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2009

Indonesia

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Table 1: Overview

Executive Summary

File Name	Content Type	Date Uploaded	Description	Uploaded By
Indonesia- CN Summary Template - Revised.doc	application/msword	11/29/2008		MLee

Country Program Strategic Overview

Will you be submitting changes to your country's 5-Year Strategy this year? If so, please briefly describe the changes you will be submitting.

[X] Yes [ ] No

Description:

The basic strategy for the Indonesia FY09 PEPFAR program remains unchanged from FY08 at the $8 million level. At the $13 million level, the Partnership Compact concept paper will replace the FY08 strategy.

Indonesia has mounted a comprehensive response to the HIV epidemic with the primary goal of slowing new infections. While growing, it is still nascent in comparison to the more mature responses of other Asian countries. The role of the National AIDS Commission (KPA) was revitalized by Presidential Regulation 75/2006, which clarified the role of the KPA and identified provincial and district leadership as key actors. The National HIV and AIDS Costed Action Plan 2007-2010 provides a framework for government priorities and development partner support, emphasizing collaboration and avoidance of duplication. Operating under the principles of the Three Ones, the KPA has defined targets for the achievement of universal access to HIV prevention, care, support, and treatment as required by the UNGASS HIV/AIDS Declaration. Essential HIV/AIDS policies are in place; however, it is necessary for work to continue to assure compliance with updated global technical standards and guidelines. Government planning for the next phase of the HIV/AIDS Strategy (2010-2014) has already begun. With the rapidly growing need for care and treatment services a move to an increased level of synergy will be critical.

The GOI continues to actively seek USG engagement in the HIV/AIDS program. Over the last several years the focus has been on creating an enabling environment for effective interventions at the community level, and on generating quality surveillance data informing evidence-based programming. Provincial and district level emphasis has been to build local NGO capacity providing critical outreach and targeted referral networks to disenfranchised MARPs; this has included capacity building at the facility level to assure quality clinical services in a Continuum of Prevention to Care model (COPC) are delivered. In Papua this focus extended to limited Health Systems Strengthening in 10 districts. The USG bilateral program has achieved a strong impact in targeted technical and geographical areas, but interventions have been constrained by funding and the expense of maintaining activities throughout the archipelago.

In FY09 the USG continues to shift focus to technical assistance that will leverage and support the needs of the national HIV/AIDS program. FY09 funding will continue to support capacity building of local NGOS and networks. Linkages with civil society will be augmented through continued work with nascent funding laws to emphasize best practice models for increased sustainability, and local empowerment and leadership. DOD will undertake a programmatic assessment of their portfolio in January 2009. Assurance that appropriate capacity is present at the district clinical level through training and supervisory support will be maintained but direct services will not; thus the FY09 COP presents with increased emphasis on upstream targets and a decrease in downstream numbers.

If the potential Partnership Compact is awarded this will be coupled with a shift towards long-term technical assistance at national and provincial levels to internalize harmonized financing, surveillance techniques, and HSS; this approach will increase capacity to manage GFATM grants and leverage resources from the commercial private sector.

With the exception of DOD continuing work with TNI, the FY09 mini-COP is presented entirely as a TBD program. The predominant USAID cooperative agreement with FHI, through which NGO capacity building has been previously conducted will end in September 2009 and a new procurement will be undertaken to replace it by that time.

A major reprogramming effort is anticipated for the FY09 Mini-COP to accommodate the new procurement(s) and, hopefully, the Partnership Compact.

Ambassador Letter

File Name	Content Type	Date Uploaded	Description	Uploaded By
Ambassador's Letter.pdf	application/pdf	11/10/2008		RWardani

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Global Fund

What is the planned funding for Global Fund Technical Assistance in FY 2009?	$0
Does the USG assist GFATM proposal writing?	Yes
Does the USG participate on the CCM?	Yes

Table 2: Prevention, Care, and Treatment Targets

2.1 Targets for Reporting Period Ending September 30, 2009

Prevention	National 2-7-10	USG Downstream (Direct) Target End FY2009	USG Upstream (Indirect) Target End FY2009	USG Total Target End FY2009
End of Plan Goal				
1.2 - Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	0	54	500	554
1.3 - Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	0	2	15	17

Care (1)	National 2-7-10	USG Downstream (Direct) Target End FY2009	USG Upstream (Indirect) Target End FY2009	USG Total Target End FY2009
		2,444	26,986	29,430
End of Plan Goal				
6.2 - Total number of individuals provided with HIV-related palliative care (including TB/HIV)	0	2,444	26,986	29,430
***7.2 - Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator 6.2)	0	168	500	668
8.1 - Number of OVC served by OVC programs	0	0	0	0
9.2 - Number of individuals who received counseling and testing for HIV and received their test results (including TB)	0	13,742	37,000	50,742

Treatment	National 2-7-10	USG Downstream (Direct) Target End FY2009	USG Upstream (Indirect) Target End FY2009	USG Total Target End FY2009
		350	9,332	9,682
End of Plan Goal				
11.4 - Number of individuals receiving antiretroviral therapy at the end of the reporting period	0	350	9,332	9,682

Human Resources for Health	National 2-7-10	USG Downstream (Direct) Target End FY2009	USG Upstream (Indirect) Target End FY2009	USG Total Target End FY2009
		0	0	0
End of Plan Goal	0			
Number of new health care workers who graduated from a pre-service training institution within the reporting period.	0	0	0	0

2.2 Targets for Reporting Period Ending September 30, 2010

Prevention	USG Downstream (Direct) Target End FY2010	USG Upstream (Indirect) Target End FY2010	USG Total Target End FY2010
End of Plan Goal			
1.2 - Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	0	2,100	2,100
1.3 - Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	0	63	63

Care (1)	USG Downstream (Direct) Target End FY2010	USG Upstream (Indirect) Target End FY2010	USG Total Target End FY2010
	800	31,473	32,273
End of Plan Goal			
6.2 - Total number of individuals provided with HIV-related palliative care (including TB/HIV)	800	31,473	32,273
***7.2 - Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease (a subset of indicator 6.2)	0	650	650
8.1 - Number of OVC served by OVC programs	0	0	0
9.2 - Number of individuals who received counseling and testing for HIV and received their test results (including TB)	6,000	35,000	41,000

Treatment	USG Downstream (Direct) Target End FY2010	USG Upstream (Indirect) Target End FY2010	USG Total Target End FY2010
	0	10,650	10,650
End of Plan Goal			
11.4 - Number of individuals receiving antiretroviral therapy at the end of the reporting period	0	10,650	10,650

Human Resources for Health	USG Downstream (Direct) Target End FY2010	USG Upstream (Indirect) Target End FY2010	USG Total Target End FY2010
	0	0	0
End of Plan Goal			
Number of new health care workers who graduated from a pre-service training institution within the reporting period.	0	0	0

(1) Total Care represents number of OVC served by an OVC program during the reporting period and the number of individuals provided with facility-based, community-based and/or home-based HIV-related palliative care, including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis(TB).

Table 3.1: Funding Mechanisms and Source

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11354.09
System ID: 11354
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11355.09
System ID: 11355
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11357.09
System ID: 11357
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11359.09
System ID: 11359
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Table 3.1: Funding Mechanisms and Source

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11360.09
System ID: 11360
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11362.09
System ID: 11362
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11363.09
System ID: 11363
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11367.09
System ID: 11367
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Table 3.1: Funding Mechanisms and Source

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11369.09
System ID: 11369
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Contract

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11370.09
System ID: 11370
Planned Funding($): [redacted]
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: To Be Determined
New Partner: Yes

Mechanism Name: Partnership Framework Development

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 12189.09
System ID: 12189
Planned Funding($): $1,000,000
Procurement/Assistance Instrument: USG Core
Agency: U.S. Agency for International Development
Funding Source: GHCS (State)
Prime Partner: US Agency for International Development
New Partner: No

Mechanism Name: USAID M&S

Mechanism Type: Local - Locally procured, country funded
Mechanism ID: 11908.09
System ID: 11908
Planned Funding($): $533,000
Procurement/Assistance Instrument: Contract
Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Prime Partner: US Agency for International Development
New Partner: No

Table 3.1: Funding Mechanisms and Source

Mechanism Name: Contract

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 11361.09
System ID: 11361
Planned Funding($): $25,000
Procurement/Assistance Instrument: Contract
Agency: Department of Defense
Funding Source: GHCS (State)
Prime Partner: US Department of Defense
New Partner: No

Mechanism Name: Contract

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 11364.09
System ID: 11364
Planned Funding($): $50,000
Procurement/Assistance Instrument: Contract
Agency: Department of Defense
Funding Source: GHCS (State)
Prime Partner: US Department of Defense
New Partner: No

Mechanism Name: Contract

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 11365.09
System ID: 11365
Planned Funding($): $48,000
Procurement/Assistance Instrument: Contract
Agency: Department of Defense
Funding Source: GHCS (State)
Prime Partner: US Department of Defense
New Partner: No

Mechanism Name: Contract

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 11366.09
System ID: 11366
Planned Funding($): $69,500
Procurement/Assistance Instrument: Contract
Agency: Department of Defense
Funding Source: GHCS (State)
Prime Partner: US Department of Defense
New Partner: No

Table 3.1: Funding Mechanisms and Source

Mechanism Name: Contract

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 11368.09
System ID: 11368
Planned Funding($): $40,000
Procurement/Assistance Instrument: Contract
Agency: Department of Defense
Funding Source: GHCS (State)
Prime Partner: US Department of Defense
New Partner: No

Mechanism Name: Contract

Mechanism Type: HQ - Headquarters procured, country funded
Mechanism ID: 11371.09
System ID: 11371
Planned Funding($): $17,500
Procurement/Assistance Instrument: Contract
Agency: Department of Defense
Funding Source: GHCS (State)
Prime Partner: US Department of Defense
New Partner: No

Table 3.2: Sub-Partners List

Mech ID	System ID	Prime Partner	Agency	Funding Source	Sub-Partner	TBD Funding	Planned Funding

Table 3.3: Program Budget Code and Progam Narrative Planning Table of Contents

Program Budget Code: 01 - MTCT Prevention: PMTCT

Total Planned Funding for Program Budget Code: $35,000

Program Area Narrative:

The relative proportion of total HIV infections that occur among women in Indonesia has grown from 12 % in 1999 to 21 % by end of June 2008 (cumulative HIV/AIDS cases, MOH, July 2008). Over 53% of all reported HIV/AIDS cases are in the 20-29 year old age group. Though the absolute numbers of women and children with HIV are still small, HIV prevention programs and intervention services regularly identify women with HIV, almost all of them of reproductive age and sexually active. Nearly 92% of women have had at least one ANC visit (DHS 2007). Over 54% of women give birth in their homes. Among women who deliver in facilities, more than 3 times as many choose private clinics. Approximately 73% of pregnant women deliver with the assistance of a nurse/midwife (DHS 2007). The MOH estimates that between 2,250 and 3,250 newborn infants are at risk for HIV each year. Pregnant women suspected to be at risk of HIV are currently offered testing using a HIV rapid test triple algorithm with opt-in testing approach. According to the MOH, 16.5% of estimated HIV infections in the country are in Papua, despite the fact that it contains only 1.4% of the nation's population. The 2006 Papua General Population IBBS found a prevalence rate of 1.9% among women in Papua, with 2.22% among ethnic Papuan women.

Between 2003 and 2005, PMTCT capacity-building training for staff from the Ministry of Health and NGOs was facilitated by UNICEF. National guidelines for PMTCT were completed in late 2005 with support from USG and recommend the use of Zidovudine and Neverapine using opt-in testing approach. The national PMTCT training curriculum has been developed, but there are on-going issues related to best practice. For the time being, the MOH is using the WHO module, which has been translated to Bahasa Indonesian. The Directorate of Maternal Health was designated in 2005 to take the lead on developing PMTCT strategies within the MOH; however, it has not provided any on-going TA or mentoring. Since the development of the national guidelines, the MOH has sponsored two PMTCT trainings which have been attended by 163 participants, including OB/GYN, pediatricians, midwives, nurses, public health officers, and NGO staff.

In the National Guidelines for the PMTCT of HIV/AIDS, the MOH is responsible for establishing a sustainable and integrated PMTCT program to be implemented within the existing primary health care system, including the family planning infrastructure at the sub-district and community levels, as well as the 75 referral hospitals supported in GFATM Round 4 to provide HIV/AIDS CST. Despite this mandate, the need for PMTCT is not widely recognized in the general population or by most district authorities. With GFATM Round 4 funds, a PMTCT assessment was undertaken in 2005. Findings suggested a very low knowledge about PMTCT services, even among health providers, and continuing high levels of stigmatization of people living with HIV/AIDS. HIV/AIDS continues to be perceived as an issue for those engaging in deviant and immoral behaviors. Stigma and discrimination makes women reluctant to avail themselves of services for fear that they will be branded as members of an objectionable group.

