they are at risk.

RECOMMENDATIONS FOR THE KANWIL/DINAS KESEHATAN PROVINSI IRIAN JAYA

1. A Master Plan for Merauke district following the Irian Jaya Master Plan should be developed. A workshop funded by the Australian Agency for International Development (AusAID) is planned for the near future. Technical assistance for local officials in developing the draft plan is recommended. In the planning phase, the concept of a drop-in center, shelter, and center for reproductive welfare should be clearly stated. Since the AIDS problem is not homogeneous among the 13 subdistricts in Merauke and resources are scarce, mapping is needed to set up priorities and to determine the epidemic status, ethnic sexual behaviors, high-risk communities, and gonorrhea susceptibility.

2. The AIDS epidemic in Merauke is further advanced than in other parts of Indonesia. A treatment program is necessary for STDs and opportunistic infections and to prevent vertical transmission (initially among pregnant women in Merauke hospital).

3. Universal precaution should be enhanced by providing training and supplying the necessary instruments. Training in counseling skills should also be provided.

4. To avoid a delay in achieving results, Jayapura should have the capacity to conduct HIV confirmation tests.

5. More attention should be devoted to the care of AIDS patients by strengthening NGOs in conducting home care and developing a buddy system.

6. One hundred percent condom use in lokalisasi is essential; a letter of instruction from related institutions is needed.

7. Prioritizing target groups and focusing the IEC programs to be locally, culturally, and group specific is necessary.

8. Improve and start sentinel surveillance among high-risk communities, male STD patients, antenatal care (ANC) for women, and tuberculosis patients.

9. Use Merauke as a field laboratory for training doctors, paramedics, and social workers in preventing and controlling HIV infection.