Australia–Indonesia Partnership for HIV 2008–15

including the

HIV Cooperation Program for Indonesia

Final

Partnership and program design

September 2007

Contents

Executive summary

A. Background

Australia has provided support to Indonesia for addressing HIV since 1995. A key element of Australia's support has been Phases 1 and 2 of the Indonesia HIV/AIDS Prevention and Care Project (IHPCP). Phase 2 of IHPCP, which due to end in August 2007, has been extended to February 2008. IHPCP has been widely recognised as making many positive contributions to Indonesia's response to HIV, in particular its work in addressing HIV associated with injecting drug use (IDU) through a harm reduction approach and, increasingly, the integration of its work within Indonesian Government systems. Contributions from the Indonesia Partnership Fund for HIV/AIDS (IPF) and local governments have enabled scaling up of IHPCP activities over the past two years, particularly in Java Barat (West Java), Papua and West Papua.[1]

Indonesia is experiencing three different HIV epidemic patterns: (i) concentrated epidemics among injecting drug users (IDUs) and their sexual partners, (ii) concentrated epidemics among sex workers and their clients, and (iii) a generalised epidemic in Papua and West Papua. All three epidemics are expanding and further delay in mounting an escalated response will exacerbate the social and economic consequences and create a heavier burden on the health sector. Without an increased response, a generalised epidemic is predicted in Indonesia by 2025, with prevalence of HIV increasing to over 1 per cent of adults. This would result in an estimated 300 000 deaths by 2010 and 1.5 million by 2025.[2] Papua and West Papua provinces are predicted to be hardest hit, with prevalence increasing to 7 per cent by 2025.

The Government of Indonesia (GOI) has requested that the Government of Australia (GOA) continue its involvement in HIV in Indonesia after the IHPCP ends. In response, a scoping mission in September/October 2006 made recommendations for a new program that would commence in February 2008. A subsequent mission was undertaken in February/March 2007 to design the new package of assistance.

There is a dynamic environment for a strengthened HIV/AIDS response in Indonesia. Recent institutional and policy developments that informed the design of the new program include:

- Presidential Regulation 75/2006, which has strengthened the National AIDS Commission (KPA) and AIDS commissions at provincial (KPAP) and district (KPAD) levels
- new KPA leadership, which has created optimism for achievement of the 'Three Ones'[3] and accelerated progress in stemming the HIV epidemic
- the new National HIV and AIDS Strategy 2007-10 and development of a draft National Action Plan for HIV and AIDS 2007–10 ('National Strategy and Action Plan')
- the New Papua Development Strategy 2006–11 and Strategic Plan for the Management of HIV/AIDS in Papua Province 2007 - 2011
- a 2007 Ministerial Regulation, which provides a strong framework for planning and implementation of activities to prevent and reduce HIV among IDU, and
- a December 2006 memorandum of understanding between the KPA and National Narcotics Board confirming a national harm reduction approach to HIV and drug use.

[1] West Papua was previously referred to as Irian Jaya Barat (or West Irian Jaya).
[2] Australian Government. AusAID. The HEMI Report. 2006.
[3] The 'Three Ones' are principles for coordinating national HIV/AIDS responses. They are: One HIV/AIDS action framework; One national, multisectoral HIV/AIDS coordinating authority; One HIV/AIDS country-level monitoring and evaluation system.

B. Australia–Indonesia Partnership for HIV

All Australian HIV activities in Indonesia will be framed within a new partnership, the Australia–Indonesia Partnership for HIV (AIPH). The partnership will commence in February 2008 and extend until the end of 2015. The goal of the partnership, which mirrors the GOI goal in the National Strategy and Action Plan, is to prevent and limit the spread of HIV, improve the quality of life of people living with HIV, and alleviate the socio-economic impacts of HIV/AIDS. The partnership will support Indonesia to achieve its Millennium Development Goal target of halting and reversing the spread of HIV by 2015.

The partnership seeks to build on the achievements of Phases 1 and 2 of IHPCP by:

- supporting a strengthened GOI response to HIV in line with national priorities and strategies at all levels of government
- increasing Australian support to Papua and West Papua provinces, where recent data suggests there is a generalised HIV epidemic, and
- intensifying efforts to address HIV associated with people who inject drugs and people in prisons and other closed settings.

The partnership will comprise:

- a new program, the HIV Cooperation Program for Indonesia (HCPI), described in Section C
- financial and technical contributions to the IPF and engagement with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), including input from and coordination with relevant steering committees
- mainstreaming of HIV into AusAID's work in other sectors
- other HIV-related initiatives in AusAID's Indonesia program, including research, health systems strengthening, child and maternal health, the NGO Cooperation Program, activities implemented by other GOA agencies in Indonesia, Australian Development Scholarships, the Australian Leadership Awards Program and the Indonesia Australia Specialised Training Program, and AusAID's regional partnerships with the Asia Pacific Business Coalition on HIV/AIDS and the Clinton Foundation HIV/AIDS Initiative, and AusAID's HIV/AIDS Regional Capacity Building Program.

AIPH will be managed by the AusAID Health Section in Jakarta. The Health Section will include a Senior Program Coordinator (HIV), along with local support staff, to provide technical oversight and assistance in stakeholder coordination.

The approach of AIPH and HCPI is new, in terms of both the management structure and the direction of the program. Consistent with the aim of optimising service delivery through Indonesian systems, the partnership will progressively support and strengthen GOI structures by working more closely with GOI at all levels, and provide increased technical support to Indonesian counterparts to lead, plan, manage and increasingly fund the HIV response. As GOI improves its capacity to deliver effective HIV responses, Australia's role in direct implementation will progressively decrease. Greater emphasis will be placed on strategic high-level policy engagement and technical support. Planning will align where possible with GOI budget cycles and funding may be managed through GOI budgetary systems in stronger settings where adequate safeguards exist and continued GOI commitment is demonstrated. AusAID will explore the option of providing incentives for and rewarding improved performance by Indonesian stakeholders. To accommodate this approach, an initial five-year time frame is envisaged for the HCPI with a three-year extension option subject to a review of partnership progress, including a comprehensive review of the role of HCPI.

The new partnership and program will be based on the following principles:

- align with and support GOI HIV strategies and priorities at all levels

- work with all levels of government (in accordance with decentralisation) and continue to work with and strengthen civil society engagement to underpin an effective response
- ensure sufficient flexibility to respond to changing circumstances, including changes in the epidemic and changes in levels of support provided by GOI and other development partners
- increase Australia's high-level engagement with the GOI on policy and strategy
- cooperate with GOI in areas in which Australia has a comparative advantage and build on the achievements of IHPCP (including the pioneering work on IDU and prisons, and the strengthening of non-government organisations and national and provincial AIDS commissions)
- increase the focus on populations with greatest need (e.g. Papua, West Papua, IDUs in Java, prisoners)
- provide a long-term commitment (eight years) to enhance impact and sustainability
- facilitate multiplier effects by demonstrating and promoting the most effective and sustainable responses
- leverage additional resources by making strategic investments that attract funding from other sources
- harmonise with other donors and development partners
- promote evidence-informed responses, as indicated by epidemiological, social and economic data and research, and
- accord special consideration to gender throughout all activities.

C. HIV Cooperation Program for Indonesia

HCPI will be a five-year program (with a three-year, or part thereof, extension option) commencing in February 2008. The program will share the goal of the Australia–Indonesia Partnership for HIV and the National Strategy and Action Plan. The goal, purpose, components and component objectives of the program are summarised in Figure 1.

By aligning with the goal of the National Strategy and Action Plan, HCPI will be able to directly support GOI priorities and needs. Preventing the spread of HIV and limiting adverse socio-economic impacts will require a comprehensive approach. Given the size of Indonesia's population and the prevalence of HIV in Indonesia, a comprehensive and adequate response can only be led by Indonesia. HCPI will strengthen Indonesia's capacity to plan and implement an effective and sustainable response. HCPI's purpose statement clearly reflects this capacity-building focus. Each component of the HCPI will include strategies for capacity building in all activities. A brief description of the main activities within each component follows.

Component 1: Leadership

HCPI will provide assistance to government (at all levels), civil society and the private sector, to build Indonesia's capacity to lead, plan and manage an effective and sustainable HIV response. This could entail a range of activities, including, for example, support for strengthened leadership and management capacity; advice on policy and legal frameworks; support for strategy development, planning and coordination; identifying and supporting national and local champions; strengthening implementation systems; providing monitoring and evaluation support; and promoting evidence-informed approaches including through support for surveillance and research. The work under Component 1, as well as providing input to national initiatives, will be integral to the work of Components 2, 3 and 4.

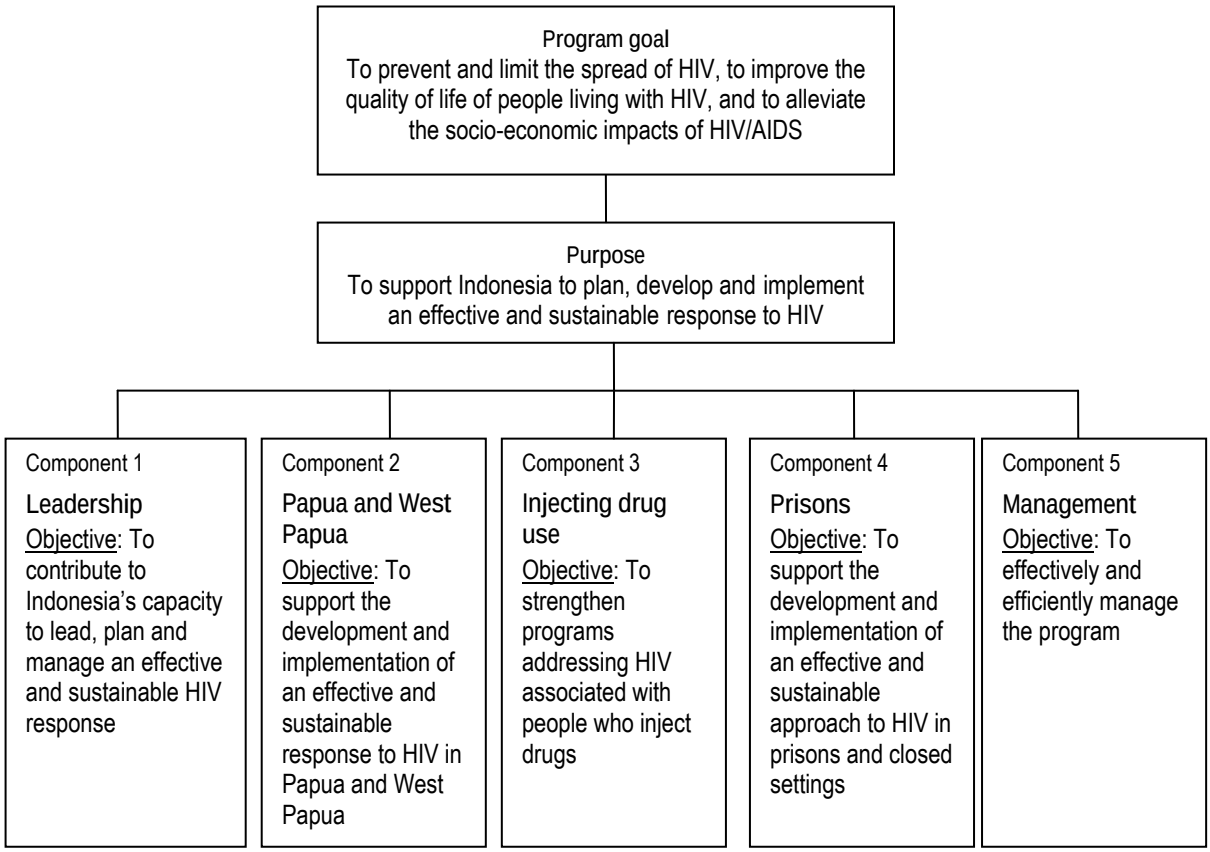


Figure 1 HCPI goal, purpose, components and component objectives

Component 2: Papua and West Papua

The activities of this component will support the provincial development strategies for Papua and West Papua in relation to HIV. While supporting a comprehensive approach in both provinces, the initial focus will be on developing more effective behaviour change approaches. This work will have a strong primary prevention element, as well as addressing health promotion for people living with HIV. It will build on the behaviour change communication work of IHPCP and other programs over the last two years. This initial focus recognises the importance of a strong prevention response to an expanding generalised epidemic, and that care, support and treatment needs are being met by other donors and GOI budgets. It is also anticipated that HIV treatment services in Papua and West Papua may benefit from other Australian inputs that fall within AIPH but will be managed outside of HCPI, such as AusAID's programs on maternal and child health and HIV regional capacity development, and the partnership with the Clinton Foundation. Some HCPI staff will initially be based in Jayapura.

Component 3: Injecting drug use

HCPI will support implementation of GOI plans that address the HIV needs of IDUs and their sexual partners. It is anticipated that this will primarily involve support for delivery of services through GOI public health systems as well as engagement of civil society. Emphasis will be given to piloting and promoting a comprehensive response to IDUs and their partners in priority locations. Consistent with GOI policy, the comprehensive response will adopt a harm reduction approach and may include needle and syringe programs, substitution therapies and other effective drug use treatments, peer education and outreach, voluntary counselling and testing, condoms, sexually transmitted infection and HIV treatment, including antiretroviral treatment and treatments for opportunistic infections. The initial focus will be locations in Java where IHPCP has ongoing activities, with a view to expanding support to other locations in Java or elsewhere, subject to available resources and based on evidence of need.

Component 4: Prisons

Component 4 activities will support the GOI in developing and implementing effective policy and program responses to HIV prevention, care, support and treatment needs for people in prisons and other closed settings such as drug treatment facilities. It is anticipated this will involve work in partnership with DepKes (Ministry of Health) and DepHukHam (Ministry of Justice and Human Rights) and their provincial and district entities and the Prison Working Group of the KPA. Harmonisation with the work of other bi- and multilateral donors working in prisons will be essential. The work will be guided by the National Strategic Plan: Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centres 2005–09 and the proposed costed work plan. The plan calls for education, health and referral programs in prisons and detention centres. Work in this component may include harm reduction approaches such as methadone, education and information, voluntary counselling and testing, and treatment programs, and will include support to non-government organisations for outreach to closed settings. Initial activities will include providing policy and strategy support at the national level, continuing the work at the Bali prison, and continuing the activities at other specific sites currently supported by IHPCP.

Component 5: Management

The management component includes the planning, coordination, monitoring and evaluation of activities and the program as a whole.

A Program Coordination Committee will be the key decision-making body for HCPI and AIPH. The committee will have prime responsibility for approving annual plans, ensuring HCPI and AIPH remain strategically focused, providing oversight of program outcomes and quality, and resolving (when possible) any significant implementation problems.

While the KPA and AusAID will be responsible for oversight and coordination of HCPI as a whole, the program aims to increase the role of the GOI agencies that have prime responsibility for implementing HIV programs associated with each of HCPI's four technical components. HCPI therefore aims to involve KPA, the AIDS commissions in Papua and West Papua, DepKes (Ministry of Health) and DepHukHam (Ministry of Justice and Human Rights) in policy dialogue and overall coordination. The advice of these agencies will be sought during the planning of HCPI activities, and they will be invited to participate in an annual component review of HCPI.

A Managing Contractor will be engaged to provide technical expertise, resources and management services; work collaboratively with and support program partners; and manage inputs to each component within HCPI. The Managing Contractor will be responsible for implementing HCPI activities and will have an office in Jakarta, some staff based in Papua and some staff based in other provinces (as needed). The number and tenure of other offices and staff will be limited, in line with the guiding principle of progressive integration of AusAID resources within Indonesian national structures.

Within each component, HCPI will plan its activities on an annual basis, working collaboratively with counterparts and other development partners. The annual planning process will be aligned with the GOI planning time frame, which will enable HCPI to plan future activities at the same time that Indonesian partners are planning future activities. This will allow closer collaboration and provide the flexibility to support current GOI priorities and needs. It should also, over time, help to strengthen GOI systems to plan and implement, and increasingly fund, HIV activities.

HCPI will support the development and implementation of a single, effective monitoring and evaluation system for Indonesia. Whenever possible, indicators for evaluating outcomes and impacts (at the goal, purpose and component objective levels) will be based on the National Strategy and Action Plan. Indicators to monitor and assess progress will be based on annual targets, developed in consultation with Indonesian agencies during the annual planning process. The monitoring and evaluation framework will therefore be updated as part of the annual planning process. HCPI will undertake an annual component review in collaboration with the lead Indonesian agency for each component and the KPA.

Results of the review will inform program planning and delivery in the following year, thereby establishing a continuous learning process that benefits both GOI agencies and HCPI. AusAID will also organise and participate in a review of both AIPH and HCPI every two years to assess overall progress and provide strategic direction.

D. Funding

The budget for AIPH is estimated at A$10 million per annum. Of this, approximately 80 per cent will be allocated to HCPI, other than in the 2007-08 start up year. During 2007-08 approximately A$5.4 million will be allocated to IHPCP. The amount allocated to IHPCP will be for costs during the transition period between July 2007 and February 2008 (see Attachment 6).

The annual budget for HCPI is estimated at A$8 million for the first five years, except in 2007–08 when there will be only five months of activities. The budget for the five-month period is estimated at $2 million. A one-month handover period from IHPCP to HCPI is planned for February 2008.

Program costs will include procurement; grants to implementing partner agencies; and project implementation costs, which includes all personnel, workshop, and training costs.

Activities supported by HCPI will be negotiated on a cost-sharing basis, with the GOI expected to increase its financial contribution to agreed activities over time. Financial contributions will be determined during the annual planning process.

Australia intends to fund a number of activities from the estimated A$10 million budget other than HCPI. It is recommended that an initial contribution of A$1 million be made to IPF. Further allocations to IPF, and funding for other activities, will be determined during the annual planning process.

E. Feasibility and risks

There should be no illusion that Indonesia faces a tremendous challenge in its attempt to avoid a generalised HIV epidemic. Such an epidemic would have serious social and economic consequences, particularly in Papua and West Papua. Indonesia must not only allocate far more resources, but employ a comprehensive response that includes adequate coverage and effective, sustainable approaches.

HCPI represents a shift in direction from previous Australian support for HIV in Indonesia. No longer is the main challenge raising awareness among political leaders and the general population, or developing appropriate approaches, or revising policies to enable appropriate approaches to be implemented. While significant progress has been made in each of these areas through the work of IHPCP and others, the rapid, progressive nature of HIV in Indonesia means that the main challenges now are increasing the overall level of resources available, increasing the effectiveness and impact of these resources, and increasing the capacity of Indonesian systems and agencies. Unless the current response is substantially increased, the number of deaths in Indonesia resulting from AIDS and related illnesses is estimated at 1.5 million by 2025. This shift in direction will require careful management. Only with increased resources and enhanced Indonesian capacity will the response be scaled up to the magnitude required.

HCPI will therefore work in partnership with, and build the capacity of, Indonesian agencies. This will:

- facilitate the strengthening of Indonesia's role in leading the HIV response by building the capacity of Indonesian agencies and supporting
- help ensure effective coordination of activities at each level of government
- provide an opportunity for successful interventions to be highlighted among policy makers and therefore replicated on a wider scale, and
- promote donor harmonisation.

Consistent with the aim of integration of program activity into Indonesian systems, HCPI will progressively support and strengthen GOI structures rather than relying on parallel infrastructure and

personnel. To facilitate this approach, HCPI will (i) synchronise its activities with those of the concerned institution; (ii) gradually integrate activities and responsibilities for these activities into the concerned institutions' systems, processes and budgets; and (iii) include effective monitoring.

Within this context, the HCPI approach and the inputs to be provided appear to be technically and institutionally feasible, and cost effective. However, success in achieving the ultimate goal is far from certain. Although the goal is common to both the National Strategy and Action Plan and Indonesia's millennium development commitments (MDG #6), there are many risks to achieving a goal that is this ambitious. The main risks are:

- insufficient allocation of GOI resources to scale up the HIV response, particularly for IDUs and prisons, and in Papua and West Papua generally
- failure of the GOI to deliver on its National Strategy and Action Plan
- lack of knowledge and/or capacity at provincial and subnational levels of government to effectively coordinate and implement the HIV response, particularly in the relatively new province of West Papua which, during the design mission, did not have a functioning AIDS commission, and
- failure to influence sexual behaviour in Papua and West Papua, despite increased public awareness of HIV and how it is transmitted.

In addition, HCPI will operate within a dynamic environment: there is uncertainty over future IPF and GFATM funding; the epidemic itself is changing; and decentralisation has left provinces and districts with variable levels of capacity and funding. The proposed annual planning process will provide the flexibility for HCPI to respond to many of the perceived risks. Close alignment with GOI structures should also better position HCPI to work collaboratively to help avoid or minimise risk. Again, however, success in achieving the ultimate goal is far from certain.

F. Next steps

An external review criticised the serious loss of momentum during the transition from Phase 1 to Phase 2 of IHPCP.[4] Building on the lessons learned from the IHPCP, there will be a transition period between July 2007 and February 2008 to enable a targeted program of support for selected activities. IHPCP has therefore been extended to the end of February 2008. IHPCP will use the extension for a targeted program of support for continuing activities, exiting from activities that will not continue, and arranging for the overall exit of IHPCP. There will be an overlap period of one month (February 2008) for a handover between IHPCP and the new program.

For locations in which the new program will no longer work other than in relation to prisons (i.e. South Sulawesi, NTT and Bali), new agreements have been negotiated with selected partners for an extension of their activities for a period up to six months. This will provide an adequate opportunity for KPAP/KPAD and these partners to seek alternative funds.

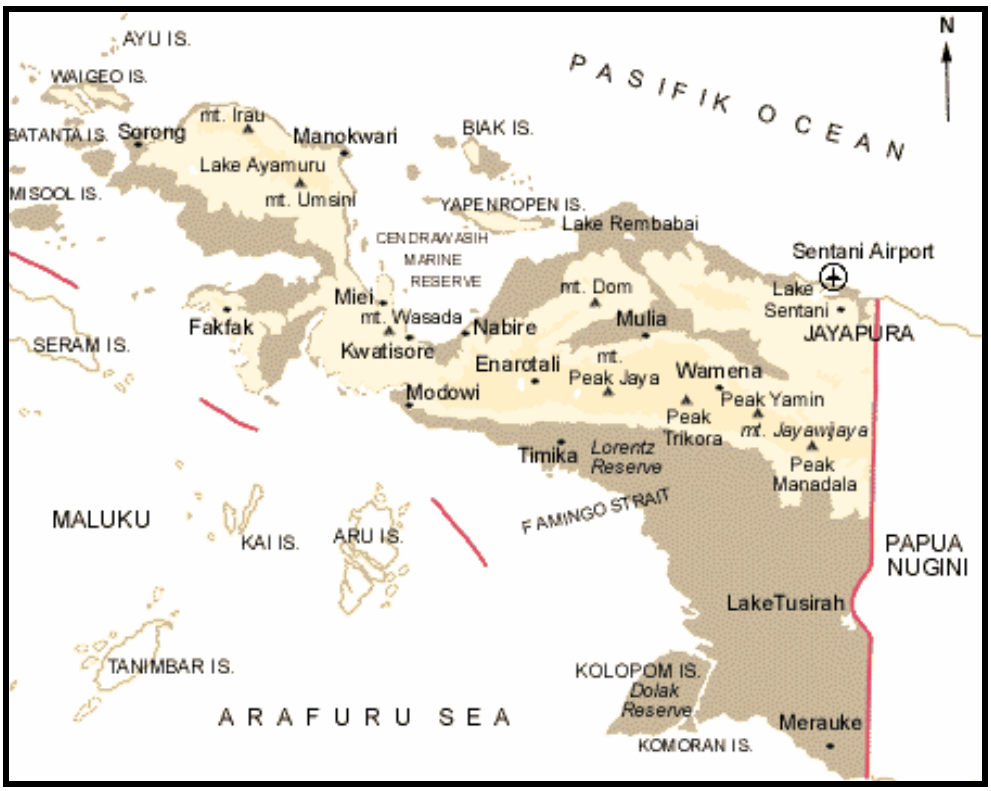
In locations where the new program will work (including DKI Jakarta, Java Barat, Papua and West Papua and prisons currently served nationally), it is recommended that new agreements be negotiated with selected partners for the continuation of their activities for an 18-month period to the end of December 2008.

It is further recommended that the current AusAID HIV/AIDS Coordinator remain in post and oversee the transition to AIPH/HCPI until June 2008, when a Senior Program Coordinator (HIV) will be appointed. This will provide consistency and continuity during the transition period.

[4] See IHPCP, Phase 2. Review of Stage 1. Final report. July 2004.