Due to a lack of funding, the current national PMTCT program exists in name only, with no generalized mainstreaming occurring within maternal and child health services. PMTCT was a focus of the Round 6 GFATM HIV proposal, which was not funded. As a result, PMTCT service coverage remains low, available only in 12 large hospitals, 2 community health centers and a handful of NGO sites. Most antenatal care in Indonesia occurs at the community level in publicly funded primary care or satellite clinics or with private midwives. While PMTCT was a part of the GFATM Round 7 proposal, Indonesia failed to receive funding.

In view of the concentrated nature of the epidemic in Indonesia, both the national program and USG-supported efforts to date have focused on most at risk groups and more recently on the general population of Papua. HIV prevalence rates Direct FSW and Indirect FSW were 6-16% and 2-9% respectively, among high risk men (HRM) was 0.2-1.8% (2006 IBBS).

PMTCT is a small component of the USG program. The USG response has focused on the integration of targeted PMTCT into a one-stop Continuum of Care (CoC) model featuring comprehensive integrated service packages including STI, CT, TB screening and treatment and case management services. The CoC service models are designed to provide services to FSW, men who pay for sex, IDU and their partners, and men who have sex with men, including male sex workers (MSW) (most of whom are married). The PMTCT services include information and counseling on the possibility of the client or their partner getting pregnant, the risk of transmitting STI or HIV to a baby, and available prevention measures. Assistance will be given for accessing contraceptive measures, if required. In Papua, USG continues to support the integration of PMTCT into the overall GOI health systems strengthening efforts, which includes the implementation of the CoC network model plus improvements in supply chain management, human resources, management systems, and infrastructure.

The USG program will continue to work towards preventing women of reproductive age who are at risk for becoming infected with HIV from contracting and passing on the virus. Specific activities include: (1) training counselors on pregnancy counseling and couple counseling skills; (3) technical assistance for implementing opt out CT, prevention for positives, access to treatment for mothers and newborns under a revised protocol; (4) increasing access to contraceptives through referral to family planning programs; (5) supporting efforts to implement capacity-building on the use of ARV for PMTCT, including training OB/GYNs, pediatricians, general practitioners and midwives; (6) supporting specific training on clinical management of drug addiction as

related to PMTCT; and (7) in Papua, further integration of PMTCT with MNH, malaria, TB and safe water programs.

In FY08, the USG supported the integration of PMTCT into the CoC service models implemented in the 3 non-Papua MARPS-focused sites. These pilots modeled for the GOI implementation of high quality PMTCT services with realistic costs. USG-supported activities were also designed to help the GOI establish service models that include linkages for care, support and treatment for eligible women and children after delivery. In model sites, USG supported the following activities (1) linking comprehensive services and developing a smooth referral system; (2) implementing counseling, couple counseling, and access to contraceptive measures; and (3) in collaboration with nearest ARV hospital, implementing antenatal care, ARV following the WHO recommendations, safe delivery, infant feeding counseling, neonatal care, and postnatal care.

In Papua, PMTCT services are being integrated into the one-stop CoC service network in 10 districts in Papua. In FY09, the USG will support a PMTCT pilot with one- stop CoC service model (PMTCT Prong III). Developed for IDUs and their partners, these services include targeted PMTCT and TB screening and treatment. The model will be implemented initially through Gondang Legi Public Health Center (PHC) and another PHC in Malang, Gambir PHC and other 3 PHC in Jakarta in collaboration with UNICEF, WHO and HCPI. In Papua, technical assistance will be continued for one-stop CoC services to be piloted through six public health centers in Jayapura and Sorong and one public health center in each of ten districts, as well as in two hospitals. These services will target HIV-positive pregnant women, and will provide appropriate ARV treatment, safer delivery, medical follow-up of the newborn, and counseling on breast feeding and informed choice.

In collaboration with partners, GOI responsibility includes scaling-up and obtaining future funding. Acceleration of decentralization of CST services from hospitals to the community health center level will facilitate the scale-up of PMTCT. The speed of the scale-up depends on how quickly and effectively the GOI can utilize GFATM funding.

There are no current plans for USG HIV specific funds to be used to strengthen approaches for infant follow-up, OVC and routine MCH beyond the pilot service models. In Papua, other USG wrap around funds may be used for the integration of PMTCT activities.

Table 3.3.01: Activities by Funding Mechansim

Mechanism ID:	11354.09	**Mechanism:**	Contract
Prime Partner:	To Be Determined	**USG Agency:**	U.S. Agency for International Development
Funding Source:	GHCS (USAID)	**Program Area:**	Prevention: PMTCT
Budget Code:	MTCT	**Program Budget Code:**	01
Activity ID:	27246.09	**Planned Funds:**	[redacted]
Activity System ID:	27246		
Activity Narrative:	N/A		
New/Continuing Activity:	New Activity		
Continuing Activity:			

Program Budget Code: 02 - HVAB Sexual Prevention: AB

Total Planned Funding for Program Budget Code: $0

Program Area Narrative:

Indonesia is comprised of over 220 million people and is at a critical crossroad in the transmission of HIV/AIDS. While the national HIV prevalence among the adult population is estimated to be 0.01%, the low prevalence rate among the general population masks HIV sub-epidemics within Most At Risk Populations (MARPSs), including Injecting Drug Users (IDU), Female Sex Workers (FSW), clients of sex workers/high risk men (HRM) and men who have sex with men (MSM), including transgenders/waria.

In 2006, the National AIDS Program (KPA) with technical assistance from the USG-funded Aksi Stop AIDS program (ASA) conducted a size estimation exercise for MARP groups. The media population sizes were determined to be 219,200 for IDU, 221,120 for FSW, 766,800 for MSM, 28,130 for transgenders/waria, and 3,161,920 for high risk men (HRM)/clients of sex workers. The figures represent varying degrees of accuracy with some estimates being more evidence-based than others. In 2007, an Integrated Bio-Behavioral Survey (IBBS) was conducted among selected high risk populations, again with support from ASA.

Direct (brothel-based) and indirect (karaoke bar) female sex workers (DFSW and IDFSW) were sampled in 16 sites across the country. In seven cities, the HIV prevalence rates among DFSW were greater than 10% with the highest rates occurring in the Papuan cities of Sorong (16.9%) and Jayapura (14.4%). Several cities also had rates over 5% among IDFSW (Batam – 8.8% and Sorong – 8.3%). STI rates were also very high among DFSW with the highest rates of STI reported in the following sites - active syphilis in North Sumatra (12.9%), gonorrhea in Jakarta (41.2%) and Chlamydia in West Java (55%).

While condom use at last sex increased between 2002 and 2007, the percentage of DFSW and IDFSW who reported that they always used condoms in the last week remains insufficient (32% and 36%, respectively). On the other hand, FSW report that when they do propose condom use to their clients, condoms often do get used – 77% acceptance by clients of DFSW and 84% by clients of IDFSW. Among FSW who report having had multiple contacts with prevention outreach workers, the rate of condom proposal increases to 90%, demonstrating the effectiveness of outreach efforts. A major challenge is that a large proportion of FSW are infected with HIV within the first six months of initiating sex work, before they are exposed to prevention interventions. Younger sex workers (< 25 years) are more likely to be HIV+ - 12.8% versus 9.4% for DFSW and 5.8% versus 3.9% for IDFSW.

Most transgender/waria report selling sex (95.6% in Bandung, 90% in Surabaya and 82.4% in Jakarta) and about half report having regular male partners. HIV prevalence among waria is high – 34% in Jakarta, 25.2% in Surabaya and 14% in Bandung – and continues to rise (21.7% in 2002 to 34% in 2007 in Jakarta). HIV prevention intervention coverage among waria is high with 80-90% of waria reporting contact with a worker in the past 3 months; STI referrals are also high and significant numbers of waria reported receiving HIV test results. Injecting drug use is virtually non-existent and non-injecting drug use is modest, but alcohol use is high with over 50% of waria reporting drinking. Consistent condom use in anal sex is insufficient ranging from less than 50% in Bandung to about 10% in Jakarta; and despite high STI referral rates, most waria do not follow-up on attendance at STI clinics.

Prevalence rates among MSM are comparable to IDFSW – 8.1% in Jakarta, 5.6% in Surabaya, 2.0% in Bandung). Among MSM who participated in the IBBS, rectal STI rates are high at around one-third of MSM testing positive for a rectal STI. The majority of MSM who engaged in insertive and receptive anal sex reported not always using a condom in the past month. Ten to twenty percent of MSM reported that they had never used a condom, and most MSM have never purchased condoms. Some MSM cite a lack of condom and lube availability. Like the waria, MSM have a high degree of knowledge about male-to-male transmission and HIV prevention. Several cities report high rates of coverage by outreach workers with multiple contacts, but limited condom use and only modest numbers of MSM (~30%) follow-up on referrals for HIV testing underscore the need to insure not only coverage, but also to develop and implement effective of behavior change interventions among MSM (and waria).

The 2007 IBBS also focused on 4 groups of HRM – dockworkers, moto-taxi drivers, truckers and seafarers. HIV prevalence among these groups revealed differing patterns between the groups according to geography. In Papua, 3.0% of dockworkers and 1.0% of moto-taxi drivers were HIV+ - rates that are in line with the 2.9% prevalence rate among general population men in Papua. In the rest of Indonesia, HIV was not detected among dockworkers and moto-taxi drivers; HIV prevalence among truckers (0.2%) and seafarers (0.5%) was higher than in general population males. The majority of seafarers and truckers had multiple partners (64% and 60%, respectively) and reported sex with FSW (45% and 60%, respectively). They also reported using condoms with FSW less than 50% of the time in the past 3 months. Less than 50% of HRM demonstrated adequate knowledge regarding HIV prevention.

In Papua, where the epidemic is generalized, the data from the recent Papua general population IBBS conducted in 2006 coupled with the 2007 MARP IBBS data for Papua, reveal that the low prevalence, generalized epidemic in Papua is still driven by commercial and transactional sex. Data showed that HIV was higher among men (2.9%) than women (1.9%); among persons who had more than 2 sexual partners in 1 year (4.0%); those who engaged in sex for payment (5.1%). The HIV prevalence among men who had a history of STI in Papua was 5.9%. More than 20% of male residents reported more than one sex partner in the past year compared to 8% of female residents. The 2007 FSW data from Papua combined with the general population data show that high risk men and commercial/transactional sex workers continue to be the main drivers of the epidemic in Papua. The World Bank is currently supporting an ethnographic study with Cendrawasih University to understand the dynamics of commercial and transactional sex work in Papua.

In most of Indonesia, the level of sexual activity among non-MARP youth is fairly low and conservative social norms are effective in discouraging pre-marital sexual activity. While data on the age of sexual debut is limited, it is believed that age at first marriage closely corresponds to the age of sexual debut. The median age at first marriage for women is 19.5 years.

The primary focus of the GOI national prevention efforts is, appropriately given the data, on preventing HIV transmission between

FSW and clients, harm reduction among IDU and sexual transmission among MSM and IDU and their partners, with minimal prevention efforts directed at the general population and youth.

The KPA and the MOH are fully supportive of comprehensive prevention efforts. However, full implementation of an effective response to prevent new HIV infections has been hindered by a variety of issues, including: (1) lack of consensus among key GOI bodies and conservative groups; (2) regulatory barriers; (3) budgetary constraints related to a general economic downturn; and (4) reluctance of the GOI to formally acknowledge the magnitude of the commercial sex industry in the country. The condom supply has been problematic. According to the IBBS condoms are not readily accessible where many FSW work. Only 45% of DFSW can obtain condoms at the localisasi (brothel area) and only 15% of IDFSW can get condoms at their place of employment. Recently, the MOH has stopped procuring condoms using GOI funding. This has led to shortages in free condoms to NGOs working with MARPs. While DKT offers several brands of socially marketed condoms, there is limited national condom advertising and distribution.

Given the nature of the epidemic in Indonesia, there are few AB programs, including those supported by other international organizations. The development of a national communications strategy featuring comprehensive HIV/AIDS prevention messages, including AB, is in process through the KPA, but has been slow in coming to fruition. AusAid has, as a focus for their HIV program, a comprehensive behavioral communication program in Papua targeting the general population, including youth. In addition, UNICEF will be expanding its efforts to general population youth in Papua, incorporating AB messages.

USG-supported program efforts targeted 80 districts, located in 8 USG priority provinces. These districts were chosen, in consultation with the KPA because they are sexual and IDU transmission “hotspots,” which means that they have considerable MARPs populations engaged in high risk behavior, and need additional resources to mount a prevention effort to impact the epidemic. USG support for NGOs targeting MARP is designed to contribute to the national objective of reaching 81% of MARPs in each of these priority provinces by 2010. The targeted MARPs for the USG-supported program include FSW, MSM, and other high risk men which include both actual clients at sexual transmission “hotspots” and potential clients (as more information defines who those clients actually are).

In previous years, ASA provided technical assistance through direct funding mechanisms to FBOs and other community groups for organizational capacity building to work with youth and high risk groups including developing AB messages for FBOs and themes for political leaders, FBOs and religious groups. Future USG programs will continue to advocate for a more active role of religious organizations, FBOs, and community groups in the fight against HIV/AIDS. USG programs continue to support groups such as the Catholic Dioceses in Papua, the Gereja Protestan Indonesia di Papua (GPI Papua), and Mohammadiya – the 2nd largest Muslim group in the country, to assist them in mainstreaming HIV/AIDS prevention, care and treatment and stigma and discrimination messages into their general programs.

In FY08, USG funding supported 66 selected NGOs and CBOs to implement the basic prevention intervention package for MSM, waria, FSW and HRM, including clients of sex workers. The basic MARP prevention intervention package consisted of peer outreach with IEC materials, including “B” messages for HRM; condoms, lubricants and safe sex kits; targeted multi-media campaigns, including innovative internet campaigns for MSM; peer support groups; negotiation skills training; and policy interventions, including 100% condom policies and STI testing for brothel-based FSW. As part of the Continuum of Prevention and Care (COPC), each community-based NGO is linked with and provides referrals to either a GOI or NGO clinic for case management, CT, and STI screening and treatment. ASA also supported the KPA’s efforts to make female condoms more widely accessible throughout Indonesia, especially to FSW and women who may be engaged in commercial/transactional sex in Papua.

In FY08, USG supported 5 NGOs who work exclusively with private sector businesses and government ministries on ABC workplace programs for HRM, including clients and potential clients of sex workers. Other NGOs targeted port workers, truck stops and other points along major highways where CSW services are available with aBC messages. Gender-based violence and inter-generational sex continued to be addressed through messages stressing that these practices are socially unacceptable, particularly among HRM in Papua. These messages as well as VCT and case management were incorporated into all IEC materials and training curricula provided to individuals in outreach areas including hotspots and workplace programs.

Alcohol and/or gender-based violence (GBV) issues among certain groups such as HRM in Papua and waria need to be addressed as part of effective HIV prevention behavior change interventions, USG/Indonesia is interested in strengthening these themes in future interventions and has initiated consultations with the MARPs TWG to undertake an assessment/programmatic design visit exploring such programming in among relevant populations.

In 2007 USG funds were used to support specific health clinics to conduct STI services. The emphasis in FY08 funding shifted the approach from funding specific clinics to helping the provincial and district health services develop systems to serve MARPs --- including expansion of local STI services to other clinics (NGOs) and strengthening the system (training, mentoring, quality assurance, reporting). Pilot studies conducted by ASA in 2008 showed that a move away from enhanced syndromic management for FSW and toward the introduction of periodic presumptive therapy (PPT) with a package of standard medication which can effectively treat STI with easier adherence requirements, can successfully address STI rates among FSW and may be able to reduce HIV transmission.

In FY07 DOD funding for peer education sessions was conducted in selected locations in South Sulawesi and East Kalimantan in support of the TNI overall peer education program. In FY08 USG funding was allocated to coordinate, plan and support ‘traveling’ peer leader workshops to Indonesian Defense Forces (TNI) throughout the country. PUSKES medical staff and TNI officers were trained as peer leaders. These activities will be re-energized in FY09 with a greater number and geographic distribution of peer education activities. Increased funding for peer education activities will allow for an additional training of trainers (TOT), bringing the total up to three peer leader workshops for non-medical military troops and new recruits. These workshops will further provide the opportunity for the TNI/PUSKES to develop its own peer leader TOT workshop using and adapting the training and material

resources from the FHI-organized, national TOT workshops. Training materials will include behavior change tools that address gender through male norms and behavior that lead to risk for infection. Condoms will be procured and funds will also support technical support and travel as required.

With FY 09 funds, USG programming will build on existing successes in support of the integration of NGOs and GOI partners to scale-up and improve the quality of the outreach-, clinic- and institution-based interventions for MARPs described above in the 80 priority districts, with an emphasis on developing, implementing and evaluating more innovative and effective behavior change interventions.

Program Budget Code: 03 - HVOP Sexual Prevention: Other sexual prevention

Total Planned Funding for Program Budget Code: $5,500,000

Table 3.3.03: Activities by Funding Mechansim

Mechanism ID: 11355.09
Mechanism: Contract
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Program Area: Sexual Prevention: Other sexual prevention
Budget Code: HVOP
Program Budget Code: 03
Activity ID: 27247.09
Planned Funds: [redacted]
Activity System ID: 27247
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Table 3.3.03: Activities by Funding Mechansim

Mechanism ID: 11364.09
Mechanism: Contract
Prime Partner: US Department of Defense
USG Agency: Department of Defense
Funding Source: GHCS (State)
Program Area: Sexual Prevention: Other sexual prevention
Budget Code: HVOP
Program Budget Code: 03
Activity ID: 27256.09
Planned Funds: $50,000
Activity System ID: 27256
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Program Budget Code: 04 - HMBL Biomedical Prevention: Blood Safety

Total Planned Funding for Program Budget Code: $0

Program Area Narrative:

The HIV epidemic in Indonesia has historically been concentrated among injecting drug users (IDU). The first case of HIV among IDU was diagnosed in 1995 and since then, HIV has spread rapidly among the IDU community. The expansion of the epidemic into other risk groups in Indonesia can be attributed, at least in part, to sub-epidemics among IDU.

According to the MOH size estimations made in 2006, there are approximately 219,200 IDU in Indonesia. The majority of these are located in urban areas on Java, Bali and in North Sumatra.

IDU are estimated to make up approximately 55% of PLWHA (range: 169,410 – 216,740). The 2007 Integrated Bio-Behavioral Survey (IBBS) of MARPs, conducted with support from the USG-funded Aksi Stop AIDS (ASA) program, reported an overall HIV prevalence among IDU sampled from 6 sites (in Java and North Sumatra) to be 52.4%, with prevalence shown to be consistently high across different provinces.

The majority of IDU are young – 31.1% are below 24 years of age and additional 46.9% are between the ages of 25-29 years old – and male (96.2%). IDU in Indonesia begin injecting at a young age with 29% reporting initiation of injecting before the age of 18 and an additional 29% reporting initiating injecting between 19-21 years of age. Most IDU report having injected drugs for more than 3 years - 60% of IDU in Jakarta and over 80% in Bandung and Surabaya. According to the IBBS, the most common drugs used by IDU in Indonesia are heroin, subutex (buprenorphine) and amphetamine. Over 90% of heroin is administered by injection, with about 50% of subutex reported to be administered by injection. Amphetamine injection is rare with less than 10% of IDU reporting injection.

According to the IBBS, the only other significant non-injecting drug use was methamphetamine use among MSM in 2 cities. Thirty -one percent of MSM in Jakarta and 25% in Batam reported using methamphetamine in the last 3 months. In all other MSM sites, 10% or less of MSM reported methamphetamine use. No other MARP group reported significant use of non-injecting drugs.

Given the high prevalence rates among IDU, sexual transmission of HIV remains a major concern. Most IDU are sexually active. Thirty percent had a single partner (with about one quarter reported being married) and 47% reported multiple partners in the past year. IDU also serve as a bridge group to FSW; 32% of IDU reported purchasing sex while consistently using condoms with sex workers only 32% of the time. Consistent condom use was also low with regular partners (13%) and casual partners (24%). Fifty percent of IDU have regular partners and IDU report that most of their regular partners (73%) know that he/she is an IDU.

IDU who participated in the 2007 IBBS demonstrated an incomplete knowledge of HIV. While 94% know that HIV can be transmitted through sharing needles, only 11% demonstrated comprehensive knowledge of HIV transmission. Most IDU know where to go to get HIV testing (84%), but only 48% have been tested and only 44% know their results. Of those who received their results, around 60% shared the results with their regular partner, but reportedly less than 20% of these partners went for testing.

Over the past several years, a primary focus of the GOI national prevention efforts has been on preventing injection-related HIV transmission among IDU through comprehensive harm reduction efforts and sexual transmission between IDU and their partners. While the KPA and the MOH are fully supportive of comprehensive harm reduction efforts, full implementation of an effective response to prevent new HIV infections among IDU has been hindered by a variety of issues, including: (1) lack of consensus among key GOI bodies and conservative groups; (2) regulatory barriers; and (3) police cooperation at the local level, although these issues are being now being addressed. There has been a degree of success with harm reduction efforts as more than half of the IDU report having used HIV-related services according to the IBBS. Outreach coverage of IDU was high in 4 cities but was only 50% in Jakarta and Surabaya, Indonesia's two largest cities.

Currently, AUSAid, GFATM, and the IPF provide the funding to support comprehensive IDU prevention efforts, including support for prison programs. Prior to 2006, USG funds were used to support the ASA program to conduct HIV prevention outreach efforts among IDU. At that time, the USG-supported ASA program leveraged a significant increase in funding from DfID and the Indonesian Partnership Fund (IPF) specifically for scaled-up and comprehensive IDU prevention efforts. Given that USG legislation DOES support prevention programs for IDU that include the use of bleach to disinfect needles and syringes and medication-assisted therapies, including methadone maintenance (MMT), but DOES NOT provide support for needle and syringe exchange programs (NSP), and because sufficient resources for coordinated IDU prevention were available through other donors it was felt that USG programming would better contribute to public health best practices, and stemming of the HIV/AIDS tide in Indonesia by concentrating USG funding on support for HIV prevention programs on the other MARPs – FSW, MSM, transgenders and high-risk men.

Forty-four NGOs and 65 puskesmas (district health centers) are currently working in the area of harm reduction with IDU. As of June 2008, there were 24 methadone clinics serving 3,000 IDU. The KPA target is to have 58 clinics opened by the end of 2008. The KPA plans to provide MMT services for 50,000 IDU by 2010.

Prior to FY08, the USG supported efforts in prisons since a significant number of those incarcerated are in prison on drug or drug-related offenses. Activities included conducting staff training, linking NGOs with prisons to conduct prevention activities on site, and strengthening referral systems for prevention, care and treatment with the objective of developing comprehensive prison

programs for national scale-up. In FY08, the USG transitioned out of its work with prisons as AUSAid in collaboration with other international donors, the KPA, the Department of Corrections, the National Narcotics Bureau, and the MOH, made the decision to build on previous USG efforts and support the development of a national strategy and roll-out plan for prison programs, including the provision of bleach, condoms, MMT and ART.

While no USG funds are being used for specific IDU HIV prevention programming, USG funding remains instrumental in enabling IDU to access CT, care and support services through the Continuum of Prevention and Care (COPC) model. HIV+ IDU receive USG supported services in COPC sites. In FY 08, pilot COPC sites for MARPs were developed at 3 sites in Java.

The COPC model involves linking NGOs and CBOs that provide outreach and harm reduction services to IDU (as well as NGOs working with other MARPs) to the district health centers which provide CT, STI services, and PMTCT. The district health centers also provide case management, HIV/TB services, OI and ART services for HIV+ IDU. As part of the model, the IDU NGOs also work in the prisons to insure that incarcerated IDU are linked to services upon discharge, and work with a variety of community providers to insure provision of home-based care for IDU who have AIDS. Community-based IDU service providers also are linked to MMT services which are currently provided at clinics and district hospitals in efforts to provide referrals and follow-up of MMT clients, as well as to residential drug treatment and outpatient and family counseling services.

The structuring of ASA program technical assistance and support to the IDU NGOs and CBOs participating in the COPC model results in these NGOs also conducting activities relating to sexual transmission among IDU and their partners.

In FY09, USG funds will continue to be used to support IDU and their partners accessing the COPC system as well as helping to address sexual transmission risks among IDU and their partners. For other non-injecting drug users among MARPs, the focus will be on establishing sexual prevention activities for MSM which address methamphetamine use.

Program Budget Code: 05 - HMIN Biomedical Prevention: Injection Safety

Total Planned Funding for Program Budget Code: $0

Program Budget Code: 06 - IDUP Biomedical Prevention: Injecting and non-Injecting Drug Use

Total Planned Funding for Program Budget Code: $0

Table 3.3.06: Activities by Funding Mechansim

Mechanism ID: 11357.09
Mechanism: Contract
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Program Area: Biomedical Prevention: Injecting and non-Injecting Drug Use
Budget Code: IDUP
Program Budget Code: 06
Activity ID: 27249.09
Planned Funds: [redacted]
Activity System ID: 27249
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Program Budget Code: 07 - CIRC Biomedical Prevention: Male Circumcision

Total Planned Funding for Program Budget Code: $0

Program Budget Code: 08 - HBHC Care: Adult Care and Support

Total Planned Funding for Program Budget Code: $640,000

Program Area Narrative:

UNAIDS estimates there are 270,000 Indonesians infected with HIV (2008). The GOI recently reported that ART services were available at approximately 237 health facilities, including 124 hospitals and a limited number of Community Health Centers. A recent round of monitoring visits to ART sites, jointly undertaken by the MOH, WHO and the USG-supported Aksi Stop AIDS (ASA) Program, implemented by FHI, suggests, however, that the number of sites actually providing services is much smaller and is largely confined to the original 25 hospitals covered in the national scale-up scheme. The Minister of Health has proposed a more rapid expansion of ART service sites, with a target of 482 facilities by the end of 2010. Sufficient resources needed to accomplish this have yet to be identified, although Indonesia was recently awarded a GFATM Round 8 grant that may help address some of the resource needs.