Location map: Indonesia

Location map: Papua and West Papua



Currency

A$1.00 = US$0.82 = Indonesian Rupiah 7,500

(August 2007)

Abbreviations and acronyms

ADB	Asian Development Bank
AIDS	Acquired Immunodeficiency Syndrome
ASA	Aksi Stop AIDS
AusAID	Australian Agency for International Development
BAPPEDA	Regional Development Planning Agency (at provincial and district levels)
BAPPENAS	National Development Planning Agency
BNN	National Narcotics Board
CDC	Centre for Communicable Diseases and Environmental Health (Ministry of Health)
CSO	civil society organisation
CST	care, support and treatment
DepHukHam	Ministry of Justice and Human Rights
DepKes	Ministry of Health
DFID	Department for International Development (United Kingdom)
DinKes	Dinas Kesehatan (Provincial Health Office)
FHI	Family Health International (the managing contractor for ASA)
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOA	Government of Australia
GOI	Government of Indonesia
GRM	GRM International Pty Ltd (the managing contractor for IHPCP)
HCPI	HIV Cooperation Program for Indonesia
HDI	Human Development Index
HEMI	HIV Epidemiological Modelling and Impact Study
HIV	human immunodeficiency virus
HR	harm reduction
IBBS	integrated bio-behavioural survey
IDU	injecting drug user/injecting drug use
IEC	information, education and communication
IPF	Indonesia Partnership Fund for HIV/AIDS
IHPCP	Indonesia HIV/AIDS Prevention and Care Project
ILO	International Labour Organization
KanWilHukHam	provincial representative of the Ministry of Justice and Human Rights
KPA	National AIDS Commission
KPAP	Provincial AIDS Commission
KPAD	District or Municipal Level AIDS Commission
MDG	Millennium Development Goal
MenKoKesra	Menteri Koordinator Kesejahteraan Rakyat (Coordinating Ministry for People's Welfare)
MMT	methadone maintenance therapy
MOH	Ministry of Health
MOU	memorandum of understanding
MSM	men who have sex with men
M&E	monitoring and evaluation
NAC	National AIDS Commission
NGO	non-government organisation
NSP	needle and syringe program
NTT	Nusa Tengarra Timur
OECD	Organisation for Economic Co-operation and Development
P2PL	Centre for Communicable Diseases and Environmental Health (CDC, Ministry of Health)
PCC	Program Coordination Committee
PEPFAR	President's Emergency Plan for AIDS Relief (USA)

PLWHA	people living with HIV or AIDS
STI	sexually transmitted infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organization

Glossary

bupati	administrative head of a district
kota	Municipality
National Strategy and Action Plan	National HIV and AIDS Strategy 2007-10 and the National Action Plan for HIV and AIDS 2007–10
National Prison Strategy	National Strategic Plan: Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centres 2005–09
puskesmas	community health centre (sub-district level)
Regulation 02/07	Ministerial Regulation 02/per/menko/kesra/I/2007, *National Policy for Control of HIV/AIDS through Reduction of the Negative Impacts of IDU*
Three Ones	UNAIDS principles for coordination of national HIV/AIDS responses: > one HIV/AIDS action framework > one national, multisectoral HIV/AIDS coordinating authority > one HIV/AIDS country-level monitoring and evaluation system
Tim Asistensi	Assistance Teams (KPA)
walikota	mayor of a municipality
waria	male transvestite/transsexual

1. Partnership preparation steps

1.1 Partnership origin

Available data and expert opinion indicate that Indonesia is experiencing three different but escalating HIV epidemic patterns: (i) concentrated epidemics in injecting drug users (IDU) and their sexual partners, (ii) concentrated epidemics in sex workers and their clients, and (iii) a generalised epidemic in Papua and West Papua. All three epidemics are expanding and further delay in mounting an escalated response will exacerbate the social and economic consequences and create a heavy burden on the health sector. Without an increased response, a generalised epidemic is predicted in Indonesia by 2025, with estimates of 300 000 deaths by 2010 and 1.5 million by 2025.[5]

The response to the epidemic by the Government of Indonesia (GOI), community groups, and the international community over the last decade, while far from comprehensive, has laid a foundation for preventing an expanded epidemic. Continued support of the international community is essential for the response to HIV.

AusAID has funded HIV/AIDS support in Indonesia for more than ten years. Much of this assistance has been provided through two successive phases of the Indonesia HIV/AIDS Prevention and Care Project (IHPCP).

The other major bilateral donor with significant direct involvement in HIV in Indonesia is the United States Agency for International Development (USAID). The majority of USAID's assistance is provided through the Aksi Stop Aids Project (ASA), which is managed by Family Health International (FHI). The other major sources of external assistance are:

- the Indonesia Partnership Fund for HIV/AIDS (IPF), which was established in 2005 with funds from the UK's Department for International Development (DFID), and
- the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

The GOI has requested that Australia continue its involvement in HIV in Indonesia. Providing further support fits within Australia's strategic interests. The 2006 White Paper *Australian aid: promoting growth and stability* emphasised Australia's ongoing commitment in the region to combating HIV. In addition, AusAID's Health Policy (2006) emphasises health systems, women's and children's health, gender equality, and leadership on HIV/AIDS. A mission was therefore fielded in September/October 2006 to consider options and prepare recommendations for Australian support following the completion of IHPCP. A concept paper was prepared, which resulted in a decision to field a detailed design mission in early 2007.

1.2 Study team and method

The design mission was in Indonesia from 3 February to 2 March 2007. The design team met with a wide range of agencies and individuals in Jakarta, Surabaya, Yogyakarta, Papua (Jayapura, Merauke, Wamena and Timika) and West Papua (Manokwari, Sorong and Raja Ampat), including government agencies at national, provincial and district levels, non-government organisations (NGOs), people living with HIV, the private sector, AusAID, IHPCP staff and other donors and development partners.

Members of the design team participated in a review of the health sector response to HIV in Indonesia.[6] The team also reviewed a wide range of documents, and held a series of meetings

[5] Australian Government. AusAID. The HEMI Report. 2006.

[6] The review was conducted jointly by the World Health Organization (WHO) and the Ministry of Health (DepKes), Indonesia, 5–17 February 2007.

in Jakarta with the National AIDS Commission (KPA) and other key stakeholders during the final week of the mission to advance the program design. These discussions culminated with the presentation of the draft aide memoire in Jakarta on 2 March.

The terms of reference for the design mission are presented as Attachment 1; a list of persons consulted during the mission is presented as Attachment 2; a list of documents reviewed during the concept and design missions is presented as Attachment 3; and the aide memoire is presented as Attachment 4.

2. Situation analysis

2.1 Policy and partnership context

Australian policy and program context

Australia has an international leadership role in HIV including through its board memberships of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and GFATM; financial contributions to GFATM at global level; initiation of the pre-eminent leadership group on HIV in the region (the Asia Pacific Leadership Forum on HIV/AIDS); and work with the business community to establish the Asia–Pacific Business Coalition on HIV/AIDS. Australia has also signed a five-year agreement with the Clinton Foundation to provide technical assistance in the health sector to support HIV treatment access in Asia and the Pacific.

In April 2006, Australia appointed an Ambassador for HIV/AIDS (Ms Annmaree O'Keeffe). The focus of this position is to encourage political, business and community leaders in the Asia–Pacific region to provide the direction and support needed to meet the HIV/AIDS threat. Australia has committed a total of $1 billion over ten years (2000–10) to global HIV/AIDS initiatives.

Australian policy drivers of future HIV/AIDS support to Indonesia include (i) the White Paper *Australian aid: promoting growth and stability* (2006), AusAID's Health Policy (2006) and Gender Policy (2007), (ii) AusAID's Indonesia Country Strategy, (iii) Australia's International HIV/AIDS Strategy (2004), (iv) commitments under UN HIV/AIDS Declarations (2001 and 2006), (v) the Millennium Development Goals, (vi) the 'Three Ones' principles,[7] and (vii) recommendations of the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (2005).

Australian support to HIV initiatives in Indonesia

Australia has funded support for HIV initiatives in Indonesia since 1995, primarily through the two phases of IHPCP:

- Phase 1 (A$20 million) from September 1995 to June 2001, and
- Phase 2 (A$41.5 million) from September 2002 to February 2008. Phase 2 activities are primarily located in Bali, South Sulawesi, Nusa Tengarra Timur (NTT), Java Barat, Papua and DKI Jakarta.[8]

Phase 2, which ends in February 2008, has trialled, modelled and demonstrated a variety of approaches to HIV prevention, care, support and treatment. It has also engaged in advocacy and worked to strengthen the capacity of key players including NGOs and the AIDS commissions at national (KPA), provincial (KPAPs), and district/municipality levels (KPADs).

Contributions from the IPF and local governments have enabled scaling up of IHPCP activities over the past two years, particularly in Java Barat (West Java), Papua and West Papua. IHPCP has been widely recognised as making many positive contributions to Indonesia's response to HIV. Particular successes have been its work in addressing HIV associated with injecting drug

[7] The 'Three Ones' are principles for improved coordination of national HIV/AIDS responses agreed by the UN and donors in 2004. They are:

- One national HIV/AIDS action framework
- One national, multisectoral HIV/AIDS coordinating authority
- One HIV/AIDS country-level monitoring and evaluation system.

[8] DKI refers to Jakarta's status as a province; it stands for Daerah Khusus Ibukota or 'Special Capital Province'.

use (IDU) and, increasingly, the integration of its work within Indonesian systems.

In 2006 AusAID engaged an HIV/AIDS Coordinator, located at the Australian Embassy in Jakarta, to strengthen Australia's support for HIV in Indonesia. Other than IHPCP, this has included:

- assistance in establishing the IPF and participation in its steering group
- participation in the Country Coordinating Mechanism of GFATM, along with various teams supporting GFATM activities
- funding of short-term HIV mainstreaming training and advisory inputs
- strategic research, for example AusAID's 2006 HIV Epidemiological Modelling and Impact [HEMI] Study
- funding to the Australasian Society for HIV Medicine to conduct clinical capacity building through AusAID HIV/AIDS Partnership Initiative grants, and
- scholarships and support for attendance at technical meetings and conferences (e.g. Australasian Society for HIV Medicine annual conferences, International Congress on AIDS in Asia and the Pacific,[9] International AIDS Society conferences).

In addition to the 2006 White Paper, the design team took into account directions outlined in *AusAID 2010: The Director General's blueprint*, in particular the commitment that by 2010:

> The dependence on managing contractor-delivered, technical assistance-oriented, stand-alone projects will have decreased markedly. There will be a significant expansion of sectoral and thematic programs, working through host government development strategies and financial systems and in concert with groups of donors. The delivery mechanisms under the program will be more complex, dependent on specific country circumstances though, in all instances, built around key partnerships. AusAID will have a much greater impact on host government policies through strategic policy dialogue that reflects both broad international priorities and areas of particular Australian interest and competency.[10]

AusAID commenced new programs in 2007 centred on health systems, emerging infectious diseases, and child and maternal health. AusAID's overall program will involve scaling up health, education and infrastructure assistance, particularly in eastern Indonesia including NTT, Papua and West Papua. New opportunities for support to Indonesia may emerge from regional initiatives to be managed by AusAID's Health and HIV/AIDS Thematic Group and the AusAID Development Research Program from July 2007. These initiatives relate to:

- strategic research, and
- HIV workforce capacity building, with a focus on health sector, community sector and research capacity through linkages to Australian HIV organisations and regional partners.

Indonesian policy and institutional context

International commitments

The Government of Indonesia's international commitments to a scaled-up HIV response include:

- its millennium development commitment (MDG #6, target 7) to halt and begin to reverse the spread of HIV by 2015

[9] The 2009 International Congress on AIDS in Asia and the Pacific, to be held in Bali, will be a milestone event for the national program.
[10] AusAID 2010: The Director General's Blueprint. AusAID. February 2007. p .4.

- commitments made in the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) 2006 Declaration of Commitment on HIV/AIDS ('2006 UNGASS Declaration'), including universal access to prevention, treatment, care and support by 2010, and
- Association of South East Asian Nations summit and Third ASEAN Work Program on HIV and AIDS 2006–2010.

KPA and national coordination

The National AIDS Commission, KPA, is the Indonesian counterpart to IHPCP. KPA was reorganised and strengthened by a July 2006 Presidential Regulation.[11] The KPA now reports directly to the President, can raise money and hire staff, and has new, strong leadership. Progress includes:

- strengthening of the KPA Secretariat
- funding support to KPA through IPF
- providing technical support through UNAIDS, IHPCP and others
- strengthening the provincial and district AIDS commissions, including reporting requirements
- finalising a National HIV and AIDS Strategy and development of a draft National Action Plan for HIV and AIDS 2007–10 (National Strategy and Action Plan).

In addition to the KPA, AIDS commissions known as KPAP and KPAD operate at the provincial and district or kota (municipality) levels, respectively. The provisions of the July 2006 Presidential Regulation also apply to these commissions (although not all provinces or districts have KPAPs or KPADs). IHPCP works closely with the national and local AIDS commissions. In some areas IHPCP and commission offices are co-located.

Key actors with leadership roles in KPAPs and KPADs are the provincial governors and vice governors, and bupatis (district head/regent) and vice bupatis.

The new National Strategy and Action Plan will provide the strategic framework for future donor support and priorities to 2010 and beyond. KPA has stated that the two key priorities for donor support are the generalised epidemic in Papua and West Papua and the concentrated epidemic among IDUs in areas of greatest need. KPA has defined targets for progressive achievement of universal access to HIV prevention, care, support and treatment services as required by the 2006 UNGASS Declaration.

The National Strategy has the following Objectives:

- To provide and disseminate information on HIV and AIDS, and to foster a conducive climate for HIV and AIDS prevention efforts, with the focus being placed on high-risk behaviour and environments, while at the same time having regard to other subpopulations in society
- To provide and improve the quality of treatment, medical, and support services to people living with HIV, and to integrate these services with the HIV and AIDS prevention effort
- To increase the roles played by teenagers, women, families, the public at large, including people living with HIV, in the HIV and AIDS response
- To develop and improve partnerships between the government and civil society, including NGOs, the private sector, the business community, professional

[11] Regulation of the President of the Republic of Indonesia. No. 75, 2006. National AIDS Commission.

organizations, and international partners at the centre and in the regions so as to heighten the national response to HIV and AIDS

- To improve policy coordination in the HIV and AIDS response and prevention effort at the national and local levels.

The National Strategy states that the following strategies are to be adopted in achieving the Strategy's objectives:

- Promoting and expanding tried and tested prevention methods, and assessing new methods
- Empowering individuals, families and communities to prevent the spread of HIV in their environments
- Strengthening the basic healthcare and referral systems so as to anticipate an increase in the number of people living with HIV requiring access to treatment and medication
- Strengthening the capacity of those involved in the HIV and AIDS response at both the centre and in the provinces through continuing education and training
- Increasing research and survey efforts so as to obtain accurate data on the progress of the HIV and AIDS response and prevention effort
- Improving national HIV and AIDS monitoring capacity
- Mobilizing resources and harmonizing their use at all levels.

Multi-agency working groups will play a monitoring and advisory role. The working groups most relevant to Australia's support include those centred on prisons, Papua and West Papua, harm reduction and communications.

The draft National Action Plan contains eight key targets for 2010:

- mobilizing 80% of the people most at risk reached by a comprehensive prevention program;
- behaviour change in 60% of the people who are most at risk
- all PLWHA who meet the conditions receiving the antiretroviral treatment (ART), support, care and treatment they need
- an enabling environment (civil society playing an active role and stigma and discrimination eliminated)
- resources and funds (domestic and international) meeting the estimated need in 2008
- pregnant women who are HIV positive receiving ARV prophylaxis
- orphans and vulnerable children receiving a package of support
- new infections reduced by 50% compared to 2005.

BAPPENAS and BAPPEDA

BAPPENAS (the National Development Planning Agency) has the key functions of formulating policies and preparing and coordinating national development plans. Under its direction, sectoral and regional plans and policies are synchronised with national equivalents. Since it has an overview of the various policies and programs in all development sectors,[12] it can provide linkages among programs to ensure maximum results and reduce overlaps. It is also

[12] The sectors covered are economic and finance, poverty, social and human resource development, regional development, environment, infrastructure and governance.

the gateway for official foreign assistance, and provides information on the priority areas/activities for donors' assistance in what is known as the 'Blue Book'.[13] Although BAPPENAS no longer holds a budgeting function, it does coordinate preparation of the annual development budget for all sectors and central funding sources for the regions.

At the provincial and district levels, these functions are performed by BAPPEDA (Regional Development Planning Agencies). Although BAPPEDA are not structurally under BAPPENAS, they have a functional relationship.

DepKes, DinKes and health service delivery

KPA and DepKes (Ministry of Health) have distinct roles in national policy development. KPA has the leadership role in coordinating and monitoring Indonesia's multisectoral HIV/AIDS response. DepKes is responsible for health sector policy guidance, standard setting and programming for the control of epidemics. The health system provides services through districts and municipalities in Indonesia's decentralised system. Health offices at district and municipality (kota) levels are responsible for service delivery. Provincial health offices (DinKes) are responsible for coordination and monitoring of services at district and municipality levels, and secondary referral care where districts or municipalities lack capacity.

Figure 2 illustrates the organisation of health services at the national, provincial and district levels.

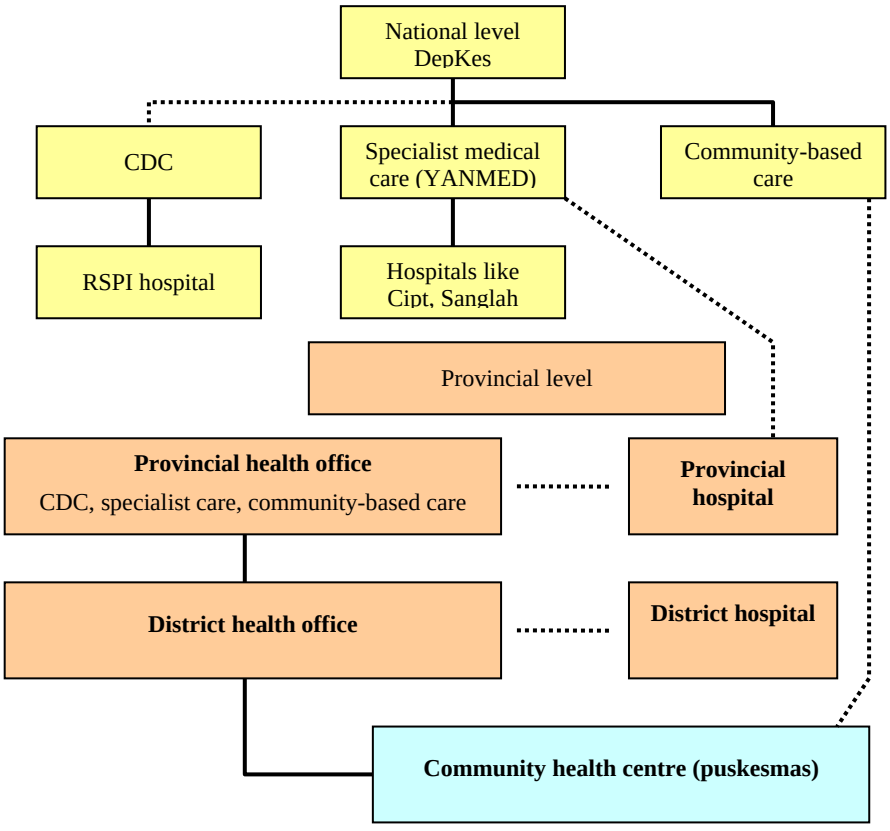


Figure 2: Organisation of health services at national, provincial and district levels

Source: WHO, Briefing Paper Prepared for the External Review of the Health Sector Response to the HIV/AIDS Epidemic in Indonesia, 5–17 February 2007

[13] The Blue Book contains a list of GOI project proposals which are offered to donors for funding.

Past support for strengthening of DepKes capacity for sentinel surveillance has come primarily from FHI/ASA and IHCPC. DepKes is the counterpart to FHI/ASA and the principal recipient of funding from the GFATM. There is likely to be a second principal recipient to strengthen participation of the NGO sector.

The DepKes HIV/AIDS response to date has been constrained by a number of factors. These include a shortage of staff and recent decentralisation, and are in part reflected in the difficulties experienced in administering GFATM funds. DepKes is responsible for implementing the policy of universal access to antiretroviral therapy and already provides antiretrovirals to 61 sites, funded through GFATM. Although antiretrovirals are free, there is often a charge for clinical monitoring (including CD4 [T cell] tests, which are vital for monitoring immune system health).

In response to the WHO/DepKes external review, DepKes is proposing to establish a new body positioned at the level of Secretary General that would coordinate all aspects of the health sector response to HIV (coordination of various DepKes directorates).

DepKes and harm reduction policy

The GOI has a Ministerial Regulation, the *National Policy for Control of HIV/AIDS through Reduction of the Negative Impacts of IDU* ('Regulation 02/07')[14]. The policy provides a strong framework for planning and implementation of activities to prevent and reduce HIV among IDUs. The Regulation includes two main aims:

- prevention of the spread of HIV among IDU and their partners and from IDU to the general population, and
- integration of IDU harm reduction into the public health system through HIV prevention and care, support and treatment (CST) services and drug dependence treatment.

The Regulation includes the following objectives:

- reach and serve 80 per cent of IDU by 2010 (to be implemented in stages)
- provide comprehensive prevention treatment and care that is sustained and continuous
- provide affordable and accessible treatment
- provide harm reduction services at government facilities, including closed settings, and at non-government services, and
- develop programs for referral from the criminal justice system into care and treatment.

Regulation 02/07 gives DepKes the main role in implementing IDU harm reduction, including through identifying resources, providing services, and monitoring and evaluating the results. A December 2006 memorandum of understanding (MOU) between KPA and the National Narcotics Board (BNN) addresses roles and responsibilities relating to harm reduction and illicit drug use.

The GOI policy supports delivery of harm reduction services through puskesmas (community health centres) and NGOs. Delivery is expanding with support from IHPCP and FHI/ASA using GFATM and IPF funds. Some local governments have also provided funding. IHPCP supports 57 needle and syringe programs (NSPs) delivered through puskesmas in DKI Jakarta, Java Barat, Bali, and South Sulawesi. There are 11 methadone maintenance therapy (MMT) sites in Bali, DKI Jakarta, Java Barat and East Java.[15]

[14] Regulation 02/per/menko/kesra/I/2007.
[15] WHO. 2007.

DepHukHam and prisons

DepHukHam (Ministry of Justice and Human Rights) has a National Strategy: Prevention and Control of HIV/AIDS and Drug Abuse: Indonesian Correction and Detention Centres 2005–09 (National Prison Strategy). The aim of the strategy is to 'minimise the distribution of drugs and the spread of infectious diseases such as HIV/AIDS and drugs misuse'.[16] It provides the legal basis for the establishment of services within the prison system. Prison and detention centres are able to provide HIV prevention, as the strategy is fully supportive of harm reduction. The following interventions are promoted by the National Prison Strategy:

- providing health education for prisoners and prison officers
- developing peer education programs in prisons
- strengthening and expanding access to drug treatment in prisons and detention centres
- providing means to prevent HIV, including bleach and condoms
- providing opiate substitution programs
- providing training for prison doctors (including universal precautions)
- strengthening health services in prisons, particularly prevention and treatment of HIV, sexually transmitted infection (STI), TB and other infectious diseases
- providing access to voluntary counselling and testing (VCT)
- providing care, support and treatment for prisoners living with HIV/AIDS (including access to antiretrovirals)
- making prevention of mother to child transmission available to pregnant women prisoners
- strengthening and expanding post-treatment programs for ex-prisoners in the community
- developing referral systems between prisons and community health facilities, and
- developing research capacity with the objective of improving the quality of programs and for behavioural surveillance in prisons.

Needle sharing programs are not precluded under the national Prison Strategy. DepHukHam is still a centralised organisation, and therefore, at the provincial level, it has a representative office, KanWilHukHam.

BNN and law enforcement

Support for harm reduction outside prisons is inconsistent across law enforcement agencies, including the BNN at the various levels of government. Indonesia's strict laws on illicit drugs (possession, use, trafficking and manufacture) can be a challenge for implementing a harm reduction response. When provided through health services, harm reduction interventions including NSPs are normally permitted. Thus the environment is conducive to the new approach of delivering IDU harm reduction services through puskesmas.

Local law enforcement authorities support NSPs at local level, either passively or actively (although in some localities where NGOs provide harm reduction services, fear of arrest among IDUs and outreach workers can be justified). Within this environment, NSPs have scaled up considerably over the last two years, supported by IHPCP, DKT International[17] and recently FHI/ASA.

[16] National Strategy 2005–09, p. ii.
[17] DKT International is a social marketing organisation (see Section 2.3).

Support (including financial) from the governors of DKI Jakarta and Java Barat for delivery of harm reduction services through puskesmas and NGOs, Regulation 02/07 and the MOU between KPA and the BNN addressing roles and responsibilities relating to harm reduction and illicit drug use are important developments toward a law enforcement and criminal justice environment that enables this approach.

Decentralisation

Decentralisation is a constraint to coordinated national responses given the current ambiguities surrounding the relevant accountabilities, responsibilities and relationships between national ministries and provincial and district/kota agencies, including oversight and supervision of the performance of regional governments and sectors. Health funding is drawn from at least five different sources, and three approaches are used to calculate health program costs: (i) a proportion of the overall budget irrespective of population or the burden of disease; (ii) per capita estimates; and (iii) program costing based on activity and input based costing.[18]

There has been donor support for modelling and piloting more robust frameworks and Presidential Regulation 65/2006 is said to clarify how mandatory service standards should be prepared. Regulatory instruments are being developed to further support a strengthened approach.[19]

Papua and West Papua provinces

In 1999 Papua was officially divided into the provinces of Papua and West Papua, although the two provinces continued to operate under a single administration until 2006. Autonomy for Papua brings considerable financial benefit. However, the rights of West Papua to financial benefits under the 2001 Papua Special Autonomy Law (which sees the transfer of 2 per cent of the central government's general allocation funds transferred to Papua in recognition of its resource revenues)[20] are not clear: West Papua has not received a share of the special autonomy funds to date. The outcome of a February 2007 meeting between the governors of the two provinces is understood to be agreement to share these funds in the future. The issue may be complicated should Presidential Instruction No. 1/2003 progress, which calls for the establishment of a third province. In early 2007 proposals were made for the establishment of South West Papua, South Papua and Central Irian Jaya.[21] The likelihood or timetable for the creation of new provinces is unclear.

The Papua Government prepared a Papua Development Strategy in late 2006. It specifies Papua's development objectives and highlights areas in which donor cooperation is sought. These include health and HIV, gender equality and public sector and other reforms. There is limited management and system capacity across all sectors to respond effectively to the strategy. The Papuan Government is seeking donor alignment and harmonisation, including through a new arrangement whereby donors work under the same roof.

There is a Strategic Plan for the Management of HIV/AIDS in Papua Province 2007 – 2011 which provides the framework for a comprehensive response to the generalised epidemic, although its application to West Papua is as yet unclear. At the time of the design team's mission the draft Strategic Plan had been costed at Indonesian Rupiah 1.2 trillion. A provincial regulation on HIV/AIDS had also been drafted and is expected to be enacted soon. Some KPADs have participated in HIV response planning, including strategic plan development and

[18] Gani, A. Excerpt from District Health Financing Reform in Decentralisation. Unpublished. Health Decentralisation Seminar. June 2006.
[19] USAID. Stock Taking Study on Indonesia's Recent Decentralization Reforms: Summary of Findings. 2006. Unpublished.
[20] This is estimated at around Rupiah 1.4 trillion per annum (Jakarta Post, 28 February 2007).
[21] Reported in the Jakarta Post, 21 February 2007.

budget allocation, and have delivered prevention-focused activities. There is strong support within them for 100 per cent condom use legislation and programs.[22] In most parts of Papua and West Papua, however, the poor state of health and transport infrastructure will pose a challenge to prevention, care and support activities.

As well as decentralisation, including the power of local governments to make laws that may be in conflict with best HIV practice (e.g. may be punitive), other institutional issues impacting on HIV include (i) West Papua being a new province with embryonic policy and planning capacity; (ii) weak KPAPs and KPADs in various stages of early establishment; and (iii) a weak health system with weak management capacity, inconsistent HIV testing and treatment capacity and weak referral systems. On the positive side, Papua is a *relatively* wealthy province, and IHPCP has indicated that co-financing of workshops or other activities is within Papua's means.