The MOH reports that by the end of April 2008, there were 28,086 people accessing some form of HIV care and/or treatment services. The MOH estimates the number of HIV+ individuals who are or should be receiving ARV therapy services to be approximately 17,095. Of these, only 13,737 persons have ever received ART - 11,142 males, 2,322 females, and 293 children under 14. Additionally, 8145 (60%) were actively on ARV treatment in April 2008 (MOH report on the 2008 Indonesian HIV/AIDS Situation Response Report). The MOH, with support from the GFATM, anticipates expanding the number of individuals receiving ARV combination therapy to 15,000 by March 2010. There are limited data available on treatment adherence, treatment failure, drug resistance, so assessing the quality of program efforts to date is difficult.

The first line ART regimen is AZT + 3TC + NVP, with the following alternative regimens: AZT + 3TC + EFV, d4T + 3TC + NVP, and d4T + 3TC + EFV. The approved second line regimen, TDF + ddI + Lop/r, is problematic because TDF and ddI should not be used in combination. The approved second line regime has been reviewed and is expected to be adjusted. According to MOH, ART drugs and CD4 tests are provided free-of-charge by the GOI, supported by GFATM. In practice, barriers to free ART and CD4 remain as local providers interpret the policy in different ways (e.g., only for registered residents of the district where they are seeking services, only for the indigent, not for active IDU). All other treatment costs must be borne by patients.

The MOH is responsible for supply chain management of ARV drugs. Although there appears to be sufficient funding from GFATM, concerns continue to be voiced from the field as to the reliability of supplies. This is particularly the case in Papua. A USAID core-funded situational assessment of the commodities management system in Tanah Papua was conducted by SCMS in October 2007. The resulting report stated that any strategic design for a supply chain management system must be constructed so that it meets the needs of the local hospital and community health center (puskesmas) level. The assessment report serves as a starting point in the development of a master plan to strengthen the supply chain system in parallel with a possible health systems strengthening initiative which could be funded under the USG Compact.

The USG, through ASA, has supported the development of a Continuum of Prevention and Care (COPC) network which links, coordinates and consolidates care, treatment, and support services for PLHIV. COPC services are provided to PLWHA in their homes, in the communities where they live, and in the health facilities that serve them through a partnership between the government (and other) supported hospital and health centers and civil society (NGO/CBO/FBO). While COPC services are generally provided by a number of different organizations, the system that links and coordinates them is planned and managed by the COPC-Coordination Committee whose members include government officials, service providers, non-governmental organization (NGO) representatives, PLHIV, and other stakeholders operating at the district/municipal level.

The USG program prioritizes implementation of the MOH strategic plan to include Community Health Centers as ART sites, starting as satellite sites to hospitals, in order to accelerate universal access to ART and through FHI/ASA has been a key MOH partner in adapting the IMAAI (Integrated Management of Adult and Adolescence Illnesses) approach for HIV/AIDS case management to provide clear implementation guidelines on initiation and management of ART patients at hospitals and Community Health Centers, respectively. Case managers function as an integral part of CST teams, providing out-of-hospital/clinic psycho-social support, advocacy, and follow-up, including adherence support. Case management is critical for supporting treatment adherence which cannot be adequately addressed by hospital/clinic staff. The role of case managers in the COPC is particularly critical with regard to ART and opportunistic infection (OI) drug supplies, which are frequently interrupted due to weaknesses in the supply chain. Case managers have served as a vital link by locating alternative supplies and ensuring that their clients can continue the therapy without interruption.

In FY07, the USG began to pilot the COPC network model focusing on MARPs in 3 sites in Java (DKI/Jakarta, West Java (Bandung) and East Java (Malang). The COPC network model focuses on 2-3 health centers in each site. In Papua, the health system strengthening effort focused on implementing the COPC in at least 1 health center in each of 5 (out of 10) priority districts. USG FY08 funds were used to scale-up services in the MARPs COPC, continue efforts in the 5 initial Papua districts and initiate the COPC in 5 additional districts. Integrated palliative care and treatment services for PLHWA were made available through these selected community health centers. Services consist of chronic, acute, and palliative care, including OI prophylaxis, OI treatment, ART, PMTCT, and TB screening and treatment.

A major initiative undertaken with FY08 funds provided leadership and technical support to the MOH in shifting care, support and

treatment efforts from a limited, facility-based “case management” model to a “community and home-based care” approach; and continued expansion of coverage and improvement in the quality of community-based ART adherence counseling and support through ASA’s network of NGO community-based case managers. Using FY09 funds, USG will pilot palliative and home and community based care (HCBC) initiatives to be implemented in Jakarta and Papua as a first step in developing long-term care services for PLWHA. Based on this experience, a model program will be defined and appropriate training curriculum and management systems will be developed for use in future expansion in East and West Java. Key components of the program will include proactive linkages among PLWHA, improve access and quality of care, treatment and support for PLWHA with a focus on increasing VCT, treatment for OI and community-based care and support, case managers, clinical service providers and HCBC service providers, and home visit teams to provide direct care and adherence support in the community. Efforts focused on refresher training in adherence monitoring and counseling for NGO and health facility staff, as well as improving linkages between community-based support staff and health facilities that provide ART clinical services through regular case and program review meetings. In addition, USG funds supported testing special palliative care service configurations to meet the needs of IDU. Several clinics that received special training in the management of HIV/AIDS for IDU received additional training in FY08 to undertake detailed health assessments for newly diagnosed IDU HIV+ individuals. The results of the health assessments will provide a basis for developing treatment and referral plans, including TB screening and treatment, and management of Hepatitis C for the above initiatives.

The concept of HIV palliative care is not well established in the Indonesian public health system; the most common perception is that it entails end of life care and an emphasis on OI prophylaxis and treatment. The MOH has developed a national policy and established targets for “PLWA care and support services,” but guidelines lack a comprehensive description of the standards and services to be included in the service package. The WHO, along with the USG-supported Aksi Stop AIDS (ASA) Program, implemented by FHI, and the AusAID-funded Indonesian HIV/AIDS Prevention and Care Program, are currently working with the MOH to develop national service guidelines and Standard Operating Procedures (SOP) for palliative care. National service guidelines were piloted in three service sites in 2007 and will expand to Papua in 2008. The goal is to adopt these as national guidelines and SOPs in 2009.

In FY 07, the USG program began to provide support to a limited number of provincial hospitals (Soetomo in Surabaya, Hasan Sadikin in Bandung, Dok II in Jayapura, Selebesolu in Sorong, and Gatot Subroto Army Hospital in Jakarta) with an eye towards creating a “center of excellence” in each province to lead the national scale-up effort. Efforts here focused on additional mentoring of hospital staff, introducing quality assurance mechanisms, and developing stronger linkages between the different HIV-related service components in order to strengthen the COPC model. Several of these sites now function as referral hospitals for the district-level COPC sites that was initiated with FY07 and scaled up with FY08 funds. USG funding now provide on-going technical assistance for the 3 model COPC district sites in Java and for the COPC district sites in Papua mentioned above. ASA provides mentoring, quality assurance training and adherence counseling training as part of ART services. DoD funds will provide support for the creation of a Center of Excellence at the Gatot Subroto Army Hospital, through a capacity development workshop related to care and treatment.

With FY08 funds, USG also supported clinical staff to continue to serve as front-line trainers for the planned expansion of sites offering ART under the national roll-out plan (for which primary funding comes from the Global Fund). The FHI/ASA Country Office Clinical Services Unit and Clinical Services Officers, located in each of the 8 USG priority provinces, are active participants in all national program scale-up activities. The USG, through ASA, supports partner organizations to provide technical assistance and collaborate with the Ministry of Social Welfare on capacity building and developing a core of case management trainers and supervisors to coordinate training, mentoring, and supervision from central to district levels. Particular emphasis is placed on “positive prevention,” communicated through the “HIV stops with me” message. Through USG support, ASA also provides assistance to the MOH and indigenous PLWHA support groups on developing a standard format for medical records and a “health passport” to be carried by patients to assist with referrals and care. ASA also provides home care kits for use by Case Managers.

Finally, ARV services in Papua are linked to the expansion and strengthening of the network model. USG is the primary supporter of the ASA Papua Provincial Health Office’s Health System Strengthening scheme, which will entail the development of a functioning network of health facilities (i.e., hospitals linked with several Community Health Centers) in Jayapura and one Community Health Center in each of the 29 districts in Tanah Papua. FHI/ASA staff played a lead role in assisting the Papua Provincial Health Office in developing the plan and in the early stages of capacity building. These efforts, which leverage both GOI and Global Funds, as well as USG funds, are geared to rapidly expanding the availability of ART and supporting services.

In Tanah Papua increased focuses on strengthening reporting and recording systems to bring these in line with the national system. In FY09, USG will focus on improving record-keeping systems to manage individual patient care, and monitor the scale-up of ART services and developing referral systems and other mechanisms to enable a functioning network model. Given physical distances involved and the limited transportation infrastructure in many parts of Papua, it is essential that community health centers are capable of managing at least non-complicated HIV/AIDS cases as quickly as possible, though it may be necessary for ART to continue to be prescribed at higher-level facilities. In order to accomplish this, USG FY07 funds were used to strengthen and standardize recordkeeping and reporting formats at Provincial Health Offices and initiate regular monitoring and mentoring visits at “network” facilities offering ART in Jayapura, the capital of Papua Province. In FY08, these efforts were expanded to 10 priority districts in Tanah Papua.

In FY09, USG funds will continue to be used to provide technical assistance to support the scale-up clinic and palliative care aspects of the COPC system as well as for on-going support to MOH in rolling out comprehensive services.

Table 3.3.08: Activities by Funding Mechansim

Mechanism ID: 11359.09
Mechanism: Contract
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Program Area: Care: Adult Care and Support
Budget Code: HBHC
Program Budget Code: 08
Activity ID: 27250.09
Planned Funds: [redacted]
Activity System ID: 27250
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Program Budget Code: 09 - HTXS Treatment: Adult Treatment

Total Planned Funding for Program Budget Code: $150,000

Table 3.3.09: Activities by Funding Mechansim

Mechanism ID: 11360.09
Mechanism: Contract
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Program Area: Treatment: Adult Treatment
Budget Code: HTXS
Program Budget Code: 09
Activity ID: 27251.09
Planned Funds: [redacted]
Activity System ID: 27251
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Table 3.3.09: Activities by Funding Mechansim

Mechanism ID: 11361.09
Mechanism: Contract
Prime Partner: US Department of Defense
USG Agency: Department of Defense
Funding Source: GHCS (State)
Program Area: Treatment: Adult Treatment
Budget Code: HTXS
Program Budget Code: 09
Activity ID: 27252.09
Planned Funds: $25,000
Activity System ID: 27252
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Program Budget Code: 10 - PDCS Care: Pediatric Care and Support

Total Planned Funding for Program Budget Code: $0

Program Area Narrative:

N/A

Program Budget Code: 11 - PDTX Treatment: Pediatric Treatment

Total Planned Funding for Program Budget Code: $0

Program Budget Code: 12 - HVTB Care: TB/HIV

Total Planned Funding for Program Budget Code: **$155,000**

Program Area Narrative:

Indonesia ranks third among countries that contribute 80% of the global TB burden. The 2008 WHO Global TB Report estimates the incidence of TB at 253/100,000. The estimated cases are therefore approximately 535,000 of TB patients all form, of which about 240,000 are new smear positive cases. Data on HIV infection among TB cases in Indonesia is limited. WHO estimates a conservative figure of 0.8%; thus, of the 270,000 estimated HIV cases approximately 2,895 are infected with TB annually. Since 2004, USG funds have contributed to training HIV/AIDS health providers in TB (in collaboration with Sulianti Suroso Infectious Diseases hospital), and testing among TB patients at PPTI in Jakarta. All patients received HIV education, nearly one-third received HIV counseling and of those, almost 98% were tested for HIV. Of the 3656 TB patients who were tested for HIV, 642 persons or 18.4% of all TB patients tested positive. Among all positive TB/HIV persons, 49.4 % people receive ART.

High defaulter rates of TB patients treated in hospitals and irrational use of first-line and second-line TB drugs form major threats to further development of MDR- and XDR-TB. The extent of the problem is still unknown due to lack of drug resistance surveillance data. A Central Java survey supported by USAID indicates MDR-TB represents 1.5% of all TB infection. The first case of XDR-TB was confirmed by reference laboratory in 2007; and it is widely believed that there are many more undocumented cases of XDR in Indonesia. The health system has poor capacity to address MDR-TB due to constraints such as inadequate laboratory capacity and facilities, unavailability of several second line drugs to treat MDR-TB, and insufficient capacity to deliver DOTS-Plus. In addition, weak regulations have caused second-line TB drugs to be freely available on the market, and many specialists use these second line TB drugs in first-line TB regimens.

While TB/HIV activities have been planned since 2000, implementation of pilot programs to start TB/HIV activities has been delayed due to a range of constraints, including competing priorities for TB case finding and Directly Observed Treatment (DOTS) expansion. Planned strategies for TB/HIV include: CT for all TB patients in high prevalence areas and TB screening for all diagnosed PLWA; strengthened referral systems to ensure HIV care and treatment services for all co-infected TB patients; intensified DOTS for all PLWHA with active TB disease; and TB infection control in congregate settings where HIV is prevalent. To date, it has been difficult to establish effective cooperation between the NTP and HIV/AIDS as well as key stakeholders at the district level. There is a working group on TB-HIV, but it has not been effective in establishing collaboration between TB and HIV programs. In 2003, the TB-HIV working group produced a booklet on clinical manual for the Management of TB-HIV co-infection.

Indonesia has received 2 Global Fund TB grants. GFATM R1 ($68.8 million) supports general expansion of DOTS and GFATM R5 Grant ($69.2 million) supports MDR-TB and TB-HIV interventions. In March 2007, the GFATM programs in Indonesia were placed under restriction by the Global Fund Secretariat for irregularities. These restrictions were conditionally revoked in August, 2007 pending completion of a number of actions to be taken by the CCM and he PRs by October 15, 2007. The restriction caused tremendous repercussions for the national TB program and have taken some time to overcome. The recently awarded Round 8 proposal ($93 million) includes a TB/HIV component. This grants primary objectives include, health systems strengthening, quality DOTS service expansion, patient education and community participation improvement, high political commitment achieved through strengthening partnerships, and improved case finding and management of TB/HIV co-infected patients. Strategies specific for TB/HIV include strengthening the collaboration between the NTP and key stakeholders at the district level and scaling-up of TB-HIV sero-prevalence surveys. The results of these surveys will enable the NTP to define specific interventions for intensified TB case finding in PLWHA, prevention of TB infections in PLWHA, and prevention of HIV in TB patients.

In FY08, USG has supported TB activities in Indonesia through the TBCAP cooperative mechanism focusing on assistance in DOTS expansion, capacity-building, training at the national and district levels, and a focus on TB/HIV. TBCAP and partners will support TB/HIV activities based on the National TB/HIV Strategy. KNCV is the lead organization; FHI, the key USAID

implementing agency for HIV through the ASA program, assumes responsibility for programming in HIV/TB.

KNCV will play a leading role to support the assessment and establishment of TB DOTS and HIV/AIDS treatment linkages in selected hospitals while USG/AIDS supported program will support HIV/AIDS, VCT, treatment, and care linkages to well established DOTS in puskesmas in Papua and West Papua and three CoC model facilities. surveillance system, 3 I's among HIV, support MDR TB prevention via improvement of TB/HIV treatment, Coordination at the national, provincial, and district levels will be supported by TBCAP partners as well. The activities will include: national TB/HIV coordination efforts; national training on TB/HIV implementation from curricula, guidelines, SOPs development and training of the national and provincial trainers; training in three CoC model districts and Papua/West Papua; development of a TB/HIV referral system between TB and HIV service sites particularly in district hospitals and puskesmas; and development of national M&E TB/HIV indicators and a M&E system.

In FY08, the USG, with support from TBCAP, provided TA to the NTP to expand cross sectional TB-HIV sero-prevalence surveys and will expand to other sites in 2007-2008. Based on the results of the TB-HIV surveys and in accordance with international standards and guidelines for TB-HIV collaborative activities, planned activities for FY 08 include: implementing policies for "opt-out" HIV CT of all TB patients in those areas where the HIV sero-prevalence is found to be higher than 5%; establishing referral systems between DOTS and CT units in these areas to ensure that all TB patients are routinely offered CT; and training staff in DOTS units on interventions for TB-HIV co-infection.

The USG is focused on integrating TB screening and treatment into a one-stop Continuum of Care (CoC) model, which includes services such as STI, CT, and case management for PLWA. Planned activities aim to improve coordination of care in different settings, including intensified TB case finding in PLWA; prevention of TB infection in PLWA through infection control measures; prevention of HIV in TB patients through HIV CT; and Cotrimoxazole Preventive Therapy for patients with dual diseases.

In FY 09, with KNCV support, USG will improve coordination between the national program and the sub-national levels to intensify TB case findings and management of TB/HIV co-infection in facilities that provide CT and ARV services. Specific activities include: establishing DOTS Units and Hospital DOTS teams in all government and private hospitals that provide HIV treatment and care; including TB/DOTS principles & guidelines in HIV/AIDS training curricula for doctors and paramedical staff to assure proper identification of TB suspects and establishing effective referral systems; and assisting with the development of guidelines for infection control in hospitals and other institutions caring for TB and HIV co-infected patients.

In FY 2009, will continue its support to the CoC model in two TB clinics, PPTI Jakarta and BP4 Semarang to implement TB/HIV among high risk and marginalized populations, as well as TB/HIV in the prisons and IDUs. Support in FY 2009 will cover: opt-out HIV counseling and testing for all new TB patients attending PPTI clinics; technical support and mentoring for clinical management of TB/HIV including ART; and linkage of TB/HIV care in communities through the IA networks of HBC. As part of the shift to systems strengthening in Papua, TB/HIV will be part of integrated service program (i.e.; TB/HIV, support HIV prevention in DOTS clinics, PMTCT, MNCH, Malaria in Pregnancy, and Safe Water and Hygiene) in two selected districts in Papua and West Papua (Kabupaten Sorong and Jayapura). USG will also phase out support for internal networking between the DOTS units and the CT unit for effective clinical TB/HIV care except in the USG-supported CoC referral hospitals.

Technical areas funded with USG FY 09 funds include: screening of TB among PLWHA and early TB treatment, Cotrimoxazole preventive therapy for all new TB patients, promotion of TB with HIV to receive ARVs, adherence support in facilities and communities, and promotion of opt out HIV testing among HIV high risk TB patients and TB patients in Tanah Papua. USG will continue providing funds to support technical capacity building for the TB-HIV component of the TB grants from the GFATM Round 5 which mainly focuses on TB/HIV seroprevalence surveillance among TB patients in high burden provinces across Indonesia. Additionally, using TB funds, USG will support development of a national TB/HIV policy as well as developing a risk assessment tool to screen out new TB patients who have low HIV/AIDS risk and refer only those TB patients with higher risk for HIV/AIDS CT. In Papua, USG will support screening all TB patients for HIV in 10 districts.

Table 3.3.12: Activities by Funding Mechansim

Mechanism ID:	11362.09	**Mechanism:**	Contract
Prime Partner:	To Be Determined	**USG Agency:**	U.S. Agency for International Development
Funding Source:	GHCS (USAID)	**Program Area:**	Care: TB/HIV
Budget Code:	HVTB	**Program Budget Code:**	12
Activity ID:	27253.09	**Planned Funds:**	[redacted]
Activity System ID:	27253		
Activity Narrative:	N/A		
New/Continuing Activity:	New Activity		
Continuing Activity:			

Program Budget Code: 13 - HKID Care: OVC

Total Planned Funding for Program Budget Code: $0

Program Area Narrative:

N/A

Program Budget Code: 14 - HVCT Prevention: Counseling and Testing

Total Planned Funding for Program Budget Code: $350,000

Program Area Narrative:

Until recently, Indonesians had limited access to HIV Counseling and Testing (CT) services, with services being available primarily through NGOs. However, in line with the GOI intention to provide universal access to HIV/AIDS-related services, the number of CT sites is being scaled up rapidly. At present, the MOH is offering CT services at 218 hospitals that are capable of implementing comprehensive HIV/AIDS services, including CT and ARV. The MOH has plans to increase the number of sites providing CT, currently MOH has established 482 VCT units in Indonesia (204 in hospitals; 14 in mental hospitals, and 119 in health centers, 115 in NGO clinics, and 30 in prisons) and more than 28,000 individuals have received complete CT services. In addition, CT has been introduced at 63 Community Health Centers in Jakarta and West Java in connection with IDU efforts supported by the respective provincial health offices, the Indonesian Partnership Fund, and AusAID.

The current MOH policy uses triple, serial rapid tests with immediate feedback of results. The MOH minimum standards for HIV diagnostic tests are: (1) registered at MOH Indonesia; (2) sensitivity first reagent should be > 99%; (3) specificity second reagent should be = 98% and > first reagent; (4) specificity third reagent should be = 99% and > first reagent; (5) antigen preparation and or principle of test from each reagent should be different; and (6) indeterminate result should be < 5%.

The first-line combination of HIV tests currently recommended by the MOH is SD HIV 1/2 Bioline (Multi) – Determine HIV 1/2 (Abbott) – HIV Tridot. To date, this combination has yielded good results – over 99% joint sensitivity and specificity, with specificity of the second and third reagents being 100%. The primary concern using this combination is maintaining cold chain during transport, as the HIV Tridot test needs to be kept at 2–8 °C. Some resistance to the use of the triple rapid test without confirmation by ELISA has been reported at the field level. This appears to reflect mistrust of rapid testing in the provinces and possibly vested interests in labs doing ELISA. The MOH is responsible for supply chain management, and with the recent Round 8 proposal success, GFATM funding appears to be sufficient. However, concerns continue to be voiced from the field as to the reliability of supply.

Since CT services are a key entry point into the full range of interventions that make up the continuum of prevention and care (COPC) and provide an opportunity to reach both HIV+ and HIV- individuals with prevention messages and information, the USG has supported the national roll-out of CT services through the USG-funded Aksi Stop AIDS (ASA) program, implemented by FHI. Through FY07, support focused on developing national policy, service guidelines and SOPs, as well as facilitating ASA staff participation as national trainers in efforts to develop a cadre of skilled service providers. ASA assisted the MOH with evaluating new HIV test kits for possible adoption by the national program and quality assurance of HIV testing being undertaken under the national program. Additionally, USG funded the reprinting of national CT service guidelines and SOP manuals to support the ongoing accelerated scale-up of CT services.

In 2007, the number of USG directly supported sites offering complete CT services was 8. An additional 39 sites were supported through joint funding with the Indonesian Partnership Fund. With the drop in IPF funding, a transition from direct services to technical assistance is taking place and this is no longer the case. The emphasis is now shifting to supporting district level facilities providing the services with limited technical support by USG. USG funding fills gaps in GOI efforts by supporting CT services at locations where HIV is transmitted sexually and via contaminated needles (by IDU). USG-supported CT services are located nearby in sexual transmission “hotspots”. CT sites are linked with NGOs providing outreach, behavior change communication, condoms and lubricants, and CT referral services to MARPs (IDU, FSW, MSM, transvestites). GOI clinics, in USG-supported “hot spots” are open extra hours each day in order to increase access by MARP. Although the official GOI policy for CT is “opt-in,” USG programs are advocating an “opt-out” policy for MARP and have pilot-tested this in CT sites. The MOH triple rapid test policy is followed at all USG-supported sites in order to maximize the likelihood of individuals tested receiving their test results. As the ASA program moves away from funding individual CT sites to supporting networks of provincial and district health facilities and strengthening the COPC model in specific sites, support for CT services will be transitioned to local and provincial governments. Items such as incentives and the purchase of reagents will have to be covered by MOH and the local government health budgets. USG FY09 funding will continue to provide support in the form of mentoring programs, quality assurance, and other technical assistance.

In FY08 the USG supported unmet need and filling gaps in CT by supporting 3 COPC MARP sites in Java. In Tanah Papua, CT

services are extremely limited (large hospitals in a few large cities). USG has been the primary supporter of the Papua Provincial Health Office's Health System Strengthening scheme, which entails developing a functioning network of health facilities in Jayapura with capacity to provide comprehensive services, including CT. With FY 08 funds, CT services have been expanded so that in each of the 10 USG priority districts in Tanah Papua there should be at least one Community Health Center providing comprehensive services (OI management, ART), including quality CT.

Additionally, in FY08, a major thrust of all CT efforts is to continue supporting the improvement of the quality of counseling and ensuring confidentiality of CT clients. Lack of privacy and confidentiality remains an issue at GOI facilities. USG continues to support capacity building within NGOs to improve their outreach skills to increase demand and use of CT services.

In FY09, USG funding will focus on providing support in the form of mentoring programs, quality assurance, and other technical assistance. The USG will support the Provincial Health Office and other partners to roll-out provider-initiated HIV testing and counseling in Tanah Papua. The Provincial Health Offise is using a "Could it be HIV" campaign for all patients who come to the public health centers, regardless of the service sought, including those receiving TB treatment. If risk factors are present or HIV is suspected, the patient will be offered CT and followed up with case management and CST for positive patients or post-test counseling on prevention, STI screening and treatment for negative patients.

In addition in FY09, the USG will work with companies, industry associations and the local health services to promote STI and CT services for high-risk men by strengthening referral systems and in particular by identifying a wider network of public and private health care providers (clinics and/or doctors) that are prepared to provide services to high-risk men.