2.2 General health and HIV situation

Human development and health indicators

Indonesia's Human Development Index (HDI) rose steadily until the mid 1990s. Since the financial crisis of 1997 there has been slow improvement in basic health and education development indicators. The national average life expectancy was 69 in 2005. Infant mortality and child malnutrition rates have continued to decline, but only gradually after 1997. The Central Bureau of Statistics uses national data to calculate its Human Development Index, ranking districts by HDI status. The average HDI for Indonesia in 2002 was 66. This masks considerable variation across the country, ranging from a national low of 47 in Jayawijawa (in the Papuan highlands) to 76 in East Jakarta.[23]

Papua and West Papua are experiencing a double burden of disease: infectious diseases have not declined and non-communicable diseases are increasing. In 2006 life expectancy was 66, the infant mortality rate was 56/1000 (national 35), the maternal mortality rate was 396/10 000 (national 307), and the estimate of risk exposure to HIV and AIDS was two to 20 times higher than nationally.[24]

National HIV situation

The HIV epidemic in Indonesia emerged in 1999 following the first reported HIV infection in 1987 and an increase in IDU from 1997. A transition to a generalised epidemic by 2025 is predicted without an increased response, with estimates of 1.5 million deaths by 2025 and two million people living with HIV (when excluding estimates for Papua and West Papua), as shown below.[25]

[22] The 100% Condom Use Program aims to prevent the spread of HIV infection among sex workers, their clients and the general population by getting owners and managers of entertainment establishments to enforce the use of condoms for commercial sex.
[23] Indonesia Human Development Report 2004.
[24] Papua Development Strategy 2006.
[25] Australian Government. AusAID. The HEMI Report. 2006.

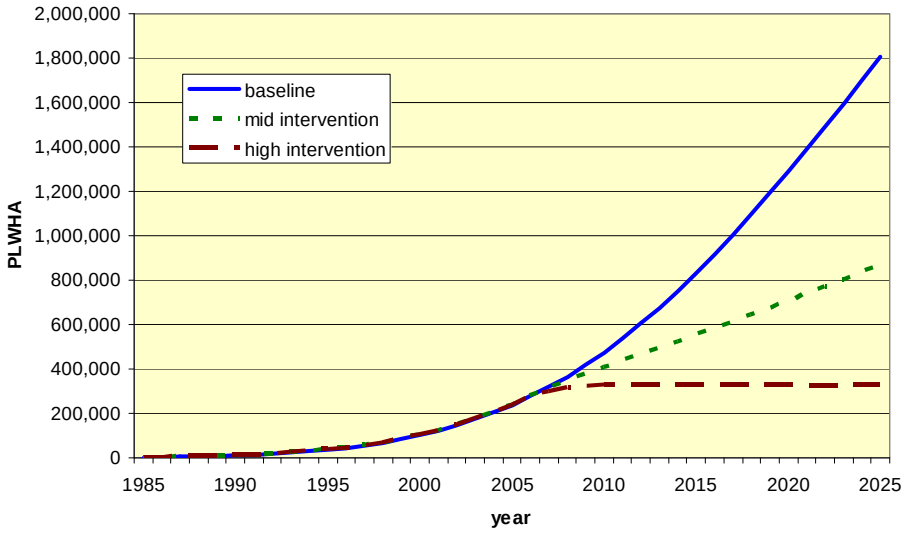


Figure 3: HIV/AIDS projections for Indonesia (excluding Papua/West Papua) under different intervention scenarios
Source: HEMI Study, 2006

In 2006 there were between 171 000 and 219 000 people living with HIV in Indonesia according to DepKes estimates, with 2 per cent[26] to 30 per cent[27] residing in Papua and West Papua, approximately 50 per cent in Java and the remainder spread across the archipelago.[28]

While validity and reliability of data and surveillance are fragile, available data and expert opinion confirm that Indonesia is experiencing three different escalating HIV epidemic patterns:

- concentrated epidemics in IDUs and their sexual partners
- concentrated epidemics in sex workers and their clients
- a generalised epidemic in Papua and West Papua.

Drivers of these HIV epidemics include IDU including in prisons, poverty, gender inequality, mobile men with money who use sex work services, and sex workers who have mobility.[29] In Papua and West Papua sexual transmission is thought to be exacerbated by low levels of circumcision, high STI rates, behavioural factors and alcohol misuse.[30] IDU is not a major avenue of transmission in Papua or West Papua.

Virtually all notified cases of HIV have been acquired through IDU or sexual transmission. Estimates produced by DepKes (2006) of the distribution of people living with HIV nationally are:

46%	IDUs
7%	Sexual partners of IDUs
14%	General population in Papua and West Papua
14%	Clients of female sex workers
5%	Female sex workers

[26] UNAIDS. HIV/AIDS Programmes in Indonesia. Status of the National Response. 1 June 2005. p. 4.
[27] World Bank. Draft Indonesia HIV Concept Note. Human Development Sector Unit. East Asia and Pacific Region. 2005. p. 2.
[28] Republic of Indonesia. KPA Nasional. Scale up plan for HR intervention for injecting drug user (draft). 2006. p. 3.
[29] Republic of Indonesia. National AIDS Commission. Reporting Period 2004–2005. pp. 16–17.
[30] ibid.

3%	Partners of clients of female sex workers
5%	Men who have sex with men
2%	Waria (male transvestite/transsexual)
3%	Prisoners
1%	Clients of waria

Data on other modes of transmission is not readily available. Mother to child transmission is a growing cause for concern, especially in Papua and West Papua. Although protocols recommend that blood donations for transfusions be screened for HIV, transmission is thought to occur due to inconsistent implementation and monitoring of protocols.

As shown in Figure 4, the provinces with highest estimated HIV cases are DKI Jakarta, Papua, East Java, Java Barat, North Sumatra and South Sulawesi.

The highest cumulative rate of *AIDS* cases in Indonesia is Papua (15.9 times national estimate), DKI Jakarta (8.4 times national estimate), Bali (2.8 times national estimate), Maluku (2.7 times national estimate), West Kalimantan (1.9 times national estimate), Riau and Riau Islands (1.8 times national estimate), North Sulawesi and Bangka Belitung (both 1.6 times national estimate).[31]

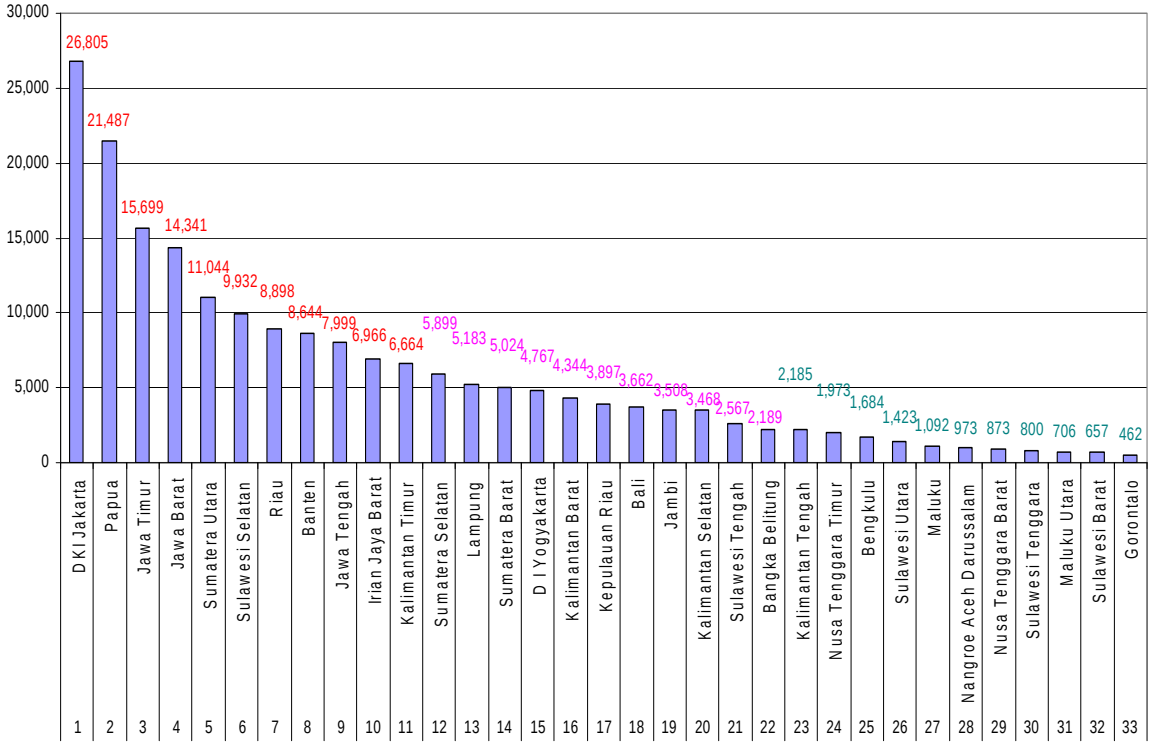


Figure 4: HIV estimates by province, 2006

Source: DepKes presentation, *Pengendalian HIV AIDS Komprehensif Papua Dan Irjabar*, February 2007

Reported HIV prevalence varies. A recent AusAID study estimated that in 2005 HIV prevalence in the adult population was 0.17 per cent (outside Papua). The study predicts that unless the response is scaled up, by 2025 adult prevalence will rise in Papua and West Papua to 7 per cent and in the rest of Indonesia to 1.08 per cent.[32]

[31] DepKes. Cumulative AIDS data up to June 2006 (from KPA website).
[32] Australian Government. AusAID. HEMI Report. 2006.

In Papua and West Papua, recent GOI survey data indicate a higher prevalence in the general population than previously found, at 2.5 per cent of adults and rising to 2.9 per cent in Indigenous Papuans.[33]

While prevalence data are useful, the more significant indicator of the longer term trend and potential social impact is the incidence of new infections. Incidence data are difficult to obtain; however, modelling can provide an indication of likely future trends. Available data and expert opinion suggest that in the majority of provinces (excluding Papua and West Papua) the concentrated epidemic in the IDU population eclipses that in the sex worker population.[34] Projections suggest that over time sexual transmission will become the major mode of transmission nationally. Currently, however, IDU is the most significant mode of transmission outside Papua and West Papua.

Around 7 per cent of deaths in Papua and West Papua are from tuberculosis. TB is an opportunistic infection associated with HIV, indicating the HIV/AIDS response in Papua and West Papua needs to address the relationship between TB and HIV through an integrated approach. It is likely that TB incidence and associated death rates will increase as HIV spreads.

HIV/AIDS and gender

AusAID's February 2007 gender policy emphasises that all Australia's development work will embrace gender equality. The policy defines gender as 'the social attributes and opportunities associated with being male and female', recognising that these are socially constructed, context and time specific, and changeable. It is noted in the policy that ideas about masculinity, particularly those related to power, ownership and violence against women, have a significant impact on women's and girls' rights. This increases the HIV risk for women and girls. The policy notes that gender-based norms and stereotypes also affect men and boys, and can have negative impacts on their health and wellbeing. While acknowledging that there may be discrimination against men and boys that needs to be addressed, and that there is diversity between people including of the same sex, the policy notes that addressing gender inequality requires working with both men and women and addressing the social, economic and institutional structures that reinforce it.

Throughout Indonesia some level of male marital infidelity is common, despite cultural and religious norms dictating that sexual relations should exist only within marriage. Reproductive health services have traditionally focused on married people, excluding single people and sexual health generally.[35] For many women, poverty influences behaviour. Some impoverished women may be forced by their circumstances to engage in transactional sex (sex in exchange for goods or services) or sex work as an economic survival strategy.

In Indonesia, the male-to-female ratio among reported HIV cases in 2003 was 4.7:1[36] and in 2006 the ratio of AIDS cases (not HIV) between male and female was 4.5:1.[37] The vast majority of the IDU HIV positive population are men.

In generalised HIV epidemics elsewhere in the world (such as the worst-affected countries in sub-Saharan Africa) women have come to represent the majority of people living with HIV. However, HIV positive men still outnumber women by 3:2 in Papua and West Papua,

[33] Integrated Bio-behavioural Survey 2006, data provided to design team and WHO mission by DinKes Papua.
[34] UNAIDS. 2005. p. 3.
[35] Hudiono, E. Women and HIV/AIDS in Indonesia. Monitoring Ten Years of International Conference on Population and Development (ICPD) Implementation: The Way Forward to 2015: Asian Country Reports. Asian–Pacific Resource and Research Centre for Women. 2005. Chapter 5.
[36] UNAIDS WHO. Epidemiological Factsheet HIV/AIDS and STIs Indonesia. 2006. p. 4.
[37] KPA website.

suggesting that male mobility and sex work remain key drivers of the epidemic in Papua and West Papua. Melanesian epidemics do, however, have unique characteristics, and caution should be exercised before drawing conclusions from observations of epidemic trends elsewhere in the world.

There is support needed to increase the influence of women in general. Many groups have special needs, including partners of IDU, monogamous women whose partners visit sex workers or have transactional sex, female IDU, women in prisons, and partners of HIV positive people in prison.

The generalised sexually-driven epidemic in Papua and West Papua places married and unmarried men and women of all ages in the general population, including young people, at risk of acquiring HIV from their sexual partners. Reported high rates of gender-based violence in Papua and West Papua aggravate women's vulnerability. Female sex workers and their partners are particularly at risk, with HIV prevalence of over 20 per cent recorded among some female sex worker cohorts. In other parts of Indonesia, there are three cohorts of women particularly affected by HIV: sex workers, women whose sexual partners are either IDU or clients of sex workers, and female IDU.[38]

The new program will ensure its strategies and activities address gender equality as it relates to increasing the HIV risk, including addressing vulnerability of women and girls to HIV/AIDS arising from poverty (e.g. transactional sex of men with girls), violence, and supporting equal participation of women in program activities (e.g. working with female sex workers as well as with male clients of sex workers). Women's organisations will be supported to articulate and lead change in preventing HIV in girls and women.[39] Behaviour change in men to support reducing this risk will also be addressed (e.g. workplace interventions in government and key private sectors such as the extractive industries in Papua and West Papua).

In line with AusAID's 2007 gender policy, the new program will support strengthened capacity of partners including government agencies to collect sex- and poverty-disaggregated data, analyse the different impacts of HIV policies and program activities on women and men, and develop strategies and activities to prevent HIV accordingly. Gender equality issues will be monitored through the M&E Framework (see Section 5.5).

Papua and West Papua generalised epidemic

The population of Papua and West Papua can be categorised into three groups: Indigenous Papuans (65 per cent), Indonesians originally from outside Papua, and foreigners. The total population in 2000 was 2.23 million, of which 1.85 million live in Papua Province (Census 2000). The most populated areas are Kabupaten Jayawijaya (417 326 people) in the central highlands and Kabupaten Merauke (318 350 people) on the south coast.

There are limited health services, and there are geographic constraints to access particularly in remote coastal and mountain areas. Other issues are lack of infrastructure, rising costs with low budgets, poor equipment, and low expertise across all levels and functions. Traditional healers are often consulted and there are technical and cultural constraints to cooperation between them and 'western' medical practitioners.

A strategic aim of government is to shift from 'the medical model' of treating diseases to a stronger public health approach that includes prevention and health promotion as well as

[38] Hudiano, E. Women and HIV/AIDS in Indonesia. Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015: Asian Country Reports. Asian–Pacific Resource and Research Centre for Women. 2005. Chapter 5.

[39] OECD. Development Assistance Committee. Review of gender and evaluation. Hunt, J and Brouwers, R. OECD DAC Evaluation Series. Paris. 2005.

treatment and care. To achieve this, strengthened health facilities are needed particularly for primary care, and strengthened networks and referral systems between facilities. Key components of referral networks will be puskesmas (community health centres), puskesmas pembantu (health centre branches), polindes (village midwife clinics) and hospitals.

There are insufficient numbers of staff and insufficient technical and managerial skills, reflecting the low levels of education across Papua and West Papua (Papua and West Papua have the lowest level of adult literacy in the nation at 74.4 per cent).[40] In addition, recruitment efforts are largely unsuccessful, chiefly because well-trained health professionals are reluctant to move from other parts of Indonesia to Papua and West Papua. There are two nursing schools in Papua and West Papua, but training is expensive and there are few Indigenous Papuan nursing students attending.

HIV situation

There are an estimated 21 487 people living with HIV in Papua and 6 966 in West Papua.[41] The epidemic is driven by sexual transmission. HIV projections for Papua and West Papua over the next 20 years indicate a rapidly escalating generalised epidemic (see Figure 5).

Prevalence of HIV in adults is 2.5 per cent and prevalence is still very high among sex workers, above 20 per cent, higher than anywhere else in Indonesia. Considered together with known data, this places Papua and West Papua at high social and economic risk from any escalation of the current generalised HIV epidemic.

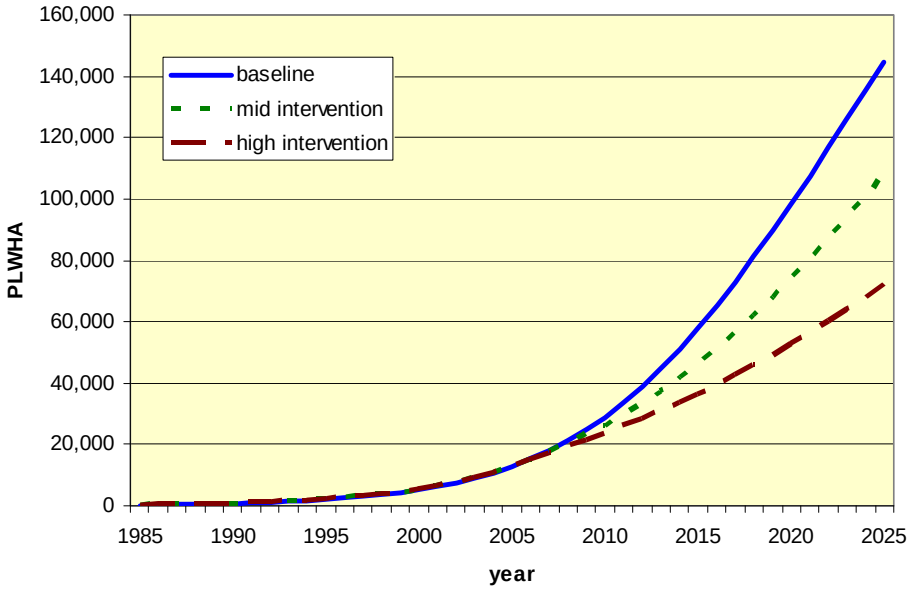


Figure 5: Total HIV/AIDS projections for Papua/West Papua under different intervention scenarios

Source: HEMI Study, 2006

IDU is not widespread in Papua and West Papua and is not currently considered an important mode of transmission.[42] Integrated bio-behavioural survey (IBBS) data indicate that men who have HIV significantly outnumber women, indicating that sex work remains a significant driver of the epidemic.

[40] Indonesia Human Development Report 2004.
[41] DepKes 2006 estimates.
[42] Republic of Indonesia. National AIDS Commission. Reporting Period 2004–2005. p. 16.

In March 2007, IBBS summary data were available to members of the WHO/DepKes review of the health sector response to HIV in Indonesia (which has since been published).[43] As shown in Figures 6 to 8, the data confirm a generalised epidemic, with HIV prevalence in excess of 2 per cent among both men and women across the general and high-risk populations and higher prevalence in mountain areas and remote coastal areas.

The IBBS data also indicate a low level of knowledge about HIV and AIDS generally; low use of condoms including among sex workers and their clients; a high proportion of men using alcohol prior to transactional or commercial sex; and high levels of STIs with a low level of treatment sought.

These results reflect the known contextual issues influencing the increase in HIV including (i) the strong culture of commercial and other transactional sex, including brothels; (ii) low circumcision levels in the non-Islamic population especially; (iii) internal, inter-island and cross-border mobility in the population in general and men seeking work in particular; (iv) mobile men with money (e.g. those engaged in the fishing, pearling, forestry, mining and petroleum industries); (v) different tribal languages impacting access to information and different customs impacting responses to any information accessed; and (vi) stigmatisation and fear of HIV.

[43] Ministry of Health and Central Statistics Agency. Risk Behaviour and HIV Prevalence in Tanah Papua, Results of the 2006 IHBS, June 2007.

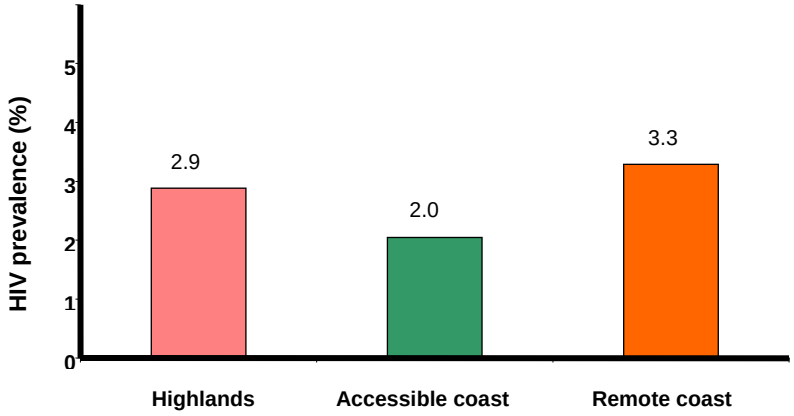


Figure 6: HIV prevalence in Papua and West Papua, by topography
Source: Papua and West Papua IBBS

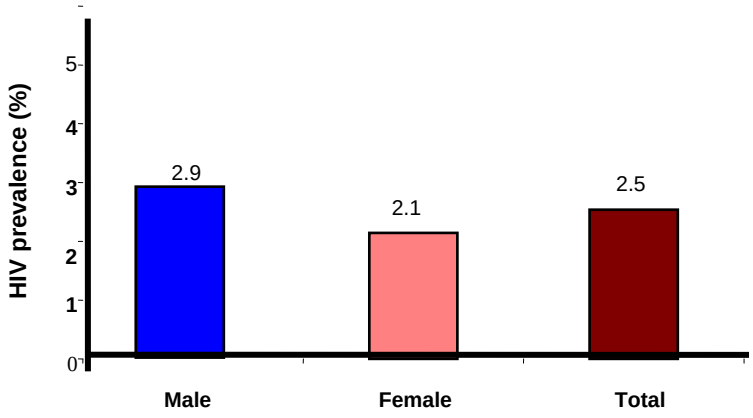


Figure 7: HIV prevalence in Papua and West Papua, by gender
Source: Papua and West Papua IBBS

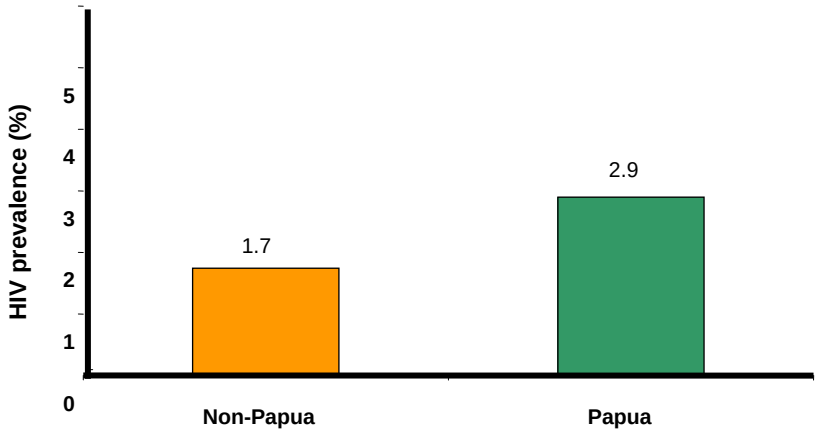


Figure 8: HIV prevalence in Papua and West Papua, by ethnicity
Source: Papua and West Papua IBBS

Gender

Papua and West Papua have a patriarchal system. Government policies do not reflect equality in gender perspectives. A 2005 analysis[44] found no local government regulations prohibiting gender discrimination or supporting harmonious family relations. Girls access education less than boys. Men are dominant in decision-making in government, at work, in the community and at home, with inequality in power and resource sharing. Many men drink and may have multiple partners, and the majority prefer not to use condoms. Girls of school age and women are said to be at particular risk from transactional sex, as are female sex workers. This in turn places monogamous wives and partners at risk.

There are increasing reports of violence against women and criticisms of their handling by police. Men are therefore a primary target group in current and future HIV work. Current efforts include promoting a positive view of masculinity, positive male role models, and alternative ways of behaving. IHPCP has conducted training courses for men in the workplace to assist these efforts, including among religious leaders and in the mining community. These efforts need to be strengthened.

One university in Jayapura has a women's studies centre, and a university in Merauke is establishing a women's and children's research centre. These may be useful points of access for the new program. Under current donor support there has been limited HIV work with women's groups, primarily with some church leaders' groups, while it is claimed that there has been greater awareness raising in women than men. Women's greater awareness is said to result in part from the fact that all pregnant women are offered VCT in the first or second trimester. The view of IHPCP is that the current stand-alone VCT services should be integrated into general health services, with provider-initiated counselling and testing for men as well as women at puskesmas level. IHPCP advises that this view is not consistently embraced across the health and community sectors.

Condoms

The low general awareness of HIV and AIDS and widespread misconceptions (e.g. that HIV is caused by mosquito bites or STIs are cured by sexual relations with a virgin), alcohol use and the low quality of condoms (brittle, uncomfortable, breakages) mitigate against progress towards 100 per cent use of condoms. Other contributing factors are religious conservatism towards condom use and traditional concepts of illness which influence not only interpretation of HIV messages but also the use of preventive measures such as condoms and seeking treatment for STIs. Effective drugs for the majority of STIs (60 per cent) may not be available until 2008.

DKT International is highly regarded across Indonesia for its social marketing of condoms including in Papua and West Papua. However, the program has a limited education outreach focus and coverage, including to sex workers, who are predominantly women. IHPCP and others recently funded education programs on female condoms in Papua. These programs have generated high interest in female condoms as an alternative prevention strategy for women, including for female sex workers. The price of female condoms is high compared to male condoms and it is too early to assess take up. There is potential for DKT International to broaden its approach in Papua to include education outreach to sex workers.

[44] Synthesis Team. A Multistakeholder Synthesis of the Development Situation in Papua. A cooperation between UNDP, the local government and multistakeholders in Papua. May 2005.

Treatment programs

IHPCP has worked with the puskesmas in Timika to support an antiretroviral program, but progress has been slow. FHI/ASA has been taking the lead in HIV and STI care, support and treatment capacity building in Papua and West Papua. Although the future of FHI/ASA in Papua and West Papua is uncertain beyond 2008, USAID is expected to provide continued support in the two provinces.

The Clinton Foundation has expressed an interest in working in Papua and West Papua on technical capacity building and health systems strengthening relating to antiretrovirals. Since 2006 AusAID has supported the Clinton Foundation to establish a major treatment capacity development program in Papua New Guinea. The Clinton Foundation may be able to bring benefits to Papua by drawing from its experience in PNG and globally in addressing treatment needs in remote and poorly served settings.