USG will continue support to the Indonesian military to scale-up the capacity of additional military clinics to provide CT services and surveillance. With FY07 funds, Defense Forces (TNI) Center for Health (PUSKES) coordinated, planned, and executed TOT counseling workshops for CT clinics. This allowed the PUSKES medical staff to reach Indonesian TNI units posted throughout Indonesia. With FY 08 funds HIV tests kits will also be procured to support CT, screening, and surveillance activities. Distribution of supplies will also be targeted to facilities in high prevalence areas. Test kits may include, but are not limited to HIV Rapid test kits (2-3 brands to satisfy testing algorithm) as well as consumables to augment testing (gloves, vacutainers, pipettes, etc).

With FY09 funds, DOD will expand and provide support to VCT activities and will be used to fund much needed HIV/AIDS rapid test kits and to build upon training provided with FY07 and FY08 funding. HIV test kits will be procured to support testing and surveillance activities. Distribution of supplies will be targeted to facilities designed by the TNI as high prevalence areas. Test kits will be those approved for use by the MOH so that they may be used both for military personnel and civilians accessing military health facilities. In addition, funds will support technical assistance and travel as required.

Table 3.3.14: Activities by Funding Mechansim

Mechanism ID: 11363.09
Mechanism: Contract
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Program Area: Prevention: Counseling and Testing
Budget Code: HVCT
Program Budget Code: 14
Activity ID: 27254.09
Planned Funds: [redacted]
Activity System ID: 27254
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Table 3.3.14: Activities by Funding Mechansim

Mechanism ID: 11365.09
Mechanism: Contract
Prime Partner: US Department of Defense
USG Agency: Department of Defense
Funding Source: GHCS (State)
Program Area: Prevention: Counseling and Testing
Budget Code: HVCT
Program Budget Code: 14
Activity ID: 27257.09
Planned Funds: $48,000
Activity System ID: 27257

Activity Narrative: N/A

New/Continuing Activity: New Activity

Continuing Activity:

Program Budget Code: 15 - HTXD ARV Drugs

Total Planned Funding for Program Budget Code: $0

Program Area Narrative:

N/A

Program Budget Code: 16 - HLAB Laboratory Infrastructure

Total Planned Funding for Program Budget Code: $69,500

Program Area Narrative:

UNAIDS estimates there are 270,000 Indonesians infected with the virus that causes HIV. The GOI currently reports offering ART services at approximately 237 health facilities, including 124 hospitals and a limited number of Community Health Centers. The MOH developed laboratory standards and guidelines and conducted national training sessions for lab technicians in each of the 237 health facilities. A recent round of monitoring visits to ART sites, jointly undertaken by the MOH, WHO, and the USG-supported Aksi Stop AIDS (ASA) Program, implemented by FHI, suggests, however, that the number of sites actually providing services is much smaller and is largely confined to the original 25 hospitals covered in the national scale-up scheme. The Minister of Health has recently proposed a more rapid expansion of ART service sites, with a target of 482 facilities by the end of 2010. However, resources needed to accomplish this have not yet been identified.

The MOH reports that 13,757 patients have ever received ARV at the end of April 2008, representing approximately 81% of the official GOI estimate of those in need. Of these, 11,142 were males, 2,322 females, and 293 children under 14. The MOH reports 8,145 patients are currently receiving ART. The MOH projects expanding the number of individuals receiving ARV combination therapy to 15,000 by March 2010; this increase will be supported with Global Fund monies. The number of military personnel currently on ART is limited.

Currently, ARV drugs and CD4 tests are provided free-of-charge by the GOI, supported by GFATM. However, all other treatment costs must be borne by patients. The MOH is responsible for supply chain management of ARV drugs. Although GFATM funding appears to be sufficient, concerns continue to be voiced from the field on the reliability of supply. The current laboratory system is weak though the GOI has set up a quality assurance system. The government financially supports an annual external quality assurance assessment for 124 hospitals that provide ART, 50 blood transfusion units, and 30 health laboratories (26 provincial, 4 central). Unfortunately, a limited number of the total primary health care centers receive annual QA due to lack of supporting funds from the GOI.

To date, the DOD funded portion of the USG program has provided laboratory equipment and supplies to two military referral hospitals in Jakarta and two other military medical laboratories not located in Jakarta. At present, efforts in supporting laboratory capacity include: AusAID support to one hospital, RS Sulianti Saroso, by supplying equipment and supplies to perform CD4 tests; Global Fund support for CD4 machines and reagents for ART referral Hospitals; Clinton Foundation is supporting External Quality Assessment (EQA) for CD4 testing, with the ultimate goal of establishing a National External Quality Assessment Service (NEQAS) in Indonesia and is supporting scaling up treatment of pediatric HIV and will assist in developing a national infant diagnosis system.

USG program focus will be placed on supporting laboratory capacity and expanding coverage of quality lab support services to PLWHA through the Indonesia Defense Forces. DOD will continue collaboration with the TNI/PUSKES to improve and support the laboratory capacity within the military laboratory facilities outside the capitol. In addition, critical HIV disposable supplies, including reagents will be procured.

With FY09 funds, DOD will support a workshop to train military laboratory technicians from throughout the country and provide necessary reagents for the three FACSCOUNT® CD4 machines previously procured with PEPFAR support. This activity will increase the number of military medical facilities that will have trained laboratory staff as well as ensure a reliable supply of reagents in support of those living with HIV/AIDS and seeking care at military facilities. Additionally, USG and implementing partner staff have collaborated with the Directorate of Public Health Laboratories, the Department of Clinical Pathology of the University of Indonesia, the HIV National Reference Laboratory at Cipto Mangunkusumo Hospital and the Balai Laboratorium Kesehatan in Surabaya to develop appropriate external quality control systems for laboratory diagnosis of HIV and STIs. FY 2009 funds will also support technical assistance as required.

Table 3.3.16: Activities by Funding Mechansim

Mechanism ID:	11366.09	**Mechanism:**	Contract
Prime Partner:	US Department of Defense	**USG Agency:**	Department of Defense
Funding Source:	GHCS (State)	**Program Area:**	Laboratory Infrastructure
Budget Code:	HLAB	**Program Budget Code:**	16
Activity ID:	27258.09	**Planned Funds:**	$69,500
Activity System ID:	27258		
Activity Narrative:	N/A		
New/Continuing Activity:	New Activity		
Continuing Activity:			

Program Budget Code: 17 - HVSI Strategic Information

Total Planned Funding for Program Budget Code: $190,000

Program Area Narrative:

The USG plays a critical role in assisting the Government of Indonesia (GOI) to strengthen Strategic Information (SI) activities by collaborating with MOH and other international donors. Such collaboration is required while the GOI continues to develop the capacity to take the lead in surveillance, data collection, and monitoring and evaluation processes. In FY08, the USG SI plan is focused on providing technical assistance and capacity building for implementation of the National Monitoring & Evaluation Framework at national and sub-national level in line with the Indonesia National HIV/AIDS Strategy. The USG will advise GOI and NGO counterparts at both the national and provincial levels to undertake in-depth analyses and advocate the use of evidence-based data for strategic planning and decision-making. As an integral part of USG prevention program implementation focused on MARP, the USG continues to support the assessment of pilot sites implementing the general population Continuum of Prevention-to-Care (CoPC) model and the integrated MARP sexual transmission prevention package model that includes Periodic Presumptive Treatment (PPT) for STI for MARP. The USG will advocate and seek to leverage other resources from GOI and/or international donors for potential national scale-up of successful models. Sustainability is a key component of the SI strategy and the USG will focus on building local capacity for M&E with an emphasis on data quality and data use for performance management and program quality improvement for NGOs, C/FBOs, and government at all levels.

USG Indonesia continues to refine the reporting system (that was developed in 2007) containing indicators that are aligned with PEPFAR requirements. With recognition of the different stages of HIV epidemic in Indonesia, USG continues to work closely with USAID partners to use the expanded program monitoring system which allows USG to disaggregate accomplishments by provinces, particularly in Papua where the epidemic is generalized versus other provinces where it is still a concentrated epidemic particularly among MARP. In addition, USG partners utilize the software and program monitoring system to keep track of individuals served at delivery sites to avoid double counting. This information is useful in order to monitor the intensity of the various interventions or monitor the quality of coverage targeting MARP.

Indonesia serves as a model for effective collaboration and leveraging of resources to implement its HIV/AIDS program. However, a weak MOH continues to rely heavily on TA and financial resources from the USG implementing partners, as well as other international, multi-lateral agencies including: GFATM, The World Bank, WHO, AusAID, DfID, and UNAIDS for strategic information/monitoring and evaluation activities. The M&E Technical Working Group was established in 2007 and continues to actively move forward “The Third One” (one national M&E system) agenda. National core indicators have been developed and finalized. The National AIDS Commission (KPA) continues to use the unified data collection tools and systems to collect national core indicators including information from facility level and community-based systems. This system was based on the FHI/ASA program monitoring system.

To date, USG’s partners have produced quarterly progress reports based on data from monthly reports from implementing agencies, monthly program site visits and routine coordination meetings. Continued technical support was provided to implementing sub-partners to assure proper functioning of the overall program monitoring system. Technical and financial support was provided for development of the national M&E database maintained by National AIDS Commission. Analysis of the 2007 IBBS data was completed, and full dissemination of these data for measuring program effects and future program planning has just taken place. Work also began on developing a comprehensive quality assurance/quality improvement system with a pilot of the system completed and broader implementation scheduled.

In FY09, proposed USG supported monitoring and evaluation activities include:

• Technical Assistance on developing unified VCT, STI, ART, and community-based programs and systems. This activity will leverage funds for implementation in collaboration with KPA, Ministry of Health (MOH), and other donors particularly Global Fund and AusAID. The recent Round 8 award alleviates some of the funding pressure, although technical assistance for quality SI becomes critical. In FY09, the USG TA will focus on improving a record-keeping system to manage individual patients on palliative care and monitor the scale-up of ART services.
• Encourage the effective implementation of the M&E framework and corresponding M&E information management system at sub-national level.
• Support development and implementation of capacity-building module including trainings for district and provincial staff to develop a provincial M&E framework, how to effectively operate the information management system, and how to use data for decision-making, strategic planning, and program improvement.
• Although the specifics of the next USG HIV program are yet to be determined due to the TBD procurement, USG will continue to support routine monitoring and reporting as well as develop rigorous program evaluation for any new prevention and care and support models developed with an emphasis on determining effectiveness in the new HIV program design.

Potential contributions include,
* Use assessment findings from pilot sites implementing the CoPC model to improve program implementation and planning. Support the replication of the model in other priority provinces/districts as appropriate by leveraging of resources from other donors, GOI.
* Use assessment findings of the PPT implementation as a part of the sexual transmission prevention package model to improve program implementation and planning. Support the replication of the model in other priority provinces/districts as appropriate by leveraging of resources from other donors, GOI.

Building M&E capacity with local NGOs and C/FBOs is a fundamental component of the USG program for sustainability. By strengthening local capacity for M&E, it ensures that local implementing partners collect high quality information for use in program planning and improvement. In FY 2009, USG will continue to provide mentorship support to USAID partners and sub-partners to improve routine program monitoring system for tracking individuals served as well as monitor intensity of intervention, conduct training or refresher training on data quality, and build capacity of USAID sub-partners to effectively use data for performance management and program quality improvement.

In FY09, USG would like to focus on use of surveillance data and support the continued strengthening of surveillance capacity of GOI. The level of intensity for such activity will be dependent upon collaboration with other donors and the newly awarded GFATM Round 8 proposal, as well as funding from any potential PEPFAR Partnership Compact. Illustrative activities are as follows:

• Technical support to the GOI for the continued dissemination of the IBBS findings.
• General surveillance TA to GOI for strengthening bio-behavioral surveillance, updating size estimations among MARP using the most recent IBBS data in 2008. If needed, work with KPA and MOH, to conduct primary data collection in order to improve accuracy of the estimations as well as support the GOI to convene a consensus building workshop among all stakeholders.
• Continuation of TA to GOI for general data analyses and data use activities, such as secondary data analyses and synthesis activities at national level using existing surveillance data as well as routine program data from various sources to triangulate information and identify outcomes/impacts of collective responses to combat HIV/AIDS among MARP in Indonesia as well as identify gaps for future program improvement.
• Work with GOI to conduct analysis of the qualitative assessment of transactional sexual behavior and sexual networks among general population in Papua (conducted 2008). This information will be critical for interpretation of recent Papua IBBS results, improvement of IBBS methodology, and for improving intervention strategy.
• Continuation of TA to develop TB/HIV passive surveillance to the GOI. This activity will be an integral part of TB/HIV program implementation.
• Collaborate with the other global, multi-lateral donors in the creation and support of a “Global Donors Surveillance Advisory Group” to work closely with the MOH, KPA, National Surveillance Technical Working Group, and GFATM on the national surveillance strategy as well as develop a plan for the continuity and quality of second generation surveillance activities in Indonesia.
• A new priority for DOD activities will be to include support for SI. Funding will be used to enhance the in-country monitoring and evaluation skills of TNI and provide a level of quality assurance for all program activities.

During the Mini-COP development process, all program area targets and target justifications were developed by the integrated USG Indonesia SI Team. Because of the TBD procurement process, the USG SI Team held general discussions with USAID partners to get current information regarding their programs in order to set downstream and upstream targets for FY 2009 based on their projected FY 2008 program results. Information was also obtained from KPA and UNAIDS on updated national level reporting data. Additionally, a meeting was held with the KPA to understand future directions for the national SI activities and GFATM priorities.

USG Indonesia currently does not have dedicated SI staff in country. In FY 2009, the USG team proposes to hire an additional FSN Program Specialist who will work part-time on program management and part-time on SI/M&E related activities (see also the Management & Staffing section).

Finally, a successful Partnership Compact agreement will allow USG to work with GOI and GFATM to provide focused surveillance TA for the next rounds of IBBS among general population in Tanah Papua and IBBS among MARP across Indonesia. USG will also support all M&E requirements related to the Partnership Compact itself.

Table 3.3.17: Activities by Funding Mechansim

Mechanism ID:	11367.09	**Mechanism:**	Contract
Prime Partner:	To Be Determined	**USG Agency:**	U.S. Agency for International Development
Funding Source:	GHCS (USAID)	**Program Area:**	Strategic Information
Budget Code:	HVSI	**Program Budget Code:**	17
Activity ID:	27259.09	**Planned Funds:**	[redacted]
Activity System ID:	27259		
Activity Narrative:	N/A		
New/Continuing Activity:	New Activity		
Continuing Activity:			

Table 3.3.17: Activities by Funding Mechansim

Mechanism ID: 11368.09
Mechanism: Contract
Prime Partner: US Department of Defense
USG Agency: Department of Defense
Funding Source: GHCS (State)
Program Area: Strategic Information
Budget Code: HVSI
Program Budget Code: 17
Activity ID: 27260.09
Planned Funds: $40,000
Activity System ID: 27260
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Program Budget Code: 18 - OHSS Health Systems Strengthening

Total Planned Funding for Program Budget Code: $360,000

Program Area Narrative:

Indonesia has mounted a comprehensive response to the HIV epidemic with the primary goal of slowing new infections. While growing, it is still nascent in comparison to the more mature responses of other Asian countries. The role of the National AIDS Commission (KPA) was revitalized by Presidential Regulation 75/2006 which strengthened the role of the KPA and identified provincial and district leadership as key actors. The National HIV and AIDS Costed Action Plan 2007-2010 provides a framework for government priorities and development partner support, emphasizing collaboration and avoidance of duplication. The plan assures services throughout Indonesia linking GOI, development partners (including GFATM) and the private sector services.

Operating under the principles of the Three Ones, the KPA has defined targets for the achievement of universal access to HIV prevention, care, support, and treatment as required by the UNGASS HIV/AIDS Declaration. Essential HIV/AIDS policies are in place; however, it is necessary for work to continue to assure compliance with updated global technical standards and guidelines. Government planning for the next phase of the HIV/AIDS Strategy (2010-2014) has already begun. With the rapidly growing need for care and treatment services a move to an increased level of synergy will be critical.

Until recently, the KPA, the MOH, and other key GOI organizations have demonstrated limited institutional capacity to plan, implement and monitor responses to the HIV/AIDS epidemic. NGO capacity is also relatively limited. There is high staff turnover both within the GOI structure and NGOs as well as a lack of human capacity and knowledge of comprehensive HIV programming. Within the uniformed services, challenges include rivalries among services, suspicion of working with foreigners, and lack of command level commitment. Decentralization has further complicated program implementation, as KPAD and District Health Offices (DHO) lack trained personnel and systems to manage the response and the KPA and the KPA/District are now charged with guiding the HIV/AIDS response in locally appropriate ways. With new leadership over the last 2 years, the KPA is now developing a solid framework for HIV/AIDS programs and providing the national leadership to ensure program success and coordination.

Various program reviews have identified numerous weaknesses in the overall health care system. These include the limited capacity of health sector personnel at provincial and district level to implement programs; weak capacity of civil society organizations and community-based organizations; difficult environment and resistance to new strategies and interventions; and poor coordination of AIDS programs among various sectors at district level. Although many improvements have been instituted since 2007, challenges remain, particularly in the area of coordination and partnership at national, provincial and district level.

A weak community health system is inadequate to cover the health care needs of all community members. The national health system performance varies widely across the 33 provinces and 440 districts. Most of the target populations are poor - they depend on public health care and often do not receive enough support and counselling from health care personnel. The national supply and procurement system is quite weak; without a dependable supply distribution system, prevention, care and treatment services continue to be extremely challenged. One of the major causes of patient drop-out and non-adherence to ART is the frequent occurrence of stock-out of essential medicines.

With a limited budget the USG's approach to HSS has been to leverage other partners and initiatives such as GFATM. Of the six recognized building blocks in the WHO framework, the USG has been most involved with leadership and governance, the delivery of quality services and referral networks (especially for MARPs), and has also had a major role in surveillance and information management. Little has been done with commodities systems and human resources. A USAID core-funded situational assessment of the commodities management system in Tanah Papua was conducted by SCMS in October 2007. The resulting

report stated that any strategic design for a supply chain management system must be constructed so that it meets the needs of the local hospital and community health center level.

While donor coordination is a KPA priority, donor and financing harmonization is a key issue and one that has not yet received attention. It is an area where targeted and effective technical assistance could yield tremendous impact. The community of development partners is small and cohesive and all recognize the value of synergizing HIV/AIDS work. At the root of harmonization and policy reform, it is important to work closely with GFATM and UNAIDS; AusAID, World Bank and WHO are currently engaged in HSS.

At the national (and increasingly the provincial) level, the USG focus has been to create an enabling environment for effective interventions at the community level, and on generating quality surveillance data informing evidence-based programming. District level emphasis has been to build local NGO capacity providing critical outreach and targeted referral networks to disenfranchised MARPs; in Papua limited HSS is also taking place in 10 districts. The USG bilateral program has achieved a strong impact in targeted technical and geographical areas, but interventions have been constrained by funding and the expense of maintaining activities throughout the archipelago

The USG has supported NGO capacity-building to manage programs and achieve expected results. The key sustainability strategy is to build capacity and skills in indigenous NGOs, including evidence-based program design, proposal writing, strategic assessment, target setting, supervision, quality assurance (QA), monitoring and evaluation (M&E), budgeting and financial tracking and reporting. In FY08 this is implemented through the USG funded FHI/ASA Program. In FY09 a new procurement will be let for the continued management of NGO capacity building.

Each NGO and government implementing partner is visited once a month by ASA Provincial Program Managers and at least per quarter by relevant technical staff from either the Provincial or Country Office. Provincial and Country Office staff review performance; provide program monitoring, as needed; and undertake QA checks during visits to NGOs. The KPADs are located in all 80 target districts and 8 provinces where USG supports HIV/AIDS activities and all supported NGOs are required to attend regular meetings with their district KPA to facilitate coordination and encourage accountability. Provincial Program Managers will accompany them. NGOs bring their M&E data for review and discussion by the KPA and other local organizations.

In past years the USG has helped build GOI institutional capacity to plan and implement programs at the national, provincial and district levels, within the national, regional and local prison systems; and in the uniformed services. The USG-supported Health Policy Initiative (HPI) conducted a rapid audit of Indonesia's National HIV/AIDS Strategy and provided TA to the KPA to develop the National HIV/AIDS Strategy for 2007-2010 and the costed action plan.

Other system strengthening initiatives have included: supporting the Department of Corrections in the development of National Strategic Plan for introducing HIV/AIDS prevention, care and treatment services in prisons and planning for implementation in prisons located in the 8 priority provinces covered by the USG; undertaking orientation and basic skill training for members of KPADs from all 80 target districts; and providing the technical support to the KPA in the development of a national database and program tracking system.

Previously, the USG supported the implementation of the Resource Needs Module (RNM) of the Goals Model to cost Indonesia's 2007-2010 Action Plan. Working closely with the University of Indonesia, HPI trained a core team of individuals from the national level on the RNM data collection, and a draft training package was developed for use at the provincial level. Currently USG funding is being used to build the capacity of national and community level leaders (for example, religious leaders, police) to advocate for the implementation of policies; support KPA and KPAD to build capacity for evidence-base decision making and resource allocation; and will provide technical assistance to KPA and involve ministry staff to revise the costed Action Plan.

In FY07 the USG program began assisting the provincial governments in Papua with their overall efforts at health systems strengthening. The USG supported an operational analysis of the policies in Papua to identify opportunities for and barriers to providing an integrated package of HIV, FP/HIV, malaria, and TB services in clinic settings. This was intended to identify policies that need to be revised or updated, so that integrated support is provided in provincial healthcare systems, increasing access to services and commodities for FP/RH, HIV, TB, and malaria and to enable policy makers to make informed choices about program integration and investment needed to ensure integration from the policy to the program level.

In FY08 a significant decrease in other donor funding has dramatically affected the jointly funded USG program's ability to effectively engage in HSS and this remains a component of the USG program limited to Papua. USG funds are being used to address key HIV-related policy and advocacy issues and provide technical assistance to build KPA capacity for evidence-based resource allocation. The FHI/ASA program supports 66 NGOs in program and financial management in the 80 target districts in 8 provinces. USG funds are also being used to provide technical assistance to GOI in program planning, monitoring and coordination skills (e.g., training, mentoring, assisting in QA/QI, logistics, monitoring, reporting/recording systems) as part of the overall health system strengthening in Papua and three COPC sites for MARPs. Through FY08 this will continue to be implemented through the FHI/ASA program.

USG continues to work on Papua health systems strengthening by supporting efforts to engage local civil groups in promoting the advantageous linkages between HIV, FP/RH, TB and malaria programs. HPI will continue to build the capacity of PLHA and civil society leaders to develop advocacy strategies that promote support for integrated services in Papua, and encourage their use. Activities will include support for meetings of relevant stakeholders, that include PLHA and other services users, to disseminate findings from the analysis, and through advocacy trainings to provide stakeholders with the skills needed advocate for integration of RH/FP, HIV, TB, and malaria services in Papua.

In moving forward strategically in FY09 and beyond, the decision regarding a Partnership Compact will dramatically affect the

focus and shape of the next phase of USG programming. At the current baseline $8 million level, programming must remain committed to building local capacity of civil society and referral networks for MARPs at the district level. The GOI is keen for continued USG support to NGOs – a recognized comparative advantage as well as a vital need to overcome nascent funding laws and lingering uncertainties regarding civil society to emphasize best practice models for increased sustainability, and local empowerment and leadership. Some limited HSS will take place in Tanah Papua but engagement will remain limited to bilateral program level interventions and technical advice rather than policy engagement. With FY09 funds, a new procurement will be tendered for the continued management of NGO capacity building for MARPs.

At the $13 million level, the USG creates an opportunity to impact systemically, engage policy reform at a strategic level, and transition to a more balanced and harmonized assistance relationship.

Table 3.3.18: Activities by Funding Mechansim

Mechanism ID: 11369.09
Mechanism: Contract
Prime Partner: To Be Determined
USG Agency: U.S. Agency for International Development
Funding Source: GHCS (USAID)
Program Area: Health Systems Strengthening
Budget Code: OHSS
Program Budget Code: 18
Activity ID: 27261.09
Planned Funds: [redacted]
Activity System ID: 27261
Activity Narrative: N/A
New/Continuing Activity: New Activity
Continuing Activity:

Program Budget Code: 19 - HVMS Management and Staffing

Total Planned Funding for Program Budget Code: $1,550,500

Program Area Narrative:

Under the leadership of the Ambassador, USG agencies maintain a core team of highly-skilled and dedicated national and expatriate staff to effectively manage the implementation of the President's Emergency Plan for AIDS Relief in Indonesia. With limited budget and staff, the USG focus is on integrating with and supporting the GOI 2007-2010 National HIV/AIDS Strategic Plan.

Current USG PEPFAR presence is comprised of STATE, USAID, and DOD managed by the Center of Excellence in Disaster Management and Humanitarian Assistance. Each of these agencies maintains strong in-country relationships on HIV/AIDS. HHS/CDC currently has full-time staff working on influenza and the HHS/CDC/GAP regional office in Bangkok provides support to several countries in the region. Peace Corps is considering opening a program in Indonesia in 2009 contingent on funding and could offer a unique opportunity at the community level.

Staffing for Results (SFR) is focused on assuring the comprehensive integration and support of the Government of Indonesia's 2007-2010 National HIV/AIDS Strategic Plan. The positions and functions included in the management and staffing budget are essential to effective planning, implementation and monitoring of the Emergency Plan. STATE, through its ECON section, is engaged with the PEPFAR process throughout the annual planning cycle. DOD activities and programs are managed by staff located in PACOM/Hawaii, while in-country liaison is provided by the Office of Defense Cooperation. USAID coordinates the Indonesia PEPFAR response and a collaborative interagency process is maintained through regular communications and field visits.