Concentrated epidemics

Sex workers and their clients

HIV prevalence in sex workers is said to be over 4 per cent nationally. In Jakarta, prevalence has increased from 1.1 per cent in 2001 to 6.4 per cent in 2004.[45] By 2025, if the response is not scaled up HIV prevalence among sex workers is predicted to rise to over 40 per cent in Papua and West Papua and 22 per cent in other provinces.[46]

Statistics on condom use vary. One study found that STI rates (syphilis) among sex workers are high and condom use low,[47] while KPA data suggest that condom use is high at 47.5 per cent and 56.2 per cent, respectively.[48] Estimates of the numbers of clients of sex workers in Indonesia vary from 7 to 10 million (GOI) to 50 per cent of the male population.[49] One estimate is that 60 per cent of clients are married. HIV prevalence among male sex workers in some sentinel sites in Jakarta in 2002 was between 2.7 per cent and 3.8 per cent in 2004, and among female sex workers in 2003 it was 6.4 per cent.[50] Consistent condom use in anal sex with clients by waria (male transvestite/transsexual) sex workers ranged from 17 per cent in Java Barat to 56 per cent in Jakarta, with around 70 per cent stating they had STI screening within the three months before the survey.[51]

MSM and waria

In 2004 KPA estimated there were up to 1.7 million MSM (men who have sex with men) and over 14 000 waria in Indonesia. In a 2004 Jakarta study,[52] 18 per cent of MSM reported also having sex with women in the previous 12 months. An unknown proportion of MSM thus place their female partners at risk.[53] Reported condom use among MSM was 56.5 per cent in 2004–05.[54] HIV prevalence in MSM is 0.23 per cent, which will rise to 1.45 per cent in 2025 if behaviours remain unchanged, or to 0.40 per cent by 2025 if behaviours do change.[55] Prevalence of HIV in waria is said to be high at 25.7 per cent in some sentinel sites in

[45] FHI. 2005.
[46] Sugihantono et al. 2003 and Basuki et al. 2002. Cited in Australian Government. AusAID. HEMI Report. 2006. p. 84.
[47] ibid.
[48] Republic of Indonesia. National AIDS Commission. Reporting Period 2004–2005. p. 13.
[49] Utomo et al. 2001. Cited in Australian Government. AusAID. HEMI Report. 2006. p. 84.
[50] ibid., p. 14.
[51] FHI/ASA. Year One Workplan. October 1, 2005 – September 30, 2006. pp. 52 & 53.
[52] Pisani et al. 2004. Cited in Australian Government. AusAID. HEMI Report. 2006. p. 85.
[53] Republic of Indonesia. National AIDS Commission. Reporting Period 2004–2005. p. 23.
[54] ibid.
[55] Australian Government. AusAID. HEMI Report. 2006. pp. 85 & 86.

Jakarta[56], with around 5.7 per cent reached by prevention programs.[57]

Prisoners

The majority of prisoners are charged for narcotics-related crimes, the number of people charged is increasing, and many are repeat offenders (see Table 1).

Table 1: Percentage of prisoners charged with drug-related crimes

Year	Total number of prisoners	Number of prisoners charged with drug-related crimes	%
2002	67 960	7 211	10.6
2003	71 587	11 973	16.7
2004	88 887	17 060	19.2
2005	89 708	21 082	23.5

Source: Ministry of Justice, 2004

HIV prevalence ranges from 10 per cent[58] to 25 per cent of prisoners in Cipinang, Jakarta[59], to more than 50 per cent in the Bali prison.[60] HIV transmission in prisons is mostly IDU related. According to a 2006 overview of HIV in Indonesian prisons by Winarso and colleagues[61]:

> There were around 89 708 prisoners in Indonesia's 396 prisons in April 2006…Prisons are working at over-capacity and with miniscule healthcare budgets. There has been an increase of deaths due to AIDS, particularly among IDUs. Official data show that HIV prevalence averages 22 per cent in prisons.

DepHukHam has made substantial progress in its response to HIV/AIDS in the last three years. With IHPCP and others supporting their response, they have been the first ministry responsible for prisons in an Asian country to enact and implement an HIV/AIDS strategy for prisoners in a systematic manner.[62]

[56] Republic of Indonesia. National AIDS Commission. Reporting Period 2004–2005. p. 15.
[57] ibid., p. 19.
[58] PadDepKesoedojo 2004. Cited in Australian Government. AusAID. HEMI Report. 2006. p. 82.
[59] World Bank. 2005. p. 6.
[60] Setewian 2002. Cited in Australian Government. AusAID. HEMI Report. 2006. p. 82.
[61] Winarso, I et al. Health and Prison Briefing, Indonesian National Strategy for HIV/AIDS control in prisons: A public health approach for prisoners. International Journal of Prisoner Health, September 2006, 2(3): 243–249.
[62] Inang Winarso et al. Indonesian National Strategy for HIV/AIDS control in prisons: A public health approach for prisoners 2006 International Journal of Prisoner Health, September 2006, 2(3): 243–249.

Table 2: HIV prevalence among prisoners in Indonesia

Province	Prevalence (%)				
	1999	2000	2001	2002	2003
DKI Jakarta	1.69	17.53	22.0	7.55	17.65
Java Barat	0.9	7.0	20.6	5.0	21.1
East Java			0.68		4.23
Bali	18.7		9.6	10.2	10.7
Lampung			2.5	2.3	2.8
Babel	1.0				
DI Yogyakarta		2.8			
Banten				10.8	21.3
East Kalimantan					0.36

Source: DepKes, September 2004

Although Indonesia has a zero-tolerance policy and legislation is strictly enforced, there were approximately 50 reported cases between 2003–05 of drugs and injecting equipment found in prisons. The majority of deaths in prison are reported as being associated with HIV-related opportunistic infections such as TB.

IDUs and their sexual partners

The contribution of injecting drug use to HIV transmission in Indonesia has increased substantially since the late 1990s. In 1999 18 per cent of IDU patients of a Jakarta drug dependency hospital were found to be HIV positive. By 2000 the rate was 40 per cent and by 2004 over 50 per cent. This increase appears to be associated with the 1997 economic crisis and to a change in drug market activity as the country changed from primarily a transit country for heroin to one where heroin was also supplied for domestic consumption. Heroin remains the drug most commonly injected in Indonesia.

The rise in availability and use of methamphetamine in Indonesia and the region is also of concern. In contrast to heroin, knowledge and understanding of the behavioural effects of stimulants is limited, and much less is known about effective detoxification and treatment of methamphetamine users. There is no accepted treatment currently available for methamphetamine users (such as methadone for dependant heroin users). Changes in patterns of illicit drug use in future years will impact on the nature of the HIV epidemic and the required response and will need to be monitored.

Estimates of the IDU population vary from 160 000 (DepKes), 124 000–195 000 (UNAIDS), and 500 000–570 000 (BNN). Estimates of HIV prevalence in IDUs also vary and include 15 per cent,[63] 19.2 per cent,[64] and 42.9 per cent in some sentinel sites in Java Barat, the latter an increase from 15 per cent in 1999,[65] and 45 per cent in East Java, 48 per cent in Jakarta, and 37 per cent[66] to 53 per cent[67] in Bali.

[63] Australian Government. AusAID. HEMI Report. 2006. p. 83.
[64] UNAIDS. p. 4.
[65] Republic of Indonesia. National AIDS Commission. Reporting Period 2004–2005. p. 15.
[66] Republic of Indonesia. KPA Nasional. Scale up plan for HR intervention for injecting drug user (draft). 2006. p. 3.

A 2006 national estimate provided by WHO, drawing on data from a KPA national estimates process,[68] reported that there were between 190 460 and 219 230 IDUs in Indonesia, with an HIV prevalence range of 31.7–52.3 per cent. It was estimated that around 90 000 IDU were living with HIV. Furthermore, 46 per cent of people living with HIV or AIDS had been infected through injecting drug use and 7 per cent as sexual partners of IDUs. Bio-behavioural surveillance in Medan, Jakarta, Bandung and Surabaya in 2004–05 showed that more than 75 per cent of IDU were using and sharing non-sterile injecting equipment. WHO estimates suggest that, at present, HIV harm reduction activities are reaching around 15 per cent of IDUs. Estimates by IHPCP and NGO partners suggest coverage of prevention services may be around 10 per cent of IDUs. Analysis of data provided by KPA indicates that the ten provinces with the highest estimated numbers of HIV positive IDUs are (in order) Jakarta, Java Barat, Central Java, East Java, North Sumatra, Yogyakarta, Bali, Banten, South Sulawesi and Riau (see Table 3).

The percentage of IDUs who adopt HIV prevention behaviours is said to be low at 18.5 per cent, with IDUs under 25 years of age more likely to adopt prevention behaviours than those over 25.[69] More than 80 per cent of IDUs report both needle sharing and no condom use.[70] More than 50 per cent of people with AIDS are IDUs or their sexual partners.[71] Coverage of prevention services is thought to be less than 10 per cent of IDUs, and coverage of VCT services is estimated at 18 per cent.[72]

Table 3: Estimates of HIV among IDU: Top ten provinces

Province	Number of IDUs	% of IDUs infected with HIV	HIV positive IDUs
Jakarta	27 536	37.5	10 326
Java Barat	22 133	27.5	6 086
Central Java	14 940	27.5	4 108
East Java	14 498	27.5	3 986
North Sumatra	18 741	20	3 748
Yogyakarta	11 738	27.5	3 227
Bali	4 419	37.5	1 657
Banten	5 952	27.5	1 636
South Sulawesi	6 194	20	1 238
Riau	5 473	20	1 094

Source: KPA 2006[73]

Despite the growing commitment by many parties in Indonesia, both GOI and others, and an increasingly enabling regulatory environment, the response to the HIV epidemic among IDUs is insufficient for the size of the problem. To date the majority of the work has been carried out by

[67] World Bank. 2005. p. 1 of Summary and p. 3 of draft Concept Note.
[68] WHO. Briefing Paper Prepared for External Review of the Health Sector Response to the HIV/AIDS Epidemic in Indonesia, 5–17 February 2007.
[69] Republic of Indonesia. National AIDS Commission. Reporting Period 2004–2005. p. 14.
[70] ibid., p. 7.
[71] Irawati et al. Indonesia Sets Up a Prison Methadone Maintenance Treatment. Addiction, Vol. 101, Issue 10, pp. 1525-1527: News and Notes.
[72] Republic of Indonesia. National AIDS Commission. Reporting Period 2004-2005. p. 7.
[73] Prevalence data drawn from: KPA. Scale up plan for harm reduction interventions for IDUs. Draft. August–September 2006. pp. 3–4.

donor-funded NGOs with little involvement from GOI health services until 2006. In 2005 there was only one puskesmas in Jakarta that provided harm reduction services in Indonesia. By 2006, the number had increased to 65. IHPCP and the local AIDS commissions are sharing the cost of these facilities for one year, with the commitment that future costs will be fully borne by the government.[74]

Drug user participation in policy, planning and delivery of programs is a key element of an effective harm reduction approach. Many Indonesian NGOs consist of current and former drug users, and two national networks are advocating the rights and interests of drug users nationally including rights to HIV prevention, treatment and care. These community-based groups are recognised by KPA and the national networks are increasingly included in government meetings and decision-making processes.

2.3 International donor response

Global Fund to Fight AIDS, Tuberculosis and Malaria

Indonesia has received significant funding from the GFATM (to date, Round 1: US$7 062 548 and Round 4: US$16 023 871). However, far lower amounts than received have actually been spent due to absorptive capacity constraints and performance problems. Indonesia's submissions for Rounds 2 and 3 were not successful. The submission for Round 6 funding, focusing on prevention of mother to child transmission of HIV, was also not successful. GOI has applied for Round 7 funding. GOI has also applied to the Debt Conversion Fund for US$50 million for an expanded prisons program.

GFATM is supporting treatment provision in 17 provinces with highest HIV prevalence, where antiretrovirals are provided free of charge.

There is considerable uncertainty regarding the future for GFATM rounds 4, 7 and beyond. Shortly before the design mission, GFATM funding to Indonesia of US$147 million was temporarily suspended. This was a consequence of a December 2006 audit by the GFATM's Office of Inspector General, which found significant irregularities.[75]

It is anticipated that there will be a period of reform of Indonesia's GFATM mechanisms and procedures in response to the suspension.

Another concern with GFATM activities in Indonesia is the reported lack of integration and coordination of funds with other health budgets at provincial and district levels.

USAID and FHI/ASA

The US$60 million five-year FHI/ASA project operates in ten provinces, building capacity in local governments and NGOs, and targets most at-risk groups including sex workers and their clients, uniformed services and major transportation hubs, as well as the general population in Papua. It promotes prevention, treatment and care, and encourages private companies to be actively involved in HIV prevention.

The FHI/ASA project was reviewed in early 2007. The project is due to end in 2008, although there may be a two-year extension depending on the outcome of the review. The project's USAID funding falls within the President's Emergency Plan for AIDS Relief (PEPFAR), although Indonesia is not classified as a PEPFAR priority country. Indonesia has been granted an exemption from PEPFAR restrictions (such as requirements to spend a percentage of funding on abstinence) because Indonesia's epidemic is concentrated rather than generalised.

[74] Mesquita, F et al. Public health the leading force of the Indonesian response to the HIV/AIDS crisis among people who inject drugs. Harm Reduction Journal, 2007, 4:9 p. .
[75] Funding was also temporarily suspended in 2006.

However, USAID funds cannot be used for harm reduction. FHI/ASA separately receives funding from GFATM and IPF, allowing it to support harm reduction and other activities.

DFID and the Indonesia Partnership Fund for HIV/AIDS

Australia played a role in the establishment of the IPF. DFID's original intention was for the IPF to enable a rapid scale-up of services for vulnerable groups as a means of reducing HIV transmission. This would be achieved by scaling up existing and effective projects (FHI/ASA and IHPCP) in the first two years, while simultaneously building the capacity of KPA. After this period, resources would shift from the projects to KPA. In addition, other donors would be encouraged to contribute to the IPF rather than commence new bilateral activities. The IPF therefore provides a way for Indonesia and its external partners to jointly resource and monitor Indonesia's HIV/AIDS strategy under a single operational framework.

Through the IPF, the United Kingdom has committed £25 million, including up to US$8 million over two years to IHPCP. Significant funding has also been provided to FHI/ASA, and in 2006, UN agencies received US$7.5 million. To date Australia's contribution has been through a form of delegated cooperation in which IHPCP was scaled up.

DFID has to date been the only contributor to IPF. Decisions regarding DFID's support to IPF beyond mid 2008 will be made on the basis of a review conducted in February 2007. There is widespread support from within the GOI and the donor community for IFP to continue with DFID and other donor support.

German Development Bank and DKT International

The German Development Bank has supported the social marketing organisation DKT International to work in promoting use of condoms and sterile needles and syringes. DKT International also receives support from the Gates Foundation. German government support ends in 2008; however, DKT has indicated that it will continue to market its products in Indonesia. Donor support is required for DKT to engage in health promotion, education and outreach to complement its work in selling/providing condoms, needles and syringes.

UNAIDS and its co-sponsors

There are ten UN agencies working in Indonesia. Their HIV work is defined by the joint UNAIDS program, first developed in 2003. In line with its mandate, UNAIDS has been leading coordination efforts to ensure better collaboration among its partners in the UN system, governments, civil society, donors and the private sector. It has also initiated work with the police and military, and some work in the humanitarian area. In the context of building up national leadership and capacity to lead the response, it has worked with and assisted the KPA Secretariat, including, for example, support for the development of the National Strategy and Action Plan and other technical support for Indonesia, including provision of an monitoring and evaluation adviser and an information centre in the KPA, and facilitation of greater involvement of people living with HIV and AIDS in policy and strategy development and implementation of activities.

UNODC plays a key role in advocating for a coordinated planning process for HIV in prisons, through the KPA Prisons Working Group. WHO has been supporting important pilots of the 100% Condom Use Program and for presumptive testing of STIs. UNICEF plays a role in procurement on behalf of GFATM. The International Labour Organization (ILO) has recently completed an assessment of workplace HIV response needs in Papua.

World Bank and Asian Development Bank

The development banks do not have large-scale HIV programs in Indonesia. World Bank involvement in HIV is currently restricted to HIV main streaming, and small-scale analytical and research inputs, e.g. part funding with USAID of the IBBS study in Papua and West Papua.

The Asian Development Bank is making funds available to support the region's HIV responses through the Swedish International Development Agency–funded Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific. Some Indonesian NGOs have applied for support from this fund.

2.4 Lessons learned

A new program of Australian support can draw upon a wide range of experiences in Indonesia and the region. Some general lessons evident during the design mission are summarised below.

- The nature and pace of the epidemic has changed rapidly and as a result the assistance provided by Australia must be sufficiently flexible to respond to changing priorities, including changing location and different target groups as necessary.
- Supporting GOI priorities and strategies will facilitate GOI support and ownership and help build sustainability.
- Because of decentralisation, the new program should work closely with a wide range of key local planning stakeholders, including governors, the bupati, local AIDS commissions and BAPPEDA.
- To maintain flexibility, outputs or targets should not be over-specified, and the program should have the flexibility to modify strategies and develop new activities and targets on an annual basis.
- To build sustainability the program should utilise GOI staff and financial systems for implementation of program activities and have a strong focus on building Indonesian capacity.
- Engagement must be for the longer term (more than 5 years), particularly in Papua and West Papua.

Lessons from IHPCP

A number of lessons (many expressed as basic design requirements) were identified during an evaluation of the first year of IHPCP (Phase 2).[76] These include:

- clarity in the intent and focus of the design
- sufficient resources and effective targeting to make a difference in halting the HIV epidemic
- use of existing and emerging data sources wherever possible to reduce time spent on situational analysis (to the detriment of developing and implementing well targeted strategies)
- strengthening and staffing KPAs
- flexibility and responsiveness:
    - a dynamic approach with flexibility to respond to changing patterns in the HIV epidemic and changing GOI structures and funding
    - a joint annual planning process with GOI
    - emphasis on donor alignment, including gap analysis against which responses can be developed
- maintaining momentum from one project phase to another
- identifying counterparts and providing clear roles and responsibilities

[76] IHPCP, Phase 2. Review of Stage 1. Final report. July 2004.

- inclusion of smaller scale interventions, particularly where these can be used as pilots or demonstrations
- preparation of work plans for advisers that reflect annual plans
- financial reporting that reflects budget allocation and disbursement
- annual reporting on gender and sustainability
- annual plans that include explicit provision for engagement, capacity building and technical assistance at each level (government and NGOs)
- analysis and reporting to AusAID of the potential impact of structural, legislative or other changes
- inclusion of an effectively implemented program management component, and
- progressive integration of donor-supported activities into Indonesian systems (to ensure activities are institutionalised within local processes and structures).

Lessons from other Indonesia programs

Lessons from other programs, such as Australia–Nusa Tenggara Assistance for Regional Autonomy and Learning Assistance Program for Islamic Schools (both funded by AusAID), include:

- It is important to clarify the role of the managing contractor and technical advisers who are contracted separately (by AusAID), as envisaged in the 2006 concept paper. In particular, it is important to identify which party is responsible for decision-making, who directs and oversights the managing contractor, and how the role of the parties differs in policy dialogue. This is especially important when the managing contractor is providing technical assistance rather than just sourcing personnel and resources.
- When hiring senior managers, it is necessary to be realistic about the skill sets required and to clearly articulate their role. For example, is the position primarily a technical or managerial position? If there are multiple functions to be fulfilled it may be better to hire more than one person, each focusing on a particular aspect.
- Support arrangements such as office space and administrative staff should be in place for any separately contracted advisers (as envisaged in the 2006 concept paper).
- Effective monitoring and reporting arrangements should be implemented for staff working in geographically remote locations.

Lessons from other international experience

AusAID experience provides several lessons:

- Experience from Papua New Guinea highlights the need to avoid creating parallel systems. For sustainability it is crucial to invest in long-term capacity development of public sector systems, adopting a whole-of-government approach that includes finance and health as a minimum, with donor-funded HIV programs fully integrated with a country's policy and strategy frameworks and annual plans.
- 'Partnership' is a frequently used word but all parties need to be clear about what it means. It is essential to define, at an early stage, the relevant roles of each partner and reach agreement on the precise nature of their mutual responsibilities. Expectations need to be agreed, constructive feedback given when expectations are mismatched, and progress negotiated in good faith, based on trust.
- Avoid raising expectations that cannot be met, for example, because of funding limitations.

In addition, an extensive review of many years of previous development assistance by the

Organisation for Economic Co-operation and Development (OECD) provides the following capacity building lessons:

- Donors have often failed to recognise the critical importance of country ownership and leadership, and have underestimated the importance of the broader political context within which capacity development efforts take place.[77]
- Donors should increasingly align programs with those of partner governments to support capacity building objectives. [78]

[77] OECD. The Challenge of Capacity Development: Working Towards Good Practice. 2006.
[78] OECD. Paris Declaration on Aid Effectiveness. 2005.

3. Partnership description

All Australian HIV activities in Indonesia will be framed within a new partnership, the Australia–Indonesia Partnership for HIV (AIPH). The partnership will commence in February 2008 and extend until the end of 2015. The goal of the partnership mirrors the GOI goal in the National Strategy and Action Plan, which is to prevent and limit the spread of HIV, improve the quality of life of people living with HIV, and alleviate the socio-economic impacts of HIV/AIDS. By adopting the goal of the National Strategy and Action Plan, AIPH will support and be aligned with GOI priorities and plans. This will also support Indonesia to achieve its Millennium Development Goal target of halting and reversing the spread of HIV by 2015.

A logical framework matrix for AIPH and HCPI is presented as Attachment 7. As shown in the matrix, the goal of the partnership is supported by two objectives:

- to combine Australia's support for HIV into a coherent partnership that benefits from synergies between each element, and
- to strengthen GOI leadership and capacities to implement an effective and sustainable HIV response.

As shown in Figure 9, the partnership will comprise:

- a new program, the HIV Cooperation Program for Indonesia (HCPI), described in detail in Sections 4 and 5
- financial and technical contributions to the IPF and engagement with GFATM, including input and coordination with relevant steering committees
- mainstreaming of HIV into AusAID's work in other sectors
- other HIV-related initiatives in the AusAID Indonesia program, including research, health systems strengthening, child and maternal health, the NGO Cooperation Program, activities implemented by other GOA agencies in Indonesia, Australian Development Scholarships, the Australian Leadership Awards Program and the Indonesian Australia Specialised Training Program, and
- AusAID's regional partnerships with the Asia Pacific Business Coalition on HIV/AIDS and the Clinton Foundation HIV/AIDS Initiative, and AusAID's HIV/AIDS Regional Capacity Development Program.

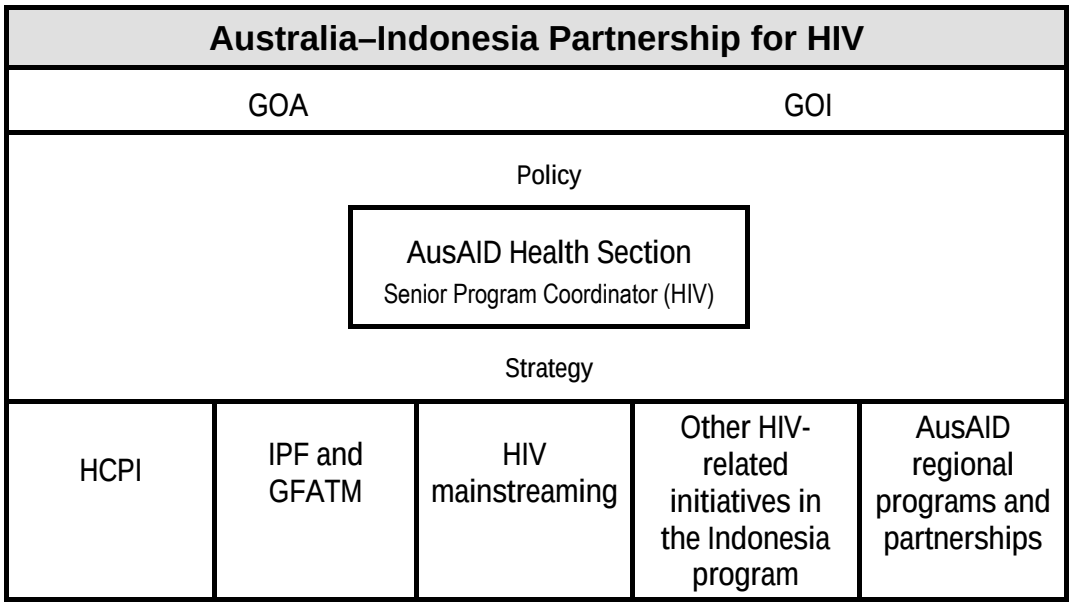


Figure 9: Elements of the Australia–Indonesia Partnership for HIV

The approach of AIPH and HCPI in particular is a new one. The program of assistance will feature a progressive reduction of a direct implementation role. It will feature an increase in the provision of technical support to GOI and other key Indonesian stakeholders to lead, plan, manage and increasingly fund the HIV response. This change-management approach to funding and engagement with partners in Indonesia is adopted with the aim of alignment and integrated programming and builds on recent IHPCP experiences.

3.1 Governance

A Managing Contractor will be responsible for monitoring the existing suite of funded activities, identifying new activities and preparing annual plans for HCPI, in collaboration with Indonesian agencies. A Senior Program Coordinator (HIV) will have this role for other activities included in the partnership. A Senior Program Coordinator (HIV) will identify new activities in consultation with the AusAID Health Section and relevant Indonesian agencies.

The various implementing agencies (including the Managing Contractor for HCPI and other contracted agencies for other activities within the partnership) will be responsible for monitoring progress and preparing periodic progress reports. Progress reports for both HCPI and other activities within the partnership will be presented to a Program Coordination Committee (PCC), along with annual plans. As discussed in Section 5.1, the PCC will play an important role for AIPH. The PCC will also have a role in recommending activities to AusAID for funding other than HCPI. Details of the other activities included in the partnership will be provided to the PCC for information and advice. This will help ensure effective coordination of activities between the various elements of AIPH (including HCPI), and the effective coordination of AIPH with GOI and other donor initiatives.

Other than for HCPI, the annual plans will specify the name of the main recipient, the objectives and proposed duration of the activity, monitoring and reporting requirements, and the proposed funding allocation.

The role of the Senior Program Coordinator (HIV) will include policy and program advice to AusAID, and advice on the integration and coordination of Australian-funded programs. In addition, the Senior Program Coordinator (HIV) will provide technical oversight of activities and provide assistance in stakeholder engagement and coordination. This may include areas such as AIPH policy and strategy inputs, GFATM, IPF and other donor cooperation. The coordinator will work closely with and report to the AusAID Health Section, based in Jakarta. The coordinator may spend an increasing amount of time in the KPA as the direct implementation role of HCPI decreases and work through GOI (including KPA) increases. Draft terms of reference for the Senior Program Coordinator (HIV) are included in Attachment 8.

3.2 Funding

Australia intends to fund a number of HIV-related activities from the AusAID annual allocation to Indonesia in support of HIV initiatives (estimated at A$10 million in 2007–08) other than HCPI. It is recommended that an initial contribution include a contribution of A$1 million to IPF. Further allocations to IPF, and funding for other activities, will be determined during the annual planning process.

The primary source of funds for AIPH activities will be AusAID, through the bilateral cooperation program with Indonesia. However, funds may also be available from other regional initiatives funded by AusAID, or from other as yet unidentified sources of funding.

3.3 Access to technical assistance

AIPH will have access to technical advisers in a similar capacity as for HCPI (and advisers may be able to provide input to HCPI and other AIPH activities simultaneously). The Senior Program Coordinator (HIV) will have prime responsibility for identifying and managing external technical

inputs to non-HCPI activities. AusAID Jakarta will provide assistance in areas such as contracting and logistical support. Generic terms of reference for external technical inputs are presented as Attachment 8.

3.4 Outcomes

Indicators that can be used to assess the achievements and impact of AIPH are discussed in Section 5.5. These will be further developed by the Senior Program Coordinator (HIV) in consultation with AusAID.

3.5 Guiding principles

The broader partnership and new program will be informed by the following principles:

- align with and support GOI HIV strategies and priorities at all levels
- work with all levels of government (in accordance with decentralisation) and continue to work with and strengthen civil society engagement to underpin an effective response
- ensure sufficient flexibility to respond to changing circumstances, including changes in the epidemic and changes in levels of support provided by GOI and other development partners
- increase Australia's higher level engagement with GOI on policy and strategy
- cooperate with GOI in areas in which Australia has a comparative advantage and build on the achievements of IHPCP (including the pioneering work on IDU and prisons, and the strengthening of NGOs and KPA/KPADs)
- increase the focus on populations with greatest need (e.g. Papua and West Papua, IDU in Java, prisoners)
- accord special consideration to gender throughout all activities
- provide a longer term commitment to enhance impact and sustainability
- facilitate multiplier effects by demonstrating and promoting the most effective responses
- leverage additional resources by making strategic investments that attract funding from other sources
- harmonise with other donors and development partners, and
- promote evidence-informed responses, as indicated by epidemiological, social and economic data and research.

4. Program description

This section refers specifically to 'HCPI'. It is recommended, however, that the program be given a local title or brand name in Bahasa Indonesia. This could be developed by KPA, AusAID Jakarta and/or the contractor appointed to manage the program.

4.1 Overview of objectives and components

HCPI will be a five-year program (with a three-year, or part thereof, extension option) commencing February 2008 and will share the goal of the National Strategy and Action Plan. The goal, purpose, components and component objectives of the program are summarised in Figure 12.

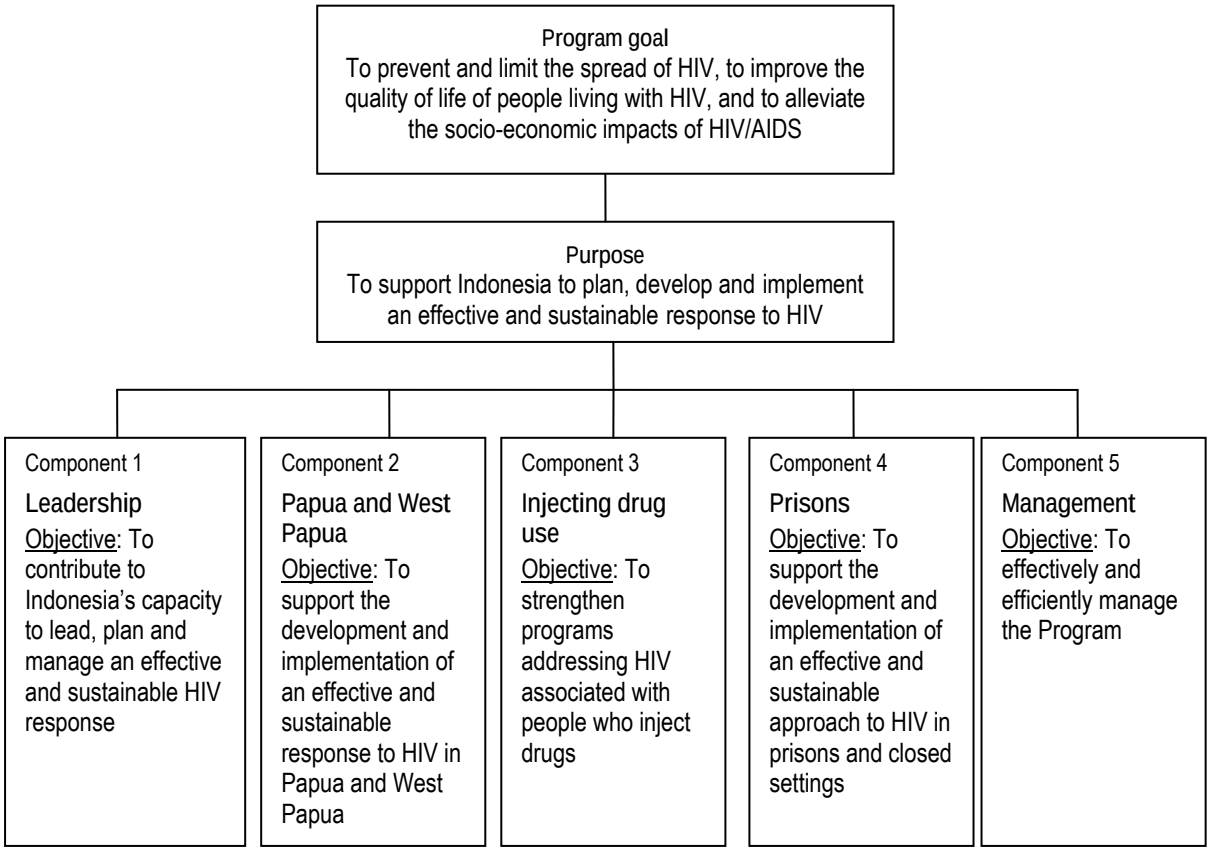


Figure 12: HCPI goal, purpose, components and component objectives

By aligning with the goal of the National Strategy and Action Plan, HCPI will be able to *directly* support GOI priorities and needs. Preventing the spread of HIV and limiting adverse socio-economic impacts will require a comprehensive approach. Given the size of Indonesia's population and the prevalence of HIV in Indonesia, a comprehensive and adequate response can only be led by Indonesia. HCPI will strengthen Indonesian capacity to plan and implement an effective and sustainable response. HCPI's purpose statement clearly reflects this capacity-building focus. Each component of the HCPI will include strategies for capacity building in all activities. There will be a wide range of GOI and civil society partners implementing activities with grants provided by the Program.

Indicators for assessing the achievements and impact of HCPI are discussed in Section 5.5. Under the proposed new approach of supporting GOI priorities and systems, HCPI will not be held responsible for achieving GOI targets. However, the success of HCPI will be determined by the degree to which these targets are achieved, and specifically the contribution of HCPI to GOI success in achieving targets and related outcomes, as HCPI is specifically tasked to work with and strengthen Indonesian systems.

4.2 Component descriptions

HCPI includes four technical components and a program management component. Each component is described below. For each technical component, this includes a description of current activities (implemented by IHPCP, GOI and other stakeholders), an outline of the type of activities that may be funded by HCPI, a description of how activities will be planned and implemented, and the roles and responsibilities of the various partners involved.

Component 1: Leadership

The objective of Component 1 is to contribute to Indonesia's capacity to lead, plan and manage an effective and sustainable HIV response.

Current activities

KPA

One of the KPA's core functions and main priorities is to build the capacity of KPAPs and KPADs to coordinate Indonesia's HIV response, and to build the capacity of other agencies to plan and implement HIV activities. The KPA has taken a number of steps to boost the provincial and district/municipal level commissions. With funding from the IPF, the KPA has supported, among other things, staff recruitment for KPADs, training of 'Tim Asistensi' (Assistance Teams) for KPAPs, and technical assistance to prepare local regulations.

IHPCP

IHPCP aimed to strengthen the capacity of the national KPA, provincial and district commissions and NGOs in strategic planning, coordination and policy development. Some of the most notable of IHPCP's activities included:

- support for KPAP Tim Asistensi, which in turn provide support to KPADs
- support to KPAP working groups for the preparation of local, sustainable and multi-sectoral responses
- support and advice to parliamentary forums regarding review and amendment of narcotics laws to accommodate harm reduction interventions
- increased capacity of partners to use data for planning and decision-making by participating in the DepKes National Estimates 2006 process, and supporting the next round of NGO 'mini-BSS' behavioural surveys of outreach program participants (thereby improving internal monitoring and evaluation [M&E])
- provision of technical assistance by seconding personnel to the KPA and four KPAPs (Bali, NTT, South Sulawesi and Papua)
- technical support for activities funded by the KPA/IPF including the 100 Kabupaten/Kota Program (which also allowed IHPCP to significantly scale up its activities); several activities were also developed or co-funded with GFATM, FHI, IPF, UNICEF and ILO, or IHPCP provided technical support, and
- support to the KPA Secretariat in preparing the National Strategy and Action Plan and budget.

While these were, and are, significant activities, the results have not always been clear given

the changing circumstances of the institutions with which IHPCP has worked. However, IHPCP has been able to influence the direction of several policies and strategies within key institutions and has encouraged local governments to provide partial funding of harm reduction activities in Java Barat and DKI Jakarta.

Activity description

Building on the achievements of IHPCP's work both at the national and provincial levels, HCPI will provide assistance to government (at all levels), civil society and the private sector to build Indonesia's capacity to lead, plan and manage an effective and sustainable HIV response. The work under this component will provide input to national initiatives and will also be integral to the work under Components 2, 3 and 4.

While specific activities under this component will be jointly identified with the KPA during the annual planning process (described in Section 5.2), the types of activities envisaged are described below.

Advocacy, networking and local leadership

The National Strategy and Action Plan highlight the need for advocacy to be undertaken continuously at all levels of government and all segments of society. The aims are to increase the commitment of decision and policy makers; increase the level of awareness of the general population, and in particular young people, of their vulnerability to HIV infection; and prevent discriminatory behaviour towards people living with HIV or AIDS. Taking the cue from the national directive, HCPI will support the KPA and KPAPs, particularly in Papua and West Papua, with policy and program advocacy work. The overall aim will be to foster a supportive cultural, social, legal and political environment that affects the ways in which HIV programming is implemented. This work will be integrated within and across the activities of the other components of HCPI.

Learning from the IHPCP experience, HCPI will attempt to bring greater coherence to advocacy messages. While much work has been done on the communications front, there has not been a clear strategy to delineate the different responsibilities and target audiences. Therefore, HCPI foresees providing support to the KPA to develop a national HIV communications strategy, which would encompass awareness raising and targeted behaviour change communication strategies as well as information, advocacy, education and networking. This strategy is also expected to set basic principles and ethics related to conveying messages that observe human rights, are non-discriminatory, and are sensitive to gender and people living with HIV/AIDS.

A clear and comprehensive communication strategy would allow HCPI to assist the KPA in building alliances and networks with other parts of society, including the business community. Many corporate sectors are paying more attention to social concerns, and under the Global Compact Initiatives, have developed their own corporate social responsibility programs. HCPI will work with AIPH and KPA in engaging the business community on a number of initiatives including (i) promotion of HIV awareness in the workplace; (ii) support to local puskesmas (community health centres); (iii) strategies to reduce adverse HIV impacts of a mobile male workforce; and (iv) other support that may be jointly identified later. The Asia Pacific Business Coalition on HIV/AIDS may be a key partner in supporting the business community to establish and implement these strategies.

The appointment of local figures as role models under IHPCP has proven to be a worthy investment. HCPI will continue to build on this as part of the overall advocacy work. HCPI will also work closely with local leaders (particularly traditional and religious leaders, and village elders in Papua; and public officials in other places). Local leaders will be trained to communicate key messages to different audiences and to work closely with KPAPs and KPADs in advocating local government commitment.

Publications can be a powerful advocacy instrument when their messages are clear and reach

the target audience. HCPI will explore with AIPH and KPA potential issues/themes for advocacy publications. The release of such publications could be strategically aligned to major initiatives such as World AIDS Day to gain momentum and wider recognition of the messages.

Institutional strengthening

Following the issuance of Presidential Regulation 75/2006, the KPA Secretariat launched a major exercise to enhance its capacity to more strategically and effectively deliver on its mission, including recruitment of a new team of professionals. As part of the new approach, the Secretariat reactivated the Tim Asistensi to assist KPAPs. The Tim Asistensi assists in preparation of strategic plans (provincial and sectoral); integration of activities into local budgets; monitoring and evaluation; and advocacy. Building on IHPCP's experience, HCPI will continue to support and work with the Tim Asistensi. Support could include leadership training or technical training related to, and delivered through, Components 2, 3 and 4.

The KPA has established a number of thematic working groups related to the National Strategy and Action Plan. IHPCP staff actively participated as members of a number of these groups. HCPI will continue to provide technical assistance to relevant working groups and support joint program strategy development, coordination, special activity development and other multi-sectoral programs. Of particular importance to HCPI will be the working groups for harm reduction, prisons and Papua and West Papua.

In addition to working with partners receiving grants from HCPI, the program will assist civil society organisations (CSOs) to better position themselves as equal and effective partners of government in prevention efforts. In recent years, Indonesia has seen a rise in the number of CSOs participating in HIV/AIDS prevention and care. Much of their work has depended on external assistance (financial and technical), and their sustainability is questionable. Many of these CSOs work independently of one another and there is weak networking between them. Stronger alliances are important for a stronger CSO platform, including for policy advocacy. Through direct assistance and through the AIPH, HCPI will help CSOs to forge links with community-based organisations and national and international NGOs. In consultation with KPA, training programs on organisational development (ranging from management, finance and resource mobilisation, strategic planning, leadership and management development) could be designed for CSOs to build capacity and promote independence.

Special attention will also be given to people living with HIV/AIDS and women's groups to ensure their full involvement at all stages of policy and program planning and implementation, including monitoring and evaluation. Providing support for their involvement and for capacity building will be an integral feature of the activities under Component 1. There is growing interest among people living with HIV/AIDS to build and enhance their skills in other areas to enable them to become more productive and independent. Through close consultations during the annual planning process, HCPI will identify such needs and consider support.

Policy and legal frameworks

A key function of the KPA is to develop and stipulate strategic policies related to the national HIV response. It is expected that during the course of the program, KPA will prepare a number of strategies (in association with the working groups). HCPI will support these policy-related activities, in consultation with AIPH.

The National Strategy gives high priority to ensuring that there is a conducive legal environment for HIV programs. In addition to reviews of existing laws, the Strategy calls for a study on the need for a national law on AIDS prevention. Under Component 1, HCPI will provide technical assistance to the KPA and KPAPs (either directly or through the Tim Asistensi) to advocate for conducive legislation, in consultation with AIPH.

Strategic planning and management

Working within the national processes and systems, HCPI will strengthen the capacity of

national entities in strategic thinking, leadership and management. Training will take an 'action learning' approach, with HCPI working directly with policy makers and implementing units within DepKes and DepHukHam. Using action learning will enable HCPI to have a greater sustainable impact on systems and processes.

While much of the planning work will be done through the KPA (national and provincial), HCPI will work closely with relevant BAPPEDA. The aim will be to create better linkages and increase the emphasis on HIV within other development programs and policies. HCPI will support the elaboration of the National Strategy and Action Plan into annual costed implementation plans at national and relevant provincial levels. To better synchronise planning, HCPI will support AIPH in harmonisation of other relevant initiatives with national and (relevant) provincial planning, including the overarching BAPPENAS and BAPPEDA plans. Working with BAPPENAS and BAPPEDA will assist understanding of the national position on international targets to better align HIV/AIDS strategic plans. Support for improved national and provincial monitoring and evaluation systems is likely to be an element of this work.

Planning will be sensitive to particular issues and needs of specific groups. Pro-poor and gender-sensitive planning is emphasised by GOI across all sectors. HCPI will incorporate this approach in all its planning and implementation, including the involvement of women's groups.

Research

Given the evolving nature of the epidemic, much work still needs to be done to understand the issues thoroughly and to better inform policy makers and decision makers. Action-research and operational research on selected topics may be undertaken to support the KPA's policy and information building work. Research on social and economic impacts, including costing and cost-effectiveness studies and modelling, may require support. Technical assistance may also be provided to strengthen surveillance systems, to ensure that adequate epidemiological information is available to inform programs and monitor impacts.

The research agenda developed under the National Strategy should be used by HCPI to guide the support it provides.

Gender

Indonesia has ratified the major international conventions that uphold principles of gender equality and empowerment of women. The GOI Medium Term Development Plan 2004–2009 identifies gender mainstreaming as a target under the theme of establishing a just and democratic Indonesia. A Presidential Instruction on gender mainstreaming (Inpres 9/2000) requires all departments and non-department government agencies to mainstream gender in planning, implementation, monitoring and evaluation of all development policies and programs. Building national capacity in this area should be a focus HCPI's work in this component.

An effective response to HIV requires addressing the social determinants of vulnerability and the gender-specific barriers to accessing information, treatment and care. The work of HCPI in Component 1 should build on the gender policy and work of IHPCP and involve support for equitable access to information and services that respond to both men's and women's needs. This includes collection and analysis of disaggregated data and participation of both men and women in leadership and decision-making around HIV responses. This applies particularly to women living with HIV, who can contribute in unique ways to strengthening responses to the epidemic. The nurturing of strong CSOs, particularly women's organisations, can improve reach.

Planning and implementation strategy

Principles underpinning planning and implementation are:

- working closely with and through the KPA and KPAPs

- co-location where possible and close working relationships with key counterparts of the other components (DepKes, DepHukHam, and KPAPs in Papua and West Papua) and other implementing partners (e.g. DinKes, BAPPEDA and CSOs)
- delivery of advisory and policy support services through national systems, processes and structures in consultation with AIPH
- aligning planning and budgeting processes with the national processes to allow gradual co-financing with GOI, and
- donor harmonisation (e.g. complementarity and cooperation with bilateral and multilateral donors, IPF and GFATM).

Co-location will enable close working relationships, coordination and technical exchange. Close working relationships and frequent interaction within the relevant institutions, whether or not co-located, will also enhance understanding of Indonesia's national systems and processes, which in turn will strengthen alignment and harmonisation efforts.

Roles and responsibilities

While the national KPA and HCPI are responsible for oversight of the component's implementation, activities will involve a range of partners, which could be government agencies (sectoral and regional) as well as non-government entities, including CSOs. During the annual planning process HCPI will work closely with the KPA Secretariat and consult the Senior Program Coordinator (HIV) on policy and strategic initiatives to be included in Component 1. Inputs to provincial and district levels in which HCPI is working will be incorporated in consultation with the KPA and Senior Program Coordinator (HIV), and, as appropriate, the PCC.

In addition to supporting the development of a national HIV communications strategy, the Managing Contractor will prepare a communications strategy for HCPI. This will be done within two months of commencement and will be included in the initial annual plan. The HCPI communications strategy will describe:

- the lines of communication between HCPI, KPA, AusAID, DepKes, DepHukHam and other national GOI agencies, as appropriate
- the lines of communication between HCPI and provincial and district/municipal agencies
- participation in program-specific and other forums
- opportunities for linking with other donors and development agencies
- initiatives to promote HCPI and its achievements, and
- the distribution of reports and other publications produced by HCPI.

The Managing Contractor will work closely with AusAID Jakarta and KPA to confirm the communication arrangements.

An HIV Adviser (Capacity Development), initially based in Jayapura, will assume prime responsibility for the planning and supervising HCPI support under Component 1. The location of the position in Jayapura reflects the extent of the need for capacity building and institutional strengthening in Papua and West Papua.

AusAID's Senior Program Coordinator (HIV) will be closely engaged in the development and implementation of Component 1 activities to ensure coherence of policy support, identify possible policy and program inputs, and identify potential linkages with other components of AIPH.

Component 2: Papua and West Papua

The objective of Component 2 is to support the development and implementation of an effective and sustainable response to HIV in Papua and West Papua.

The program will align with the Strategic Plan for the Management of HIV/AIDS in Papua Province 2007 – 2011 and complement the role of other elements of AIPH in engaging and negotiating with (i) government for strengthened national and provincial leadership for coordination and complementarity, and (ii) other donors to achieve harmonisation, including other donor support for STI diagnosis and treatment, maternal and child health, and HIV treatment and care. HCPI will also align with AusAID's health systems strengthening and MCH programs in Papua and West Papua, including the AusAID-supported UNICEF maternal and child health project.

Current activities

IHPCP and FHI/ASA are the two principal HIV and AIDS donor-funded projects in the two provinces. The HIV response in Papua and West Papua is still in its early stages and is, as yet, small in scale given the size of the problem. IHPCP began work in Papua under Phase 2 and has expanded some education and awareness-raising activities since 2005. Some GFATM funds became available from 2003. USAID has supported a program of activities in Papua through FHI/ASA since 2000. It has been difficult for donors to access many remote areas these provinces. The HIV response is particularly under-developed in rural areas and generally in West Papua (there are very few HIV activities that have received support in West Papua). Coordination between IHPCP Australian funded HIV initiatives and ASA/FHI in both Papua and West Papua will need to improve in the future. Aligning the HCPI annual planning process with government annual planning, and the Papua governor's specificity about requiring donor harmonisation, should assist in strengthening bilateral and multi-lateral donor coordination.

IHPCP

IHPCP has made progress in building an integrated multisectoral response, increasing reach with prevention information using a range of traditional and broadcast media, and improving access to and the quality of care, treatment and support for STI as well as HIV. Specifically, IHPCP activities include:

- Improved quality of KPAD planning and management:
  - strengthening the KPAD and KPAD secretariat, including funding of four staff positions, and supporting the improvement of evidence-based planning and coordination at provincial and selected district levels, and
  - strengthening KPAD capacity for collaboration and coordination of donor programs to increase the scale and quality of the response to HIV/AIDS by the provincial government of Papua and partners.
- Developing strategies to reduce sexual transmission:
  - supporting condom social marketing programs in large urban centres
  - promoting condom use and safer sexual behaviour by sponsoring radio spots, working with the provincial football team (Persipura), which has won national championships in recent years, and workplace interventions including with the mining community
  - developing a province-wide media and communications strategy using materials specific to Papua, and
  - supporting the promotion of prevention messages and reducing discrimination against people living with HIV or AIDS and vulnerable population groups through the local media, traditional theatre, and traditional and religious leaders.
- Improved quality of and access to care, support and treatment:

- supporting the development of a comprehensive approach to the provision of care, support and treatment for people with HIV and STIs including through public health centres
- supporting the establishment and scaling up of VCT services
- supporting the training of health care personnel in the management of HIV and opportunistic infections, and rational introduction of antiretroviral therapy, and
- supporting the development of local peer support and peer advocacy by people living with HIV or AIDS.

- Behaviour change communication:
  - developing media and information campaigns on HIV/AIDS prevention
  - supporting information and behaviour change programs in the health and education sector and through faith-based organisations, and
  - supporting programs to reduce alcohol abuse and unsafe/risky sex with groups of men at high risk of HIV.

One of the primary target populations for IHPCP-supported activities in Papua is religious leaders, who are well placed to influence attitudes and mores in the population at large. Currently, IHPCP support does not include the military or police. Local organisations supported by IHPCP in Papua and West Papua are summarised in the Table 4.

Table 4: Local organisations supported by IHPCP in Papua and West Papua

Organisation	Area of work
PKBI Papua	Reproductive health through clinic services, peer-group based youth services, community services and training for health officers
KPAD	Training, program support, strengthening capacity of local organisations
Yayasan Peduli AIDS Timika	Support for people living with HIV or AIDS
Jayapura Support Group	HIV/AIDS care and support
Yayasan Merauke	Support and facilities for people living with HIV or AIDS, health education for the public
Yayasan Santo Antonius (Yasanto)	Outreach to brothel, bar and street-based female sex workers and clients, VCT, care and support, peer support groups for people living with HIV or AIDS (Merauke)
Yayasan Sosial Agustinus	Outreach to female sex workers and clients, VCT, STI services, care and support, case management (Sorong)
Indonesian Red Cross	Outreach to brothel and street-based female sex workers, STI services and case management
Yayasan Kesehatan Bethesda Papua	Outreach to female sex workers and transvestites, STI clinics, support for MSM (Oksibil, Jayapura)
Yayasan Pengembangan Kesehatan Masyarakat	VCT for TB patients (Jayapura)
Maestrasama	Outreach to female sex workers in bars and clients (Jayapura)
Dian Harapan Hospital	STI clinic, VCT, case management (Jayapura)
Sele Besulu Hospital	VCT, case management (Sorong)

FHI/ASA

FHI aims to:

- help contain the HIV/AIDS epidemic among most at-risk groups and prevent its spread into the general population
- help limit the epidemic to a low-level general population epidemic
- help reduce rates of new infection
- help facilitate care, support and treatment for those already infected, and
- build capacity to expand and sustain the response.

Specific activities in Papua and West Papua include:

- health systems strengthening focused on hospitals in Jayapura and Sorong, with the intention of creating hospital/puskesmas/remote area networks
- improving access to effective first-line STI treatments
- mobilising communities using Stepping Stones
- assisting with the development of a communications strategy through the already established HIV/AIDS communication working group, of which IHPCP is part, and engaging religious, tribal and government leaders
- supporting the extractive industries through, for example, a partnership with BP on HIV/AIDS within their corporate social responsibility agenda, where FHI will train their physicians and link them to community outreach in the Bentuni District and, over time, beyond, and
- support to World Vision, since 2006.

Future involvement of ASA/FHI in HIV and AIDS in Papua and West Papua is dependent on a 2007 USAID review and issues internal to the US Government. FHI is continuing, however, to plan for the longer term in three areas:

- health systems strengthening in all districts
- community mobilisation, and
- targeting high-risk groups (e.g. commercial sex workers).

FHI/ASA expects to remain active in prevention and health promotion in both Papua and West Papua, alongside HCPI. The effectiveness of the prevention and health promotion response will be enhanced where these two programs can coordinate their efforts. This may include exploring joint programming in support of GOI priorities in the two provinces.