At the $8 million base level for Indonesia, USAID will maintain 6 staff members working on PEPFAR for a total of 3.8 FTE. Two FTE manage the program in entirety including all coordination aspects with OGAC and the individual agencies. This includes one USPSC working 1.00 FTE and one FSN working 1.0 FTE. Other personnel include an FSN at 0.5 FTE and two FSNs at .15 FTE. An additional 1.0 FTE FSN will be added in FY09 to assume a 50% level of effort on TBD implementing partner grant/contract management and 50% level of effort on program monitoring, evaluation, data analysis, and PEPFAR reporting requirements, as well as share increased coordination responsibilities with the GFATM.

USG staff provides critical technical assistance to the GOI MOH and National AIDS Commission (KPA) and are active members of national level Technical Working Groups for HIV/AIDS. Additionally, USG representatives sit on the GFATM CCM and are responsible for grant/contract management of our implementing partners. USG Indonesia will continue to rely on staff technical expertise from USG personnel based in the United States to provide backstop support.

USAID has allocated $512,072 for management and staffing costs. ICASS costs are estimated at $14,004 and $6924 is being levied for the IRM tax. The mission is not contributing to Capital Security Cost Sharing. DOD is allocating $17,500 of GHAI funds to program management support for USPACOM/COE.

PEPFAR requirements create a significant management burden on posts, especially in non-focus countries with few PEPFAR resources. This burden results in significant staff time managing interagency processes and reporting and reduces time managing programs. This has potential to exacerbate vulnerabilities over time, particularly in an environment like Indonesia where corruption is still a major issue. Further attempts to simplify, streamline and reconsider the administrative burdens imposed by these processes would be greatly appreciated. While a differentiation of reporting requirements does exist between focus and non-focus countries, this should be re-visited to better define the balance of reporting needed from other bilateral countries on the basis of funding levels.

The Government of Indonesia (GOI) is pleased to work with USG on these and other issues, but they have expressed a desire for increased partnership. They do not believe that US bilateral assistance investments, including PEPFAR, are consistent with the principles of the Paris Declaration. To a great extent, GOI perceives the process and investment decisions are driven by Washington and not by the development needs and priorities of Indonesia.

The proposed Partnership Compact presents an opportunity to offset this dynamic. In FY 2009, pending approval for a PEPFAR Partnership Compact agreement in Indonesia, the USG will propose to hire additional staff to support development, implementation and in-country coordination. The configuration of USG agencies would also be negotiated internally and with the GOI to assure the best level of support. At minimum, a "Partnership Compact Liaison" position is envisioned as a 1.00 FTE. This new position would assume the primary role and responsibility of coordinating the USG and coordinating with the GOI to ensure a smooth and effective negotiation of the Partnership Compact as well as the subsequent implementation of related compact activities. The Partnership Compact Liaison, along with all USG staff, will work with other donors, particularly the GFATM and UN agencies, Indonesia Partnership Fund, AusAID, and the World Bank to ensure that overall PEPFAR efforts are most effective, are not duplicative of current efforts, are aligned with the National HIV/AIDS Strategy, and support the GOI's priorities in HIV/AIDS.

Table 3.3.19: Activities by Funding Mechansim

Mechanism ID:	11371.09	**Mechanism:**	Contract
Prime Partner:	US Department of Defense	**USG Agency:**	Department of Defense
Funding Source:	GHCS (State)	**Program Area:**	Management and Staffing
Budget Code:	HVMS	**Program Budget Code:**	19

Activity ID: 27263.09 **Planned Funds:** $17,500

Activity System ID: 27263

Activity Narrative: Management and Staffing Narrative

Budget: $17,500

The objective of this activity is to provide the resources necessary for the successful management and oversight of the DOD PEPFAR Indonesia program. This activity provides managerial, administrative, and technical support to the DOD PEPFAR program in Indonesia through a program manager working out of US Pacific Command (USPACOM) as well as in-country Program support provided by the Office of Defense Cooperation (ODC).

The DOD executor for HIV/AIDS in the PACOM AOR is the Center for Excellence in Disaster Management and Humanitarian Assistance (COE). In Indonesia, COE works in coordination and consultation with the Office of Defense Cooperation (ODC), US Embassy/Jakarta to implement a direct military-to-military HIV/AIDS prevention program with the Indonesian Armed Forces Medical Services (TNI PUSKES).

The PEPFAR program provides funding for the Program Manager:
• Program Manager: This position is located at the PACOM/COE headquarters in Honolulu, HI, the home of the US Pacific Command, and provides overall program management, guidance, and technical support. Additional responsibilities include coordination and preparation of documents such as Administrative Procedure Agreements (APA), after action reports of training activities, program planning and annual reporting as well coordination of commodity procurement as required.

Support and collaboration for program implementation are provided by the ODC staff. This support is not supported with PEPFAR funds.

• ODC Staff Support: ODC Chief, ODC Deputy and an FSN dedicated to program implementation. The ODC Chief and Deputy provide local knowledge and awareness as well as provide a mil-mil face to the program. The FSN dedicated to the program ensures execution of DOD activities under the PEPFAR program, including coordination and facilitation of program activities, receipt of commodity procurement at Post and assistance in preparing budgetary requirements and other program documents. Office equipment, supplies and travel, including ICASS costs as required are also included.

It is anticipated that the management and staffing requirements for the DOD PEPFAR program will remain unchanged for the foreseeable future as requested by the ODC office.

Activities and Expected Results:
USPACOM, though a program manager at COE, will provide overall program management, guidance and technical assistance. The program manager develops and coordinates necessary documents to ensure participation of all DOD parties as well as works with the COE Budget office and ODC to monitor and track funds. The ODC FSN assigned to the project works directly with the ODC to provide on the ground program administration, liaise with the TNI, facilitate and coordinate receipt of commodity procurements, Funding also supports office equipment, supplies and travel. It is expected that this activity will allow the DOD PEPFAR program to have the human and material resources necessary for the successful management, planning, and monitoring of all program activities, including preparing and meeting reporting requirements.

HVMS - Management and Staffing
DOD Cost of Doing Business Narrative

Total Planned Funding: Total DOD $0

DOD has allocated $17,500 for management and staffing costs. This supports .2 FTE working on PEPFAR. Program management is monitored from off-shore and is based in PACOM Hawaii.

To support this level of personnel, no ICASS, IRM Tax, or CSCS is being allocated.

New/Continuing Activity: New Activity

Continuing Activity:

Table 3.3.19: Activities by Funding Mechansim

Mechanism ID: 11908.09 **Mechanism:** USAID M&S

Prime Partner: US Agency for International Development **USG Agency:** U.S. Agency for International Development

Funding Source: GHCS (USAID) **Program Area:** Management and Staffing

Budget Code: HVMS **Program Budget Code:** 19

Activity ID: 27264.09 **Planned Funds:** $533,000

Activity System ID: 27264

Activity Narrative: HVMS - Management and Staffing
USAID Narrative

Total Planned Funding: Total USAID $512,072

Under the leadership of the Ambassador, USG agencies maintain a core team of highly-skilled and dedicated national and expatriate staff to effectively manage the implementation of the President's Emergency Plan for AIDS Relief in Indonesia. With limited budget and staff, the USG focus is on integrating with and supporting the GOI 2007-2010 National HIV/AIDS Strategic Plan.

Staffing for Results (SFR) is focused on assuring the comprehensive integration and support of the Government of Indonesia's 2007-2010 National HIV/AIDS Strategic Plan. USAID coordinates the Indonesia PEPFAR response and a collaborative interagency process is maintained through regular communications and field visits.

At the $8 million base level for Indonesia, USAID will maintain 6 staff members working on PEPFAR for a total of 3.8 FTE. Two FTE manage the program in entirety including all coordination aspects with OGAC and the individual agencies. This includes one USPSC working 1.00 FTE and one FSN working 1.0 FTE. Other personnel include an FSN at 0.5 FTE and two FSNs at .15 FTE. An additional 1.0 FTE FSN will be added in FY09 to assume a 50% level of effort on TBD implementing partner grant/contract management and 50% level of effort on program monitoring, evaluation, data analysis, and PEPFAR reporting requirements, as well as share increased coordination responsibilities with the GFATM.

USAID has allocated $512,072 for management and staffing costs.
ICASS costs are estimated at $14,004
IRM Tax is levied at $6924.
The mission is not contributing to Capital Security Cost Sharing.

USAID Cost of Doing Business Narrative

Total Planned Funding: Total USAID $20,928

USAID has allocated $512,072 for management and staffing costs. This supports 6 staff members working on PEPFAR for a total of 3.8 FTE. Two FTE manage the program in entirety including all coordination aspects with OGAC and the individual agencies. This includes one USPSC working 1.00 FTE and one FSN working 1.0 FTE. Other personnel include an FSN at 0.5 FTE and two FSNs at .15 FTE. An additional 1.0 FTE FSN will be added in FY09 to assume a 50% level of effort on TBD implementing partner grant/contract management and 50% level of effort on program monitoring, evaluation, data analysis, and PEPFAR reporting requirements, as well as share increased coordination responsibilities with the GFATM.

To support this level of personnel, ICASS costs are estimated at $14,004 and the IRM Tax is levied at $6924. The mission is not contributing to Capital Security Cost Sharing.

New/Continuing Activity: New Activity

Continuing Activity:

Table 3.3.19: Activities by Funding Mechansim

Mechanism ID: 12189.09 **Mechanism:** Partnership Framework Development

Prime Partner: US Agency for International Development **USG Agency:** U.S. Agency for International Development

Funding Source: GHCS (State) **Program Area:** Management and Staffing

Budget Code: HVMS **Program Budget Code:** 19

Activity ID: 29691.09 **Planned Funds:** $1,000,000

Activity System ID: 29691

Activity Narrative: To carry out planning and preparation in support of developing a Partnership Framework.

New/Continuing Activity: New Activity

Continuing Activity:

Table 5: Planned Data Collection

Is an AIDS indicator Survey(AIS) planned for fiscal year 2009?	**Yes**	**X**	**No**
If yes, Will HIV testing be included?	Yes	X	No
When will preliminary data be available?			
Is an Demographic and Health Survey(DHS) planned for fiscal year 2009?	**Yes**	**X**	**No**
If yes, Will HIV testing be included?	Yes	X	No
When will preliminary data be available?			
Is a Health Facility Survey planned for fiscal year 2009?	**Yes**	**X**	**No**
When will preliminary data be available?			
Is an Anc Surveillance Study planned for fiscal year 2009?	**Yes**	**X**	**No**
If yes, approximately how many service delivery sites will it cover?	Yes		No
When will preliminary data be available?			
Is an analysis or updating of information about the health care workforce or the workforce requirements corresponding to EP goals for your country planned for fiscal year 2009?	**Yes**	**X**	**No**

Supporting Documents

File Name	Content Type	Date Uploaded	Description	Supporting Doc. Type	Uploaded By
FINAL PPP table.xls	application/vnd.ms-excel	11/4/2008		PPP Supplement	RWardani
FINAL Global Fund Supplemental template 11-07-08.doc	application/msword	11/9/2008		Global Fund Supplemental	RWardani
Ambassador's Letter.pdf	application/pdf	11/10/2008		Ambassador Letter	RWardani
FINAL Mini COP 09 Gender Program Area Narrative.doc	application/msword	11/10/2008		Gender Program Area Narrative*	RWardani
FINAL Mini COP 09 Human Resources Program Area Narrative.doc	application/msword	11/11/2008		HRH Program Area Narrative*	RWardani
FINAL Mini COP FY09 Staffing Analysis.xls	application/vnd.ms-excel	11/13/2008		Staffing Analysis	RWardani
FINAL Indonesia Intervention Area Map.doc	application/msword	11/12/2008		Other	RWardani
FINAL Mini COP FY09 Budgetary Requirements Worksheet (updated for VCT policy change).xls	application/vnd.ms-excel	11/13/2008		Budgetary Requirements Worksheet*	RWardani
FINAL Mini COP 09 List of Acronyms.doc	application/msword	11/13/2008		Other	RWardani
FINAL Proposed Management and Staffing Budget Table for Other Bilat.xls	application/vnd.ms-excel	11/13/2008		Management and Staffing Budget Table	RWardani
FINAL Mini COP 09 Global Fund Supplemental Narrative.doc	application/msword	11/13/2008		Global Fund Supplemental	RWardani
Indonesia Partnership Compact Concept Paper FINAL.doc	application/msword	11/17/2008	Indonesia Compact Concept Paper	Other	AConforto
Budgetary Requirements Justification OVC.doc	application/msword	11/26/2008		Budgetary Requirement Justifications	TPerdue
Budgetary Requirements Justification - Care and Treatment.doc	application/msword	11/26/2008		Budgetary Requirement Justifications	TPerdue
Indonesia_Summary Targets and Explanations Table.xls	application/vnd.ms-excel	11/26/2008	Table 3 Summary Targets & Explanations Table 2 Target Explanations	Summary Targets and Explanation of Target Calculations	MLee
Indonesia- CN Summary Template - Revised.doc	application/msword	11/29/2008		Executive Summary	MLee