Other donors

Other donor support includes UNICEF, which is exiting from its current support of maternal and child health/HIV networks, but possibly developing a new program of targeted work on HIV education, treatment and care for infants, children and young people. There are WHO doctors in Jayapura and Merauke with whom HCPI could coordinate on HIV-related activities. ILO is supporting workplace activities and assessing support to the informal sector. The European Commission is supporting puskesmas pilots in Merauke and Keerom. The Global Fund has been financing harm reduction, AIDS treatment programs, and TB and malaria initiatives. DFID is providing funding support through the IPF. DKT International has recently strengthened its presence in Papua and West Papua for condom social marketing through German Development Bank funding.

Activity description

HCPI will work alongside other donors to develop a comprehensive response to HIV in Papua and West Papua. The primary focus of HCPI activities in the early years will be:

- HIV and STI prevention for sexually active young men and women in the general population and for vulnerable populations, particularly sex workers and their clients:
  - information, education and communication (IEC) and behaviour change programs including participatory methods, outreach and peer education
  - condom programs
- HIV prevention and health promotion for people living with HIV:
  - IEC addressing HIV and STI treatment options, prevention of mother to child transmission, and clinical monitoring, and
  - HIV prevention information and access to male and female condoms.

HCPI will support outreach and progress towards 100 per cent condom use and a shift from awareness to behaviour change. The initial focus on prevention and health promotion recognises that FHI/ASA is currently concentrating on clinical services including STI treatment and scale-up of HIV treatment and care, and that GFATM resources may be available to support clinical services. Key changes from IHPCP will be in working with a broader range of local agencies (including, for example, BAPPEDA), contributing specifically to the Strategic Plan for the Management of HIV/AIDS in Papua Province 2007 - 2011, and specifically targeting West Papua in addition to Papua.

Some of the IHPCP activities that may be continued under HCPI could include, for example, radio programming, television messages (subject to budgeting), development and use of Papua-specific language materials, working with sporting clubs, providing education for religious leaders (e.g. through the work of Bethesda), sexual health curriculum development, working with community and women's groups, and using drama in local languages.

Depending on other donor activity and need, expansion of HCPI's focus may include:

- providing support to STI treatment and care initiatives including new approaches to STI management such as those that address the limitations of syndromic approaches particularly for women
- integration of HIV prevention and care into maternal and child health services, and
- helping to prepare the community for an expanded HIV testing and treatment initiative. In particular, should an aggressive testing campaign result from the response to the IBBS data, HCPI may need to work with newly diagnosed people and their families in providing information about care, support and treatment options, as well as HIV prevention information, and work with communities to address the stigma that may accompany testing campaigns.

An element of AIPH is likely to be support to the Clinton Foundation for a rapid assessment of GOI technical assistance and drug procurement needs for antiretroviral scale-up in Papua and West Papua, including access to paediatric drugs, which is a current gap. If the Clinton Foundation establishes a presence in Papua or West Papua, an HCPI priority may be community-based health promotion to complement Clinton Foundation activities, including treatment education.

Specific strategies and activities will emanate from the annual planning process (see Section 5.2). In West Papua, support may also be provided for the development of an HIV/AIDS strategic plan.

Although subject to the annual planning process, it is envisioned that HCPI could support the following aspects of Papua's HIV/AIDS Strategic Plan:

- behaviour change interventions, specifically community education, outreach support to high-risk groups and their clients, and workplace interventions, such as mining, logging, fisheries, government

- education and advocacy on care, support and treatment, including advocacy to public figures, and health promotion for people living with HIV or AIDS, stigma reduction campaigns, and technical capacity building for NGOs, communities and people living with HIV
- multisectoral coordination across programs, regions and borders, specifically KPAP/KPAD planning and monitoring, cooperation with PNG, and multisector partners' work plan development and monitoring, and
- mapping of high-risk areas.

The majority of resources are expected to be allocated to behaviour change interventions. Strategies will most likely include general awareness interventions including through use of mass and targeted media (continuing on from the work of IHPCP); peer interventions; participatory education; condom provision and promotion including through social marketing to all and targeted social marketing and outreach to vulnerable populations; targeting of high-risk settings for community-based prevention advocacy and education, drawing on lessons learned from the PNG–Australia HIV program; targeting of sexual violence; and support for capacity building of provincial and district DinKes, KPADs, and KPAD member organisations (see also Component 1).

While IHPCP has recommended an extensive list of communication activities for Papua and West Papua,[79] the activities need to be well targeted, focused and identified after consultation with KPAP and other stakeholders in both provinces. Options chosen will be informed by evidence about appropriate targeting of resources (e.g. age ranges and geographic areas within which HIV is most prevalent). This will include consideration of evidence of the reach and impact of previous prevention and health promotion interventions and evidence of what works in both raising awareness and in changing behaviours. This may include considering evidence of effectiveness of interventions drawn from other similar settings including PNG.

Gender

The HIV epidemic in the two provinces is distinctly different from the concentrated epidemics in other parts of Indonesia. Transmission is primarily sexual; a far higher proportion of women are infected than in other provinces; and women will carry a far higher proportion of the burden through their typical role as the prime carers in the family. Prevention strategies need to consider the role of women, and the impact of HIV on women (see also Section 2.2). Girls are also a vulnerable group, and specific strategies may be required for adequate targeting (e.g. through schools, village leaders and women's community groups). HCPI will need to be innovative in looking for ways to target women and girls and address gender issues. The use of female condoms is one example of this.

The IBBS data indicate that men with HIV outnumber women by 3:2 in Papua and West Papua. One possible explanation for this disparity is that sex work may still be a significant driving factor for the generalised epidemic. HCPI activities will need to address the gender-specific factors that contribute to the risk-taking behaviours of mobile men with money, and the gender-related economic and social factors that determine women's participation in sex work and transactional sex. The low rate of circumcision among Papuan men is thought to contribute to Papuan men's high rates of acquisition of HIV. Should circumcision be proposed for HIV prevention in Papua and West Papua, a policy will be needed that takes account of cultural and gender factors, including the risk that men may abandon condom use and place women at increased risk.

[79] See IHPCP Response to the Tasking Request from AusAID (2 February 2007), p. 29.

Planning and implementation strategy

The principles underpinning HCPI implementation in Papua and West Papua are:

- a series of partnerships for delivery of activities
- 'pan-island' training, events and capacity building
- alignment with provincial strategies and plans and harmonisation with other donors
- co-financing with government, the private sector and other donors/sources (e.g. FHI, IPF and GFATM)
- building on relevant IHPCP activities
- working closely with local leaders including traditional and religious leaders and village elders
- exploring the possibility of using, where appropriate, village-level facilitators from other programs[80]
- using local languages for communications and training, and
- working with DinKes and KPAPs as key counterparts.

ASA/FHI has done some initial development work (early 2007) on a broad communications strategy, which should assist HCPI to identify priority activities to be funded in 2008. Of importance is ensuring that activities include both awareness and education and that the roles and responsibilities of all stakeholders are clarified. HCPI should be able to identify activities that align with provincial priorities, and therefore enable a strategic transition from IHPCP to HCPI, ensuring the new program is well targeted and supports a unified approach in both provinces.

HCPI should fund activities in both Papua and West Papua, although activities are likely to focus more on Papua until West Papua has a functioning KPAP and an HIV strategy, with support for both possibly provided through HCPI.

Key early partners will be DKT International to strengthen outreach activities, and Bethesda to ensure no loss of momentum during the transition. IHPCP, in consultation with KPA and the Senior Program Coordinator (HIV), will negotiate funding extensions with selected organisations for the transition period. HCPI will need to make an early decision on staffing support for the Papua KPAP.

From 2008 all GOI community development activities are to be harmonised under one umbrella program (known as PNPM), to minimise the number of different strategies and mechanisms and improve coordination. HCPI will need to be aware of this program and ensure its activities at community level are effectively integrated and coordinated with GOI processes and structures.

Roles and responsibilities

The lead agencies for the HIV response in Papua and West Papua are the respective KPAPs (although, as noted previously, the West Papua KPAP was not yet established when the design mission visited Manokwari). The KPAPs are expected to take a lead role in planning the HIV response, coordination (between Indonesian partners and donors), and monitoring and reporting.

[80] The Ministry of Home Affairs, for example, is in the process of rolling out a nationwide program (Kecamantan Development Programme) that provides community infrastructure and includes training of village facilitators. From 2008 the program will extend funding to other community interventions (other than infrastructure), which could provide opportunities for HCPI.

HCPI is expected to work closely with and support the KPAPs and KPADs and other partners in the planning and implementation of activities in both provinces, as IHPCP has in the past. However, it is expected that the KPAPs will progressively take more responsibility for planning and coordination, and the provinces will fund an increasing proportion of HIV expenditure. As well, HCPI will work closely with provincial health offices, particularly for cross-cutting activities through Component 1. The Office of the Governor, for both Papua and West Papua, is seen as playing a key role. It is anticipated they will:

- encourage the effective operation of working groups to coordinate the HIV response (including the operation of working groups at municipal/district level)
- facilitate a planning mechanism that progressively integrates the planning of HCPI activities within the provincial planning process (working closely with BAPPEDA and other local agencies, as appropriate)
- support an integrated, multisectoral approach for the implementation of activities
- help ensure adequate data collection (and the sharing of data), and
- assist in resolution of implementation constraints and issues as they arise.

As HCPI is expected to plan activities collaboratively with government agencies in Papua and West Papua, and the provincial governments are expected to allocate a higher proportion of funds for the HIV response, HCPI will be expected to also work closely with BAPPEDA (at both provincial and municipal levels) to encourage the provision of adequate GOI funds by specifying funding request correctly and ensuring that funding requests are realistic given the resources available from the provincial and municipal/district governments.

There will be close liaison with the national KPA's Papua/West Papua Working Group through the Jakarta-based Team Leader and the Jayapura-based HIV Adviser (Capacity Development).

Other partners in Papua and West Papua are expected to include Bethesda, DKT International, other faith-based organisations, tribal leaders, and traditional leaders. Both Christian and Muslim leaders will be key stakeholders in the new program.

Component 3: Injecting drug use

The objective of Component 3 is to strengthen programs addressing HIV associated with people who inject drugs. HCPI activities will support and have direct linkages to national initiatives. Activities within this component will align with:

- Regulation 02/07
- the December 2006 MOU between KPA and BNN and the January 2003 Joint Decree of KPA and BNN on the reduction of the negative impacts of injecting drug use
- objectives, priorities and targets of the new National Strategy and Action Plan
- Sentani Commitment to Combat HIV/AIDS in Indonesia 2004 and Sentani Plus
- laws on narcotic and psychotropic drugs, and
- the Ministerially-approved program for scaling up harm reduction activities, based on the partnership approach between DinKes and NGOs.

The primary focus of this component will be delivery of services to IDUs and their sexual partners through the GOI public health system and NGOs using a comprehensive approach that includes harm reduction strategies. The aim of these services will be primarily to minimise HIV infection among IDUs and care for those infected with HIV.

The program will complement the work of AIPH in engaging and negotiating with government for enhanced government leadership, coordination and complementarity, and with other donors to achieve harmonisation with their work with IDUs.

Current activities

IHPCP and FHI/ASA are the two principal HIV donors working with IDUs. DepKes and, at provincial and district level DinKes, are key GOI partners.

IHPCP

Reducing the risk of HIV transmission associated with IDU was a key component of IHPCP (Phase 2). A key finding of the review of IHPCP in 2004[81] was that coverage (the number of IDUs reached by IHPCP and other donor/GOI programs) was insufficient to reduce HIV incidence at a population level. In response to this shortfall, and in an attempt to scale up existing efforts, IHPCP has, over the past two years, implemented an approach which includes the public health system, in particular puskesmas, in the delivery of HIV services to IDUs. IHPCP has implemented a comprehensive package of prevention to targeted IDUs. The package includes sterile injecting equipment, IEC, alcohol swabs, MMT, condoms, referral for VCT, CST and antiretroviral therapy as required, and health care for opportunistic infections. There has been significant scale up of IDU harm reduction projects in both DKI Jakarta and West Java (particularly NSPs). Partner grants were signed with DinKes in these locations for work in puskesmas. Both vice governors are providing political and financial support.

IHPCP works with national, provincial and city governments to develop HIV policies and legislation. Work with KPA has included providing technical support to help develop the new National Strategy and Action Plan, and an active support role for the KPA Harm Reduction Working Group. IHPCP also provides assistance to establish and support KPAP/KPAD harm reduction working groups.

IHPCP provides grants and technical support to national and provincial NGOs for outreach, advocacy and IEC activities. These are an essential part of the public health approach to HIV among IDUs. IHPCP also works with IDUs to increase their involvement in advocacy for health care access and equity, and on human rights and HIV issues. IHPCP has supported research activity and has co-authored, with national partners, a significant body of internationally published research on IDU and harm reduction work in Indonesia.

FHI/ASA

The primary focus of FHI/ASA in 2005–08 is to significantly increase prevention and CST coverage to over 60 per cent of most at-risk groups, including IDUs. Strategies include peer-based outreach for behaviour change, condom promotion, integration of outreach with VCT and case management, CST services and working with DepKes and IHPCP to pilot MMT and referral to rehabilitation. USAID funds cannot be used for procurement or distribution of needles, syringes or bleach. Using IPF and GFATM funds, however, FHI/ASA work includes NSP harm reduction strategies in a comprehensive package of risk reduction and elimination approaches. FHI partner organisations are primarily NGOs, and the Burnet Institute Indonesia is contracted to provide technical training. Insecurity of GFATM funding has prompted ASA to reduce dependence on this source and most of their work with IDU is now funded by IPF. A March 2007 mid-term review of FHI/ASA will provide comment on their work with IDU. The FHI/ASA program is scheduled to end in August 2008.

DepKes and DinKes

DepKes and DinKes provide essential HIV services to IDU, primarily with GFATM funding. These services included prevention information programs, treatment programs including training of health care workers, STI treatment, VCT, antiretroviral therapy, CST services and MMT. Small grants are provided to community-based NGOs that support people living with HIV or AIDS. At the time of writing the future of GFATM funding to Indonesia was uncertain.

[81] See IHPCP, Phase 2. Review of Stage 1. Final report. July 2004.

WHO

WHO partners with DepKes at national and provincial levels and provides technical assistance for the HIV response. WHO has a number of harm reduction advisers in Indonesia.

DKT International

DKT International provides social marketing of condoms, needles, syringes and other IDU paraphernalia, and IEC materials.

Activity description

Building on the work of IHPCP at both national and provincial levels, HCPI will support implementation of GOI plans that address the HIV needs of IDUs and their sexual partners. It is anticipated that this will primarily involve:

- support for delivery of services through GOI public health systems as well as engagement of civil society
- emphasis on expansion of delivery of a comprehensive response to IDUs and their sexual partners, and
- a focus on priority locations, initially in Java (DKI Jakarta and West Java) where IHPCP has ongoing activities, and possibly expanding support to other locations (subject to available resources) in Java and elsewhere if supported by evidence of need.

GOI targets for NSP and MMT coverage are included in Attachment 5.

HCPI's comprehensive harm reduction approach may include NSPs, substitution therapies and other effective drug treatments, peer education and outreach, VCT, STI and HIV treatment (including antiretroviral therapy and treatment for opportunistic infections). Specific activities under this component will be jointly identified with partners during the annual planning process (see Section 5.2). This will ideally involve joint program planning with KPAP/KPADs and DinKes, supported by coordinated implementation. Possible areas of support in the early years include:

- supporting a coordinated approach to attain the established targets, aims and objectives of Regulation 02/07, including for a strengthened enabling environment (e.g. input to policy, legislation, and standards in consultation with AIPH, and support for strategies to reduce stigma) and monitoring and evaluation nationally and locally
- technical assistance and funding via partner grants, and other support as agreed, in DKI Jakarta and West Java for:
    - NSPs
    - substitution therapy (MMT)
    - peer education/advocacy
    - primary care including STIs
    - antiretroviral therapy and treatment for opportunistic infections
    - VCT
    - IEC
    - sexual health promotion including condom programs
    - strengthening KPAPs and KPADs
    - strengthening NGOs
- advocacy and awareness activities, and
- research, including activities to train local researchers and use of existing data to document the outcome of harm reduction activity.

Reducing the current high levels of risk behaviour amongst IDUs and their sexual partners (in

particular needle sharing and low condom use) will continue to be a major challenge. HCPI will build on the support from IHPCP for IDU community development activities and funding for peer-based organisations to produce HIV and drug use education material for IDUs.

The comprehensive response will include continuing the current expansion of MMT and NSP to puskesmas, recognising that engagement of DepKes will be important, given the current model of their supervision of hospitals to which puskesmas are attached. An additional complexity is reports of increased police activity in late 2006 around IDUs including near, and in, puskesmas. It will be necessary to continue engagement and advocacy with National Police and BNN and relevant authorities at the local level to address this. The impact of the increase of NSP and other harm reduction activity will need to be monitored to ensure any adverse outcomes, such as inappropriate disposal of used injecting equipment, are identified and managed.

HCPI will build strong relationships and alliances within GOI to enable joint planning for expansion of harm reduction activities. HCPI will support the national and provincial Harm Reduction Working Group, including for the possible development of harm reduction handbooks (in line with the KPA 'buku pinter' initiative), guidelines for harm reduction services for implementing agencies, capacity building if required, and possibly small grants. Activities in Component 1 to work with GOI to remove policy and other barriers to NSP will be important.

HCPI will build on the work of IHPCP in supporting the involvement of IDUs in advocacy for health care access and equity, and on human rights issues. This has included funding drug user organisations to increase their involvement in planning and implementation. The KPA is also actively promoting IDU involvement in this regard.

In response to the rise in availability and use of methamphetamine, the limited knowledge and understanding of its behavioural effects and effective treatment, HCPI will need to monitor patterns of use, encourage behavioural studies of associated risk behaviours and keep informed regarding developments in treatment approaches.

Changes in patterns of illicit drug use in future years will impact on the nature of the HIV epidemic and the required response and will need to be monitored.

Gender

A significant majority of IDUs are thought to be male[82] and educational approaches should address the gender-specific factors that contribute to men's drug use and risk-taking behaviours. There are significant challenges for ensuring female IDUs have access to information and services. Female IDUs are frequently severely marginalised, and experience high levels of discrimination and stigma and often poor self-esteem. These factors are increased for women who are also sex workers and/or HIV positive. Female IDUs are often introduced to injecting by their sexual partners, including being injected by partners, and as with condom use, are at times not in a position of equality and empowerment to negotiate for the use of, or access to, sterile needles. HIV services often have difficulty reaching non-IDU female partners of IDUs. The economic and psychological determinants underlying IDU and sex work are complex and need to be addressed for successful targeting of comprehensive HIV strategies for IDUs.

To address gender equity issues it will be important that (i) advocacy occurs at all levels of government for policies and processes that foster both female and male IDU involvement in service design, delivery and management and (ii) support is provided to NGOs/CBOs for programs supporting female IDUs and women living with HIV.

[82] See Devaney, Reid & Baldwin. Situational analysis of illicit drug issues and responses in the Asia–Pacific region. 2006.

Planning and implementation strategy

Sites for Component 3 activities in DKI Jakarta and West Java will be determined through collaboration and planning with the KPAP/KPAD and DinKes in the respective provinces and/or municipalities. Coordination with FHI/ASA and other relevant GFATM-funded activities will also be needed. Most sites are expected to be in cities in Java with higher IDU populations. HCPI will finalise criteria against which specific sites will be selected, in consultation with KPA. It is anticipated that the criteria will include:

- estimated IDU numbers, and prevalence and incidence of HIV and AIDS
- local support for harm reduction approaches (including counterpart contributions), and
- gaps that exist in current or planned support for IDUs, other high-risk groups, and people living with HIV/AIDS.

The identification and selection of Component 3 sites, while based on the above criteria (or similar), will involve a process of discussion and negotiation with KPA and key stakeholders at provincial/municipal levels, which will begin prior to or at commencement of the annual planning process (see Section 5.2).

Roles and responsibilities

While DepKes will play the lead role with HCPI in implementation, the lead agency for coordination of the national response to harm reduction in IDU is KPA, through its Harm Reduction Working Group. Provincial and district/kota chairs of KPA will appoint working groups to support implementation. It is envisaged that HCPI will work closely with the relevant working groups.

DepKes will play a lead role in coordinating the national response in the health sector. DepKes, following a recommendation from the February 2007 WHO-led review, has signalled its intention to establish a high-level committee to help coordinate its HIV response. It is envisaged that HCPI will work with this new committee.

Within each location, HCPI will typically engage with and/or support a range of key stakeholders, which would include the KPAP/KPADs, DinKes, puskesmas, NGOs and IDU networks, and which may also include KanWilHukHam, the Department of Social Affairs (Dinas Social) and BAPPEDA.

Component 4: Prisons

The objective of Component 4 is to support the development and implementation of an effective and sustainable approach to HIV in prisons and other closed settings.

Component 4 will be implemented nationally and will align with:

- DepHukHam's National Prison Strategy
- Regulation 02/07, and
- MOUs and standard operating procedures regarding prison work involving DepKes, DepHukHam and the Ministry of the Interior.

HCPI will complement the work of other elements of AIPH in engaging and negotiating with government for better government leadership in coordination, planning and implementation, and with other donors (particularly UNODC and FHI/ASA) to achieve harmonisation with their work in prisons and closed settings.

The work will be guided by the National Prisons Strategy. At present, of 95 priority prisons in Indonesia, 34 prisons in 16 provinces have been identified as 'top priority'. A number of 'narcotics prisons' have been established. The National Prison Strategy calls for education programs, health programs and referral programs in prisons and detention centres. Work in this component may include harm reduction approaches such as methadone, education and

information, VCT, STI, antiretroviral therapy and treatment for opportunistic infections, and will include support to NGOs for outreach to closed settings. The increasing size of the prison population is of concern and work in this component may also include approaches to address this such as strategies for diversion of offenders from the criminal justice system and law reform.

Current activities

A national strategy, KPA working group, significant partnerships and bilateral work are in place; however, the current level of HIV activity in prisons in Indonesia is low. Data are incomplete but it is clear that conditions in prisons and detention centres at present are not conducive to HIV prevention or care, support and treatment for those inmates affected. Prisons are overcrowded (118 453 inmates but capacity for 60 000), the budget varied but generally low (on average food Rupiah 10 000/day and health care Rupiah 3 500/year per prisoner), and numbers of health care staff limited (283 doctors and 433 nurses, over 50 per cent of these part-time). Mortality is high, with 813 deaths in 2006, of which 70 per cent to 75 per cent were among narcotic offenders. There are no data on the number of HIV/AIDS-related deaths in prisons, but primary causes of death (TB, pneumonia, acute diahorrea and hepatitis) would suggest many are AIDS related. At the time of writing, sources of funding for expansion beyond current levels of work were not clear. Applications for funding from GFATM (debt conversion scheme and Round 7) are underway. IHPCP and FHI/ASA are the two principal donor-funded projects contributing to HIV work in prisons. UNODC is playing an important role in supporting the National Prison Strategy.

DepHukHam

Under the National Prison Strategy, a comprehensive response in 95 priority prisons is planned for the period 2006 to 2010. Twenty-five prisons will be targeted in the first year of the strategy. Priority prisons were selected that had a high density of inmates charged with drug offences (at least 45 per cent), high rates of HIV infection, available personnel and medical facilities. Twenty of the prisons will also deliver methadone. A subcommittee of the KPA Prison Working Group was recently formed to develop a costed work plan for implementation of the strategy.

The National Prison Strategy has as its gold standard the comprehensive strategy applied in Kerobokan prison in Bali. This approach involves access to IEC and behaviour change programs, the provision of condoms and bleach, assistance for around 25 prisons to access methadone and referral of patients for VCT and antiretroviral therapy. VCT is currently available in five prisons. DepHukHam is preparing manuals for HIV work (including VCT, CST and case management, prevention of mother to child transmission for women's prisons and MMT). DepHukHam policy with regard to NSPs was undetermined at the time of writing. Support for NSPs should not be excluded as a possible Component 4 activity.

KPA

The KPA together with DepHukHam is coordinating the expansion of the response in the prison system. The KPA Prison Working Group is very active and membership includes all key partners. DepHukHam have indicated that the group is keen to partner with AusAID in the national prison program. Supporting the work of this group, including membership, will be essential.

DepKes

DepKes is responsible for general medical services in prisons, and plans to improve these including provision of medical officers for 40 of the 95 priority prisons. At present 34 of the 95 prisons have no doctor and 26 have neither doctors nor nurses. It appears that funding for these services will be provided collaboratively through the DepHukHam and DepKes budgets. An MOU is in place between DepKes, DepHukHam and Ministry of Home Affairs to ensure collaboration of these ministries in prisons.

DepKes also has a role in developing minimum standards (ranging from number of staff through to competencies such as technical skills in prison officers to provide information to prisoners).

BNN

BNN's work in prisons includes drug programs, detoxification, therapeutic community approaches and criminals anonymous peer groups (CrimAnon).

IHPCP

IHPCP currently works in 17 prisons (DKI Jakarta, West Java, Banten, South Sulawesi, North Sulawesi, Central Java, Yogyakarta, Bali and Papua) with seven partner NGOs. IHPCP work is primarily led by NGOs and involves a comprehensive integration of prevention (promoting bleach, condoms, peer education and IEC inside prisons) and care, support and treatment (including basic health care for those affected by AIDS). Activities also include membership of the KPA Prison Working Group, meetings for VCT, CST and antiretroviral therapy in prisons, and work to expand the prison methadone program. IHPCP and WHO have carried out prison staff training.

In its six-monthly report of July–December 2006, IHPCP reported little progress on promotion of bleach and condoms inside the prison system. It appears that the Kerobokan prison in Bali is an exception in this regard. Proposed activities include provincial visits and workshops, support for prison working groups in provinces, VCT/CST prison training, expansion of prison inmate HIV education in prisons, workshops for prevention and CST in prisons, and peer educator training for prevention and CST in prisons.

FHI/ASA

ASA is working in 61 prisons (West Java, DKI Jakarta, East Java, North Sumatra, Central Java, Papua and Riau Island) with 18 NGO partners. FHI/ASA has conducted prison staff education, developed of training-of-trainers materials for behaviour change communication, and assisted in referral to VCT and STI treatment and training. ASA reports that for some of these NGOs this is new work and they are inexperienced. Most FHI/ASA prison work is funded through the IPF. The March 2007 mid-term review of FHI/ASA, will provide comment on their work in prisons. The FHI/ASA program is scheduled to end in August 2008, subject to review. It is reported that FHI commissioned the Centre for Harm Reduction to conduct a rapid assessment and response study of prisons in 2005.[83] At the time of writing, the report of the study had not been released.

UNODC

UNODC has one international HIV/AIDS adviser and plans to add a national position in Indonesia. UNODC has been active in prison work for over 12 months and intends to continue. UNODC has made a significant contribution to the scale-up planning for prisons and is a key member of the KPA Prison Working Group. UNODC has documented the current situation with regard to HIV in prisons, and is funding the development of Prison Officer Academy curricula for HIV and drugs. It has seed funding available for development of a prison M&E framework and has funded translation of numerous prison-related documents into Bahasa Indonesia, including the UNODC prison program framework. It is actively seeking funding to expand HIV work in prisons in Indonesia.

A recent study by UNODC of NGO work in prisons[84] found:

- IEC for prisoners and training on HIV/AIDS for prison officers was the most common

[83] Desk Appraisal. Australia Indonesia Partnership for HIV 2008–2015.
[84] UNODC. A Review of the NGO Program in the Indonesian Prison System. Jakarta. February 2007.

activity

- additional activities include case management, facilitating CST, VCT, condom and bleach, support for people living with HIV or AIDS, and pre-release information
- there were no standard training modules and approaches varied
- there was uneven coverage in target prisons (i.e. NGO staff levels, numbers of sessions in prisons and of prisoners/officers targeted)
- some NGOs were working in both IHPCP and FHI/ASA programs
- a number of NGOs were newcomers to prison work and had little experience, and
- there was no monitoring or evaluation of programs.

The NGOs surveyed by UNODC reported:

- coverage was insufficient
- condoms, bleach and MMT have very limited coverage (and acceptability)
- not every prisoner receives IEC
- planned activities were subject to sudden change
- a need to increase access to VCT and CST and pre-release programs
- a lack of coordination between NGOs, between NGOs and prison authorities and with KPAD/KPAP
- no standard instruments, quality control or monitoring and evaluation, and
- lack of confidentiality and private space for counselling.

UNODC has expressed interest in working with HCPI in the national prison program and will be an important partner in this component.

GFATM

GOI has submitted a proposal to fund HIV work in the 95 priority prisons under the debt conversion scheme (US$50 million over three years). An application under Round 7 was also planned. The outcome of these proposals should be known by early 2007.

IPF

IPF funding has been used for training of prison officers in 95 prisons and in 50 prisons to build the capacity of labs for analysis following HIV testing. FHI/ASA also was using IPF funding for prison work.

WHO

The recently completed and translated WHO MMT guidelines include closed settings. WHO carried out an assessment of prison readiness for MMT in 2006.

Activity description

HCPI will support the GOI in developing and implementing effective policy and program responses to HIV prevention, care support and treatment needs in relation to prisons and other closed settings such as drug treatment facilities. As described further below, this may include harm reduction approaches such as methadone, provision of condoms and bleach, education and information, VCT, antiretroviral therapy and treatment for opportunistic infections, and will include support to NGOs for outreach to closed settings. The National Prison Strategy and MenkoKesra Regulation 02/07 will form the basis for planning and coordination of the national HIV response in prisons. Initial activities will be guided by the proposed costed work plan of the National Prison Strategy and will include policy and strategy support at the national level in partnership with the KPA Prison Working Group, continuing the work at the Bali prison, and continuing the activities at other specific sites currently supported by IHPCP.

The program in prisons will be agreed through an annual planning process involving key partners. Possible activities include:

- Implementation of the National Prison Strategy and costed work plan:
  - working with the KPA Prison Working Group
  - support for a rapid assessment and response and/or mapping of HIV work in prisons to date
  - securing support of prison governors, which will be essential for implementation
  - support for development of HIV teams in prisons.
- Programming support for:
  - GOI to further develop and promote the Kerobokan prison (Bali) HIV program as a demonstration of best practice
  - continuation and expansion of NGO work, including integration into prison schedules and improved access to prisons
  - work in narcotics prisons
  - the development of more pre/post-release programs
  - a review of prison transfer policy
  - special attention to the needs of women
  - developing standard monitoring and evaluation instruments
  - monitoring and evaluation of programs, and
  - surveillance and research.
- Support for coordination:
  - between all national stakeholders for the development of a truly national response
  - of donor-funded activities including the funding of all aspects of programming (NGO work, training material, levels of coverage, NGO staff levels, numbers of sessions in prisons and of prisoners/officers targeted)
  - between KPAD/KPAP and KanWilHukHam for local responses
  - possibly a partnership with BNN for HIV and drug treatment.
- Advocacy to GOI for increased funding to prison health and medical services.
  - This is an important activity as the current and proposed funding for the prison program is significantly reliant on GFATM. Current expenditure on prison health services is inadequate to meet needs.
- Exploring the feasibility of prison NSPs.
  - Prison NSPs operate in more than 50 prisons in eight countries. Evaluations have consistently identified improved prisoner health and reduction in needle sharing. Negative consequences such as increased violence and drug consumption have not been found. In many countries prisoners, as peer health workers, operate prison NSPs under supervision of medical staff.
- Advocacy to GOI regarding effective policies to reduce the size of the prison population.
  - Regulation 02/07 stipulates that programs for referral from the criminal justice system into care and treatment must be developed. Diversion programs have the potential to reduce the number of offenders incarcerated and increase access of drug users to prevention information, treatment and care.
  - Non-custodial sentencing and cautioning options are also effective in helping

to reduce the number of prison inmates.

Gender

Men are the majority of prisoners. HIV education should address gender factors including specific aspects of male attitudes and behaviour that contribute to HIV risk taking. Female prisoners have specific prevention, care and support needs, including the need to access prevention of mother to child transmission programs. Female prisoners living with HIV experience significant stigma and discrimination, which may be compounded by their status as a drug user and/or sex worker. Low self-esteem is associated with this. Sexual assault and sexual coercion are said to be experienced in most prison settings and HCPI activities will address the implications of this for the health and safety of women in particular.

Planning and implementation strategy

The principles underpinning HCPI work in prisons are:

- planning and implementation in partnership with the KPA/DepHukHam Prison Working Group and working groups at provincial and district levels
- planning and implementation in accordance with the National Prison Strategy and the proposed costed work plan
- harmonisation and alignment with particular attention to coordination between HCPI and FHI/ASA
- co-financing with GOI and other sources, including GFATM, IPF and the private sector, and
- key partnerships with DepHukHam (KanWilHukHam), DepKes (DinKes), KPA (KPAD/KPAP), UNODC, DepKes, and WHO.

The pioneering work in the Bali prison, supported by IHPCP, will provide a foundation for HCPI activities, as will lessons learned from Bali and the current roll-out of activities nationally. The first annual plan will be developed in collaboration with the KPA/DepHukHam Prison Working Group, which will be HCPI's key partner for this component.

Roles and responsibilities

As the lead agency for the response to HIV in prisons, DepHukHam will collaborate with HCPI on the implementation of this component. The lead entity with which HCPI will work for national coordination is the KPA/DepHukHam Prisons Working Group. It is likely that this group or members of this group (in particular DepHukHam, DepKes, UNODC and ASA) will be central to decisions on prioritising prisons in which HCPI will work and the content and timetable for such work. HCPI will need to have a close working relationship with the working group and its member entities.

DepHukHam is responsible for leading the development of a costed work plan for implementation of the National Prison Strategy. The completion and/or implementation of this plan will form the basis for HCPI work in prisons beyond that currently undertaken by IHPCP.

For planning and implementation at provincial and district levels HCPI will partner with KanWilHukHam as well as with prison governors. Without the support of governors, prison programming cannot occur. It is also envisaged that multi-disciplinary HIV teams will be established in prisons by prison authorities. Partnership with these teams should occur. DepKes, in collaboration with DepHukHam (and their provincial counterparts), has responsibility for the funding and provision of medical services in prisons. It is expected that for coordination and co-funding of activity HCPI will work closely with them. Implementation of activities will also involve non-government agencies, with which HCPI will be required to

negotiate partner grants. It is expected that over time the GOI ministries will progressively take responsibility for planning, coordination and funding.

UNODC has expressed strong interest in working jointly with AusAID, particularly with regard to technical input and identifying funding for the program. This should be followed up by HCPI in the early stages of the partnership. FHI/ASA is the other bi-lateral donor project working in prisons nationally. Lack of coordination between FHI/ASA and IHPCP and their partners has been identified as a weakness of the current bi-lateral work in prisons. HCPI will be required to harmonise with FHI/ASA where possible in both design and implementation

For HCPI, an HIV Adviser (IDU) will take the lead in the planning and implementation of this Component (and Component 3 to ensure consistency of input). Integration with Component 1 will also be important. The Senior Program Coordinator (HIV) will work with the HCPI Team Leader and HIV Adviser (IDU) to ensure coherence of policy support, identify possible policy and program inputs, and identify potential linkages with other components of AIPH.

Component 5: Management

The objective of Component 5 is to effectively and efficiently manage HCPI. The resources to be provided by the Managing Contractor are discussed in Section 5.4. The overall management and financing arrangements are outlined in Section 5. The Managing Contractor will have responsibility for implementing HCPI activities in close collaboration with relevant GOI agencies.

The Managing Contractor will provide technical expertise, resources and management services, work collaboratively with and support key stakeholders; and manage inputs to each component within HCPI. The Managing Contractor will report to the Counsellor, Health Section, AusAID Jakarta, with technical input provided by the Jakarta-based Senior Program Coordinator (HIV).

The specific roles and responsibilities of the Managing Contractor are summarised below.

Establish and operate offices in Jakarta and Jayapura

It is envisaged that the office in Jakarta will be in the vicinity of the KPA, while the office in Jayapura will be on the premises of the KPAP. Both offices will contain a full range of facilities and provide any necessary administrative support. The number and tenure of these and other offices and staff may be limited (as needed), in line with the guiding principle of progressive integration of AusAID resources within Indonesian national structures.

Prepare annual plans

The Managing Contractor will support and help coordinate the annual planning process (as outlined in detail in Section 5.2), working with a wide range of partners and preparing annual plans for individual activities, for each program component and for the program as a whole. The annual planning process will be used to prioritise and plan activities, finalise annual budget allocations, and specify annual implementation targets. The Managing Contractor will need to have planning skills and experience in Indonesian planning systems to help ensure annual plans:

- are progressively integrated within GOI systems (including increasing levels of GOI financing of HIV activities)
- incorporate gender-sensitive responses
- specify clear outputs and include adequate provision for collecting data to monitor the success in achieving these outputs, and
- includes adequate support and capacity building for Indonesian staff.

It is essential that the guiding principles, outlined in Section 2.5, be adequately incorporated in annual plans at all levels.

The Managing Contractor will also need to liaise closely with AusAID and the KPA during the annual planning process to prepare plans that are consistent with GOA and GOI priorities and available resources. Early in the planning process, the Managing Contractor is to seek AusAID guidance on the funding allocation available to support activities for the upcoming planning period.

Coordinate financial management of grants

A wide range of partner organisations will be implementing activities with grants provided by HCPI. HCPI will be required to develop detailed guidelines for the eligibility of grants, criteria for selection of grants, transparent and accountable approval processes (which include the AIDS commissions at national, provincial and district level) and comprehensive financial and progress reporting processes to monitor and evaluate the activities. The Managing Contractor will submit the guidelines to AusAID for approval. The guidelines will be adapted from the processes used in Phase 2 of IHPCP and will include the following:

- The Managing Contractor will negotiate a program of assistance with its implementing partners, which will determine the inputs by various partners and their roles and responsibilities, and will specify indicators, the collection of baseline and performance data, the responsibility for data collection, and reporting requirements.
- The Managing Contractor will consult with AusAID and KPA, as appropriate, during the preparation of the agreements and negotiation of partner contracts. Partner agreements may be signed with government, non-government or private agencies. It is recommended that the initial agreements under Components 2, 3 and 4 be negotiated by IHPCP in 2007 (under the direction of KPA and AusAID) and extended until the end of December 2008. It is recommended that subsequent agreements be for 12-month periods.
- Funds will only be released from the HCPI Trust Fund to implementing partners that have been approved through the predetermined approval process (which is documented for each individual proposal).
- The Managing Contractor (or the Team Leader or Deputy Team Leader) will manage the HCPI Trust Fund and be a signatory of cheques when funds are released to implementing partners.
- Implementing partners must have in place proven comprehensive financial accountability and reporting structures.
- Implementing partners will acquit on a quarterly basis to the Managing Contractor and further tranches will be released once the previous grant funding is fully acquitted.
- The Managing Contractor will monitor partner agency financial reporting on a quarterly basis (and assist where necessary) and conduct routine spot checks and audits on implementing partners as part of the conditions of accepting the grants.

Align support and build capacity

In all aspects of implementation, the Managing Contractor will need to align support with GOI systems and processes and build Indonesian capacity. As reflected in the HCPI purpose statement, the capacity building focus needs to be integrated within each component and applied throughout the period of implementation. All HCPI staff and short-term advisers need to understand and support this strategy.

As GOI improves its capacity to deliver effective HIV responses, Australia's role in direct implementation will progressively decrease. Greater emphasis will be placed on strategic high-level policy engagement and technical support. Planning will align where possible with GOI budget cycles and funding may be managed through GOI budgetary systems in stronger

settings where adequate safeguards exist and continued GOI commitment is demonstrated. AusAID will explore the option of providing incentives for and rewarding improved performance by Indonesian stakeholders.

Communicate effectively with all partners

The Managing Contractor has an important role in assisting program coordination. As KPA is the agency responsible for coordinating Indonesia's HIV response, the Managing Contractor will work with and support KPA, particularly at the national level. The Managing Contractor will also work closely with and support DepKes and DepHukHam to help ensure effective collaboration and cooperation between stakeholders. As discussed in Section 5.1, the Managing Contractor will also provide secretariat support to the PCC.

The Managing Contractor is expected to liaise closely with a range of multilateral organisations and other donors and promote donor harmonisation in line with the Paris Declaration on Aid Effectiveness. The Managing Contractor will also facilitate effective coordination between donors and the GOI.

Effectively manage staff and technical advisers

The Managing Contractor will have a number of staff and short-term advisers. All will need to be briefed on the objectives of the program, its capacity-building focus, and the joint planning and implementation arrangements. As discussed in Section 5.5, HCPI staff will also be expected to cooperate and work effectively with GOI agencies when conducting annual component reviews or with external advisers engaged by AusAID to review the program.

Staff and technical advisers will need to be familiar with and understand the guiding principles outlined in Section 3.5. It is also important for all staff and technical advisers to be sensitive to the policy environment and cultural norms in which the program is being implemented, and at the same time promote an atmosphere of cooperation, continuous learning and improvement.

Help develop innovative and sustainable approaches

The Managing Contractor's team is expected to contain, and access, expertise to bring international best practice and adapt this, as required, to the Indonesian context. The team will be innovative, especially in Papua and West Papua, where the challenges are perhaps the most difficult. HCPI is also expected to help develop and promote sustainable approaches. It will do this by working closely with Indonesian systems and processes, and working closely with and supporting the lead agencies in each component (as described further in Section 5.1).

Develop and implement effective M&E and risk management systems

The Managing Contractor will have prime responsibility for monitoring and evaluation, even though much of the data to be used in assessing the goal, purpose and component objectives is to be collected by GOI agencies (as part of a single, unified national HIV/AIDS M&E system). The Managing Contractor will have a direct role, however, in specifying outputs for activities as part of the annual planning process, and report adequately on the progress in achieving these outputs. The M&E requirements are discussed in detail in Section 5.5 and a preliminary M&E framework is presented as Attachment 10.

The Managing Contractor will also have prime responsibility for managing risk. Risk management will be an integral part of the annual planning and reporting processes. An initial assessment of risk is undertaken in Section 6.2 and a risk management matrix is presented as Attachment 11.

5. Management and financing arrangements

5.1 Roles and responsibilities of key stakeholders

Figure 10 provides an overview of HCPI's institutional arrangements, and illustrates how the key institutions relate to one another.

Program Coordination Committee

The PCC will be the key decision-making body for the program and will have prime responsibility for (i) approving annual plans, (ii) ensuring HCPI remains strategically focused, (iii) providing oversight of program outcomes and quality, and (iv) resolving (when possible) any significant implementation problems.[85] The PCC will be co-chaired by KPA and AusAID and include representatives from BAPPENAS, DepKes and DepHukHam. Representation on the PCC from Papua and West Papua, people living with HIV/AIDS, and civil society will be considered by the PCC during their inaugural meeting. Given the strategic and decision-making responsibility of the PCC, its representatives are expected to be at a senior management (or executive) level.

The PCC will meet formally twice each year, and is expected to exchange information and advice on an informal basis as and when required. The PCC will:

- provide direction in terms of priorities and funding levels at the commencement of the annual planning process
- recommend annual plans to AusAID for approval
- review progress reports
- keep HCPI strategically focussed
- provide oversight for monitoring of program outcomes and quality, and
- resolve (where possible) any significant implementation problems.

The Managing Contractor will have responsibility for implementing HCPI activities in close collaboration with relevant Indonesian agencies. The Managing Contractor will also provide secretariat support to the PCC. Specifically, the Managing Contractor will:

- organise PCC meetings in consultation with PCC members, provide briefing materials and presentations as required, record the minutes of PCC meetings, and provide information and advice to PCC members as required
- interact with the lead agencies for each component, and various working groups under these agencies, to promote HCPI and its achievements, help ensure HCPI contributes to GOI priorities, help ensure HCPI is clearly focused on developing effective and sustainable solutions, maximise donor harmonisation, and provide other support as deemed appropriate
- assist KPA at national level in its role of coordinating Indonesia's HIV response, and
- liaise closely with AusAID Jakarta to ensure AusAID (and the other elements of AIPH in particular) are aware of GOI priorities and initiatives concerning HIV.

[85] Although the PCC will be the key decision-making body for HCPI and AIPH, financial authority for GOA funds rests with AusAID. As such, the PCC will provide recommendations to AusAID on matters directly affecting GOA expenditure.

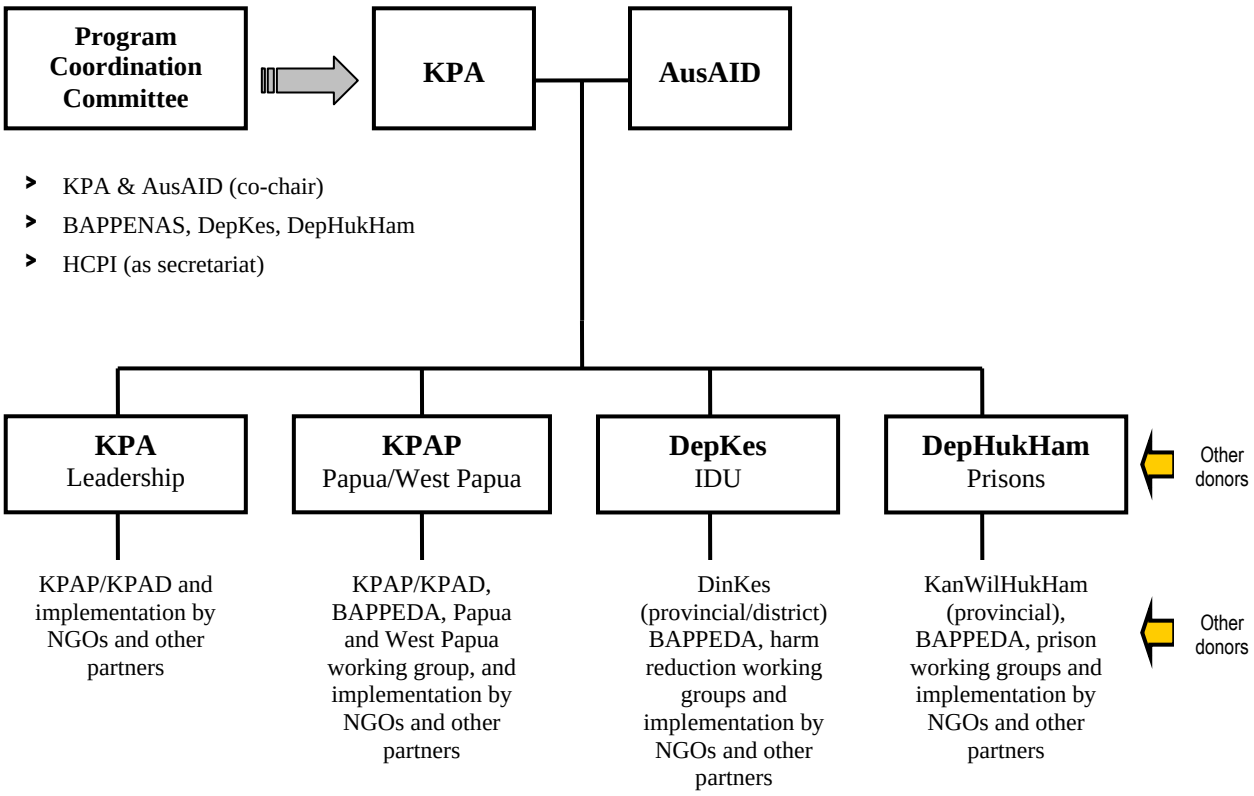


Figure 10: HCPI cooperation arrangements

As discussed in Section 3, the PCC will also play an important role for AIPH. While the PCC will not have a decision-making role in terms of the bilateral support (other than for HCPI) and regional partnerships included in AIPH, details of these activities will be provided to the PCC for information and advice. This will help ensure the effective coordination of activities between the various elements of AIPH (including HCPI), and the effective coordination of AIPH with GOI and other donor initiatives.

KPA

KPA and AusAID Jakarta will be jointly responsible for oversight and coordination of HCPI. KPA will help ensure HCPI is supporting GOI priorities and is working effectively with both GOI and other development agencies. KPA and AusAID Jakarta are expected to build a close working relationship.

The national KPA will:

- co-chair PCC meetings and take the lead role in the coordination of HCPI activities on behalf of the GOI
- ensure effective coordination between HCPI activities and those of GOI, donors and other key stakeholders
- facilitate coordination across all levels of government: national, provincial, and municipal/district
- assist in identifying priorities for HCPI
- play an advisory role during the annual planning process, in particular during the finalisation of annual plans at component level and the program as a whole
- promote lessons learned, best practice models and strategic policy initiatives among Indonesian government agencies, and
- maintain dialogue and build relationships with the GOI agencies, NGO partners and

other key stakeholders to support an effective and sustainable HIV response.

In its role as the lead agency for Component 1, the KPA will have added responsibility, as described below under 'Lead agencies for components'.

KPA may provide a venue for various program meetings and may provide temporary office space for HCPI staff or consultants that are working with KPA on specific activities.

AusAID Jakarta

AusAID Jakarta is responsible for programming Australian assistance and monitoring and evaluating Australia's inputs.

AusAID Jakarta will:

- co-chair PCC meetings and take the lead role in the coordination of HCPI activities on behalf of the GOA
- provide input to the annual planning process, including provision of forward budget estimates and articulating GOA development priorities
- maintain dialogue and build relationships with the GOI, other donors, NGOs and other stakeholders
- manage the contract with the Managing Contractor, including oversight of planning and monitoring and evaluation processes
- prepare Tasking Notes for technical advisers, and following approval by the PCC, contract and brief the advisers for each input
- prepare terms of reference (in collaboration with the PCC), and organise and contract teams to undertake periodic reviews
- promote linkages between HCPI and other Australian activities in Indonesia and the region, including, for example, health sector reform programs in Indonesia, and HIV activities in Papua New Guinea and Asia
- promote HCPI in Australia and in Indonesia
- participate in forums in HIV and related fields, and
- provide guidance to the Managing Contractor on the content of the program completion report.

AusAID's inputs will be provided by the Senior Program Coordinator (HIV) and AusAID's Health Section. The Senior Program Coordinator (HIV), along with locally engaged support staff, will provide managerial and technical inputs to ensure HCPI activities are strategically focused on agreed priorities and support AusAID's Health Policy and HIV Strategy. The Senior Program Coordinator (HIV) will liaise regularly with HCPI staff, particularly during the preparation of implementation strategies and annual plans.

The Senior Program Coordinator (HIV) will have access to leading technical experts as and when required. Draft terms of reference for the Senior Program Coordinator (HIV), and generic terms of reference for the independent technical advisers, are presented as Attachment 8.

BAPPENAS

BAPPENAS will:

- participate in PCC meetings and provide advice/guidance as appropriate
- provide input to the annual planning process, in particular, by articulating GOI development priorities and providing guidance on planning collaboratively with GOI agencies
- provide advice on how Australian funds could be channelled through the GOI system (as discussed further in Section 5.3)

- facilitate links between HCPI and GOI agencies
- assist in the effective coordination of the program with other donors and GOI programs
- facilitate GOI approval for activities, as per the annual plans
- assist in identifying and facilitating budget allocations for activities deemed appropriate/ready for adoption (institutionalisation), and
- help overcome implementation problems should they arise.

Lead agencies for components

While the KPA and AusAID will be responsible for oversight and coordination of HCPI as a whole, the program aims to increase the role of the GOI agencies that have prime responsibility for implementing HIV programs associated with each of HCPI's four technical components. HCPI therefore aims to involve KPA, the Papua and West Papua KPAPs, DepKes and DepHukHam in policy dialogue and overall coordination .The advice of these agencies will be sought during the planning of HCPI activities, and they will be invited to participate in an annual component review of HCPI. Strengthening links with the agencies responsible for each component will help ensure that HCPI is effectively integrated within Indonesia's HIV response, and that information and lessons learned are shared between HCPI, the lead agency and other stakeholders. This will help to improve the effectiveness and sustainability of the activities initiated by HCPI and increase the impact of Australian support beyond the geographic areas in which HCPI is located.

In its capacity of the lead agency for a component, each of KPA, KPAP (Papua and West Papua), DepKes and DepHukHam will:

- provide policy guidance on the component plans and implementation arrangements
- assist and facilitate coordination across all levels of government: national, provincial, and municipal/district (including other units/departments within the lead institution), and with other donors
- assist in identifying priorities and play an advisory role during the annual planning process, in particular during the finalisation of annual plans for the component
- provide input to the annual component review, including provision of recommendations on policy and program development matters
- promote lessons learned, best practice models and strategic policy initiatives among GOI agencies
- provide counterpart staff to work with and support HCPI advisers, as appropriate
- provide access to relevant documents, data and facilities that will facilitate implementation of agreed activities
- facilitate GOI approval for activities, as per the annual plans
- organise working group meetings as a mechanism for providing inputs into the planning and monitoring of activities supported by HCPI, and
- help overcome implementation problems should they arise.

In addition, DepKes and DepHukHam will participate in PCC meetings. Representation in the PCC from Papua and West Papua, civil society and people living with HIV/AIDS will also be considered by the PCC members during the inaugural meeting.

Working groups

KPA has established national-level working groups to facilitate the implementation of programs as defined under the National Strategy and Action Plan. Group members are representatives of relevant government and non-government organisations. The national working groups have the

following tasks:

- to assist KPA in policy and program development, advocacy and socialisation
- promote consistency of activities with the National Strategy and relevant policies
- assist KPA in capacity building and resource planning, and
- monitoring and evaluation.

HCPI should interact with and support (as appropriate) the following working groups (at national, provincial, district and kota levels):

Harm Reduction Working Group – chaired by DepKes, co-chaired by the National Police. KPA is the secretary of the working group (at each level). Membership includes other relevant government agencies and non-government agencies, including CSOs.

Prisons Working Group – chaired by DepHukHam.

Papua/West Papua Working Group – chaired by the Secretary of KPA and co-chaired by UNAIDS. Membership includes DepKes, Papua's KPAP, provincial and district parliaments, and other agencies.

These working groups should be constant partners for HCPI during the planning, implementation, monitoring and evaluation of activities under the respective components. HCPI's links to these groups are strengthened by the fact that chair of the respective working group is held by the lead agency for the respective component.

Consideration will also need to be given to participation in the Communications Working Group, particularly within Component 2 (Papua and West Papua), as this group is responsible for awareness and information programs to help prevent the spread of HIV.

Provincial and district agencies

At provincial level, the main counterparts will be the KPAP, the Office of the Governor, DinKes, KanWilHukHam, BAPPEDA and other relevant agencies. At district/municipal level, the main counterparts will be the bupati and walikota, KPAD, DinKes, BAPPEDA and other local agencies.[86]

Collaborating partners for the planning and implementation of specific activities will include the above agencies along with legislators, NGOs, professional and community-based organisations, people living with HIV, faith-based organisations, traditional and village leaders, women's groups, and the private sector.

If the Managing Contractor enters into an agreement with the KPAP or KPAD, it is envisaged that the agreement will reference the principle of increasing GOI financial support for agreed activities over time.

It is expected that the KPAP (with support from the Office of the Governor, if required), will:

- encourage the effective operation of working groups to coordinate the HIV response in the province (including the integration of activities with local HIV/AIDS strategic plans)
- facilitate a planning mechanism that progressively integrates the planning of HCPI activities within the provincial planning process (working closely with BAPPEDA and other local agencies, as appropriate) and commits to increasing the provincial contribution for HIV programs and activities
- support an integrated, multisectoral approach for the implementation of activities
- help ensure adequate data collection (and the sharing of data), and

[86] The bupati is the administrative head of a district. The walikota is the major of a municipality.

- assist in resolution of implementation constraints or issues, as they arise.

The KPAD will assume similar responsibilities for activities implemented at district and municipal levels.

Other donors

To facilitate donor and GOI partner harmonisation, HCPI will interact with Indonesian partners and other donors at two levels:

- during consultations with the lead agencies for the components (including the working groups under these agencies), and
- during consultations with the KPAP and associated agencies at provincial and lower levels.

At both levels, effective interaction between HCPI and other donors will help harmonise the support provided to Indonesian agencies and contribute to the sharing of information and lessons learned. Interaction will also occur during the planning and implementation processes.

It is also expected that the Senior Program Coordinator (HIV) will participate in a number of forums to support Indonesia's HIV response, including for example, the Global Fund's Country Coordinating Mechanism Technical Working Group and the IPF's Program Steering Group Sub Committees. The Senior Program Coordinator (HIV), along with selected HCPI staff, is likely to participate in various working groups and other committees.

5.2 Annual planning process

Within each component, HCPI will define its activities on an annual basis, working collaboratively with counterparts and other development partners. This annual planning process will mirror the GOI planning timeframe, which will enable HCPI to plan future activities at the same time that Indonesian partners are planning future activities. This will allow closer collaboration and provide the flexibility to support current GOI priorities and needs. It should also, over time, contribute to the strengthening of GOI systems to plan and implement and increasingly fund HIV activities.

The annual planning cycle will follow the GOI's planning and budget calendar (i.e. January to December). The annual planning process is illustrated in Figure 13 below.

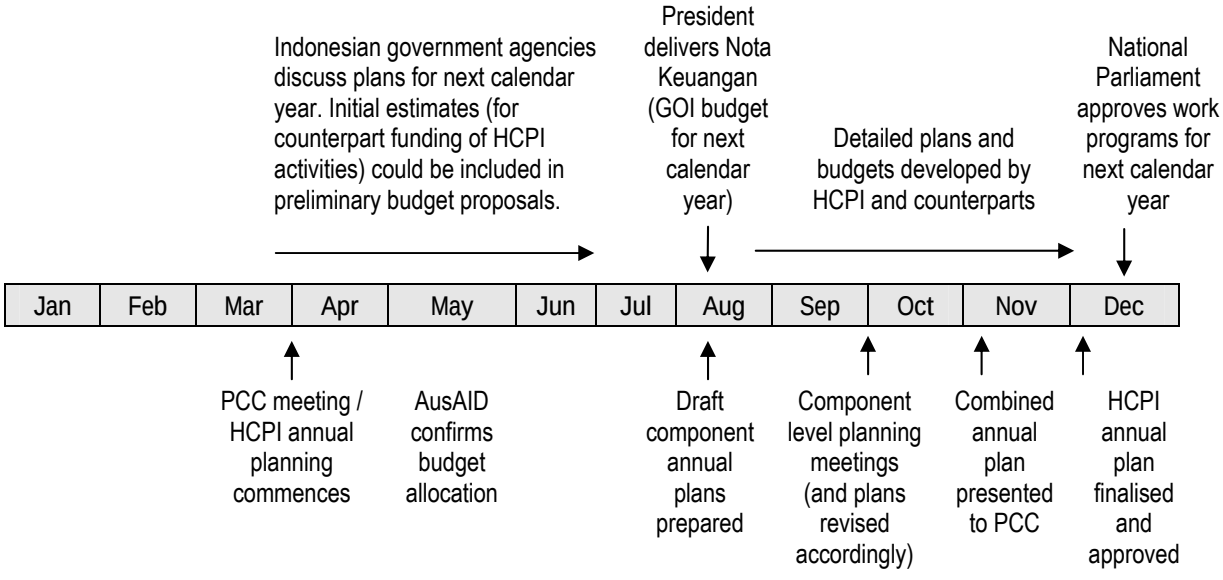


Figure 13: HCPI annual planning process

The PCC meeting in March/April will review progress, referring in particular to the annual component review (which, as discussed in Section 5.5, is undertaken by HCPI in collaboration with the lead agencies for the components); outline any significant changes in focus (as reflected in either GOI or GOA priorities); and provide a forward budget estimate for the next calendar year. Plans for expanding HCPI support to new provinces (in particular, under Components 3 and 4) would be discussed by the PCC at this stage. This will enable HCPI to commence discussions with both existing and new Indonesian partners, and over the following four to five months, progressively and collaboratively develop plans for the next calendar year.

Assurance of strong local support will be a prerequisite for any detailed program of support proposed for a new location. Local support could be gauged in terms of:

- the presence of provincial HIV strategies or the incorporation of HIV activities in development plans
- the allocation of provincial and/or municipal/district funds for HIV activities
- agreement by local agencies to fund specific HIV activities (with endorsement by senior officials as appropriate), and
- agreement for HCPI to work with BAPPEDA and other local agencies during the planning process.

As discussed in Section 5.4, the potential to attract additional investments from GOI and other sources should be considered during the annual planning process. Carefully planned expenditure will leverage Australian assistance and maximise impact.

Local planning will occur at provincial and/or municipal/district levels and include a range of counterparts (government agencies, NGOs and the private sector). Planning will preferably be done in consultation with or under the auspices of the KPAP and/or KPAD. During the planning process, the President of Indonesia will announce the financial envelope for the next fiscal year (a statement referred to as Nota Keuangan), which will help counterpart agencies predict the level of resources available. Throughout the planning process, the role of BAPPEDA – at both provincial and municipal/district levels – should not be underestimated. BAPPEDA is the local planning authority and has responsibility for aggregating and finalising government budgets. HCPI and local government agencies will need to collaborate closely with BAPPEDA to ensure plans are developed within realistic resource levels and receive adequate funding.

Once activities have been endorsed at provincial level, in general, by both the KPAP and BAPPEDA, HCPI will aggregate plans and present a summary to the lead agency for each component. The lead agency – preferably in consultation with other relevant agencies, that may for example, be represented in a national-level working group – will assess the summary component plans and provide recommendations. HCPI will endeavour to incorporate these recommendations before the plans are aggregated and an overall summary presented to the PCC.

While the lead agency for each component will not be required to formally approve detailed plans for specific activities or the summary component annual plans, input by the lead agency is important to help ensure consistent approaches and effective coordination with Indonesian and external partners. In addition, this gives HCPI an opportunity to promote successful techniques and approaches, and therefore to influence policy and/or promote best practice beyond the locations in which HCPI operates.

The annual planning process will be expected to include strategies for advancement of gender equality in planning and service delivery. M&E frameworks that are developed for annual plans should incorporate measures of gender equality. Such measures may include:

- whether or not gender inequality issues are constraining programs and GOI ability to deliver an effective and sustainable response to HIV

- the program's success in building GOI capacity to implement a gender-sensitive response to HIV
- identification of constraints that may restrict men's and women's participation and access
- monitoring of the contractor's ability to promote gender equality through the program.

It is expected that KPA and AusAID Jakarta will provide regular inputs to the annual planning process, particularly once the component-level plans have been drafted and summaries presented to the lead agencies for each component. Early in the planning process, the Managing Contractor is to seek AusAID guidance on the funding allocation available to support activities for the upcoming planning period. The Managing Contractor will need to ensure the annual plans fit within the AusAID budget and conform to the contract. It will also be important to consult other donors, and include them in the planning process, whenever possible. This will not only harmonise donor support, but help align donor activities with Indonesian systems.

Formal approval of the annual plan by the PCC will enable HCPI to implement activities during the following calendar year and provide a basis for monitoring progress and performance.

The content of the annual plan is discussed in Section 5.5. It is recommended that a summary of approved plan be prepared, translated and circulated among all relevant stakeholders, both to promote HCPI and its achievements in the past year, and to raise awareness of the activities and approaches to be undertaken in the year ahead.

While the annual plans will focus on the calendar year, HCPI will also include an estimate of expenditure for the six months following the calendar year (i.e. the plan will include a detailed description of activities and costs for 12 months, and a cost estimate for each component for the following six months). This will enable AusAID to provide forward expenditure estimates in March/April for the following Australian financial year (July to June).

As the Managing Contractor will commence in February 2008, it will not be possible to follow the full annual planning process for Year 1. Therefore, the Managing Contractor, in consultation with AusAID, IHPCP and other key parties, will prepare an abbreviated annual plan for the period April to December 2008. This will be prepared by the end of March 2008 and include a description of proposed activities and personnel inputs and cost details. IHPCP will provide a plan for ongoing partner grants. The PCC will review the 2008 annual plan during its inaugural meeting. It is suggested this occur in April 2008.

5.3 Contracting and financing arrangements

Australian bilateral aid to Indonesia is governed by a General Agreement on Development Cooperation, signed in 1999. The GOI and GOA will enter into a Subsidiary Arrangement for AIPH (which will include HCPI). This arrangement will be formalised once the partnership and program design has been approved by the two governments.

Following a competitive tender process, a Managing Contractor will be engaged to provide technical expertise, resources and management services; work collaboratively with and support key stakeholders; and manage inputs to each component within HCPI. A five-year contract is proposed with an option for an extension of up to three years. The decision whether to extend will be based on the outcome of periodic reviews (which, as described in Section 5.5, will be undertaken every two years) and AusAID's programming parameters.

The Managing Contractor will report to AusAID Jakarta, with technical oversight provided by

the Senior Program Coordinator (HIV).[87]

HCPI will have an office in Jakarta, some staff based in Papua and some staff based in other provinces (as needed), but the number and tenure of other offices and staff will be limited. This is in line with the guiding principle of progressive integration of AusAID resources within Indonesian national structures. It is envisaged that the Managing Contractor may provide limited technical and training inputs (in addition to monitoring visits) but the majority of assistance provided will be sub-contracted.

The Managing Contractor will negotiate a program of assistance with its implementing partners, which will determine the inputs by various partners and their roles and responsibilities, and will specify indicators, the collection of baseline and performance data, the responsibility for data collection, and reporting requirements.

The Managing Contractor will consult with AusAID and KPA, as appropriate, during the preparation of agreements and negotiation of partner contracts. Partner contracts may be signed with government, non-government or private agencies. It is recommended that the initial contracts under Components 2, 3 and 4 be negotiated by IHPCP in 2007 (under the direction of KPA and AusAID) and extended until the end of December 2008. It is recommended that subsequent contracts be for 12-month periods.

In the longer term, it may be feasible for HCPI to channel financial support through GOI financial management systems rather than enter contracts and have direct financial transactions with a range of partners. HCPI would engage with local government and other development partners during the annual planning process, agree on the activities to be implemented in the following year, and the cost. When the annual plans (of both the concerned government and HCPI) are approved, HCPI would transfer funds to the appropriate account. It is expected that this process would be trialled in selected provinces or municipalities/districts that have taken an active role in the planning and implementation of HIV activities in the past, have demonstrated ongoing commitment (by increasing their allocation of funds for HIV programs), and have proven accountability, governance and reporting processes in place. BAPPENAS should provide guidance on the process for channelling funds through the GOI system.

It is recommended that the Senior Program Coordinator (HIV) have local support staff, and be able to access additional external technical assistance to provide an independent assessment of progress (when required), and provide technical and managerial advice and support on a periodic basis. AusAID Jakarta will be responsible for identifying, contracting and managing all external technical inputs. Generic terms of reference for external technical inputs are included in Attachment 9.

5.4 Resources

The budget for AIPH is tentatively estimated at A$10 million per annum. Of this, it is recommended that approximately 80 per cent be allocated to HCPI annually, other than in the start-up year. During 2007-08 approximately A$5.4 million will be allocated to IHPCP. The amount allocated to IHPCP will be for costs during the transition period between July 2007 and February 2008. A detailed description of the transition arrangements is presented as Attachment 6.

The annual budget for HCPI is estimated at A$8 million for the first five years, except in 2007–08 when there will be only five months of activities. The budget for the five-month period is

[87] It is recommended that the current HIV/AIDS Coordinator be tasked to fill this position until June 2008.

estimated at $2 million. A one-month handover period from IHPCP to HCPI is planned for February 2008.

In addition to AusAID funding, HCPI may source additional funds from the IPF, GFATM or other sources. Strategic investments by AIPH and HCPI will potentially attract additional investment by GOI agencies, multilateral organisations and other donors. Carefully planned expenditure may therefore leverage additional assistance and maximise impact. The potential to attract additional investments from other sources should be considered during the annual planning process.

HCPI is expected to include the following resources:

- expertise in harm reduction, HIV prevention and health promotion, capacity development, institutional strengthening, gender issues, program planning and budgeting, program management and M&E
- locally engaged technical and administrative staff
- office, transport and other operational inputs
- training and short-term technical inputs, as required
- grants to local partners for implementation of agreed activities, and
- materials and supplies.

While the Managing Contractor will propose a team that encompasses the range of expertise required, the design includes indicative positions as a guide to the allocation of duties among senior team members and the experience that would be required to fill these positions. The indicative positions include:

- Team Leader, based in Jakarta
- HIV Adviser (IDU), based in Jakarta
- HIV Adviser (Capacity Development), based in Jayapura, and
- HIV Adviser (Prevention & Health Promotion), based in Jayapura.

Draft terms of reference for each of these positions are presented as Attachment 9. While the capacity to promote gender equality and gender-sensitive responses has been included as required experience in each of the above positions, it may be appropriate to include a Gender Adviser in the program team, particularly during the initial program development stage (e.g. the initial 12 to 18 months).

The GOI contribution has not yet been estimated. The Managing Contractor will negotiate with government partners on a cost-sharing basis during the annual planning process, aiming to increase the level of financial contributions made by provincial and municipal/district levels of government over time. The level of funds committed by the GOI in the fight against HIV and AIDS is an indicator in the national monitoring and evaluation system currently being developed, and as discussed in the following section, will also be an indicator used by HCPI at purpose level and for Components 2, 3 and 4.

5.5 Program performance and monitoring and evaluation

Overview of national monitoring systems

Surveillance

The GOI introduced a Second Generation Surveillance System in 2001, with collection and analysis of behavioural data being the responsibility of the Central Bureau of Statistics. A range of other data collection methods have since been introduced:

- HIV sero-surveillance (targeting IDUs, sex workers, male STI patients and prisoners)

- integrated behavioural and serological surveys (focusing on high-risk groups, and expanding over time to an increasing number of cities)
- STI surveillance (in government health facilities)
- AIDS reporting in hospitals, and
- antiretroviral therapy monitoring.

WHO, the World Bank, AusAID and USAID have played supporting roles in the development of Indonesia's HIV and AIDS surveillance systems. Although there are concerns with some of the data (for example, some health facilities and hospitals use alternative databases and provide reports of varying accuracy), DepKes can now provide a more accurate estimate of the number of HIV positive people than previously. DepKes also plans to introduce a VCT-based surveillance system (initially in four sites in DKI Jakarta and two sites in Bali). Improvements in surveillance will, however, enable HCPI to use GOI data as the basis for assessing changes in HIV prevalence, and in some instances, behavioural changes.

Monitoring

Indonesia has not had a unified HIV monitoring system to date. Work by KPA, the Central Bureau of Statistics, DepKes, IHPCP, FHI/ASA and GFATM on a joint donor database ceased with the introduction of the Country Response Information System (CRIS) in early 2006. Although the new system is used by KPA in 106 districts or kota, DepKes, GFATM and the key donor projects use separate databases. KPA reports that these databases are neither uniform nor compatible.

KPA, the agency with responsibility for monitoring the National Strategy and Action Plan, is in the process of developing a new national monitoring and evaluation system. Indicators and baseline data for inputs, outputs, results and impacts are summarised in Table 5. The information in Table 5 was derived from an unofficial translation of the draft National Strategy and Action Plan, which was being finalised as this document was prepared, and is therefore subject to change.

The results of all monitoring and evaluation efforts are required to be reported in line with the hierarchy set out in Presidential Decree Number 75 of 2006. The National HIV and AIDS Monitoring, Evaluation and Reporting Guidelines published in 2006 will be used as the basis for monitoring and evaluation of the National Strategy.

Table 5: Indicators specified in the draft National HIV/AIDS Action Plan

Indicator	Source data	Responsible institution	Reporting frequency	Baseline data
A. Input indicators				2005
Government budget allocation	Workshops with the government sector	KPA	Every year	US$13 million
National composite policy index			Every two years	75%
B. Output indicators				2005–06
% of high-risk population covered by prevention programs	SSP	P2PL,[88] DepKes	Every year	IDU: 7.1%
				Female sex workers: 20.7%
				Waria: 44.6%
	Program monitoring	ASA, IHPCP, GFATM, DepKes, other sectors		MSM: 2.1%
				Transgender sex workers: 0.5%
				Inmates: 4.7%
C. Results indicators				2004–05
% of high-risk populations that tested for HIV and received results in past 12 months	Behaviour survey	P2PL, DepKes	Every two years	IDU: 18.1%
				MSM: 15.4%
				Female sex workers: 14.8%
				Clients: 3.3%
% of IDUs applying behaviour that can reduce risk of HIV transmission through using sterile injecting equipment and using condoms in the last two months	Behaviour survey	P2PL, DepKes	Every two years	DKI Jakarta: 18.5%
% of MSM that report using condoms during the last sexual relations with male partners	Behaviour survey	P2PL, DepKes	Every two years	DKI Jakarta: 56.4%
% of high-risk populations that understand methods of transmission and reject misconceptions of how HIV is transmitted	Behaviour survey	P2PL, DepKes	Every two years	DKI Jakarta: - MSM: 43.3% - IDU: 6.7%
% of female and male sex workers who report using condoms with current partners	Behaviour surveillance	P2PL, DepKes	Every two years	DKI Jakarta: 54.5%
% of schools with teachers trained in life skills education	Behaviour surveillance	P2PL, DepKes	Every two years	
% of companies with HIV and AIDS policies for the workplace	Behaviour surveillance	P2PL, DepKes	Every two years	
% of teens aged 15–24 who can correctly identify wrong perceptions of HIV sexual transmission	Behaviour surveillance	P2PL, DepKes	Every two years	
D. Impact Indicators				
% of high-risk population infected with HIV	HIV surveillance	P2PL, DepKes	Every year	Female sex workers: 6.2% (DKI, 2003)
				IDU: 47.9% (DKI, 2001)
				IDU: 42.9% (Java Barat, 2003)
				Inmates: 19.7% (DKI, 2003)
				Transgenders: 25.7% (DKI, 2004)

[88] P2PL refers to Centre for Communicable Diseases and Environmental Health, within DepKes.

AIPH indicators

AIPH will support the development and implementation of a single and effective monitoring and evaluation system for Indonesia. Whenever possible, indicators used to evaluate AIPH outcomes and impacts (at the goal, purpose and component objective levels) will be based on the National Strategy and Action Plan. Indicators to monitor and assess AIPH progress (not including those developed for HCPI) will be developed by the Senior Program Coordinator (HIV) in consultation with AusAID at the commencement of the partnership. Indicators will also be based on annual targets, developed in part during the annual planning process. The M&E framework will therefore be updated as part of the annual planning process. A preliminary M&E framework for AIPH (and HCPI) is presented as Attachment 10.

Goal: Assessment of impact

The partnership goal mirrors that of the National Strategy and Action Plan: to prevent and limit the spread of HIV, to improve the quality of life of people living with HIV, and to alleviate the socio-economic impacts of HIV/AIDS. The partnership also aims to support and be aligned with GOI priorities and plans and support GOI to achieve its Millennium Development Goals. Evaluation of the partnership should include its objectives, key activities and key players as follows:

Objectives

- To combine GOA support for HIV into a coherent partnership that benefits from synergies between each element
- To strengthen GOI leadership and capacities to implement an effective and sustainable HIV response.

Key activities

- A new program, the HIV Cooperation Program for Indonesia (HCPI)
- Financial and technical contributions to the IPF and engagement with GFATM, including input and coordination with relevant steering committees
- Mainstreaming of HIV into AusAID's work in other sectors
- Other HIV-related initiatives in the Indonesia Program, including research, health systems strengthening, child and maternal health, the NGO Cooperation Program, activities implemented by other GOA agencies in Indonesia, Australian Development Scholarships, the Australian Leadership Awards Program and the Indonesian Australia Specialised Training Program, and
- AusAID's regional partnerships with the Asia Pacific Business Coalition on HIV/AIDS and the Clinton Foundation HIV/AIDS Initiative, and AusAID's HIV/AIDS Regional Capacity Development Program.

Key players

Senior Program Coordinator (HIV)

Responsibilities and activities

- Provide policy and program advice to AusAID
- Provide advice to AusAID on the integration and coordination of Australian funded programs
- Technical oversight of activities
- Assistance in stakeholder engagement and coordination. This may include areas such as AIPH policy and strategy inputs, GFATM, IPF and other donor cooperation
- Work closely with and report to the AusAID Health Section, based in Jakarta.

Program Coordination Committee

Within the AIPH the PCC will have a decision-making role for HCPI activities. The PCC will be responsible for the planning, monitoring and coordination of HCPI, and providing

recommendations to AusAID. AusAID will have final approval for activities within each annual plan based upon recommendations from the PCC. Details of the other activities of the partnership will be provided to the PCC for information.

Aim

- Assist AusAID to ensure effective coordination of activities between the various elements of AIPH (including HCPI), and the effective coordination of AIPH with GOI and other donor initiatives.

Activities

- Provide direction for priorities and funding levels at the commencement of the annual planning process
- Review annual plans, provide comments/recommendations, and when satisfied, formally approve annual plans
- Provide oversight for monitoring of program outcomes and quality
- Approve terms of reference or tasking notes for technical assistance inputs
- Encourage a culture of coordination, collaboration, innovation and high performance within HCPI
- Identify opportunities to promote HCPI and its achievements, including the presentation (when appropriate) of results and recommendations that may influence policies in Indonesia
- Help resolve disputes that arise during the planning or implementation of activities, and
- Approve terms of reference for the periodic reviews and program completion report and provide input to relevant teams.

HCPI indicators

HCPI will support the development and implementation of a single and effective monitoring and evaluation system for Indonesia. Whenever possible, indicators for evaluating outcomes and impacts (at the goal, purpose and component objective levels) will be based on the National Strategy and Action Plan. Indicators to monitor and assess progress will be based on annual targets, developed in consultation with Indonesian agencies during the annual planning process. The M&E framework will therefore be updated as part of the annual planning process. A preliminary M&E framework for AIPH and HCPI is presented as Attachment 10.

Goal: Assessment of impact

HCPI's goal mirrors that of the National Strategy and Action Plan: to prevent and limit the spread of HIV, to improve the quality of life of people living with HIV, and to alleviate the socio-economic impacts of HIV/AIDS. The National Strategy and Action Plan includes, as its indicator on which the goal will be assessed, the prevalence of HIV within high-risk groups. Baseline data have been documented, including HIV prevalence within selected populations of female sex workers, IDUs, prisoners and waria.

Given the nature of the epidemic in Papua and West Papua, it is suggested that HIV prevalence among the general population in Papua and West Papua also be included as an indicator at the goal level.

Reversing the spread of HIV is a key part of Indonesia's millennium development commitment, which it will report on every two years under the 2006 UNGASS Declaration. However, it will also be important to develop indicators to assess Indonesia's success in improving the quality of life of people living with HIV, and minimising adverse socio-economic impacts. Possible indicators on which these could be assessed include:

- the proportion of people living with HIV or AIDS receiving CST and/or the proportion of

people living with HIV or AIDS requiring treatment who receive antiretroviral therapy

- the quality of CST services provided, and
- policies and practices which reduce discrimination, differentiate by gender, protect the rights of people living with HIV or AIDS, and minimise adverse socio-economic impacts.

It is envisaged that the KPA will over time expand the number of impact indicators, establish a baseline for additional indicators, and introduce a system for periodic assessment (in line with the commitment to the 2006 UNGASS Declaration to report on progress every two years). It is also anticipated that all data will be disaggregated by gender.

Although HCPI has a focus on prevention, it should not be seen in isolation from the other aspects of Indonesia's HIV response. Therefore, while HCPI will be evaluated in terms of its specific contribution to reducing the spread of HIV in Papua and West Papua and among IDUs (including IDUs in prisons and other closed settings), it will also be evaluated in terms of its relative contribution to Indonesia's overall HIV response. Although attributing Australia's contribution to the overall impact may be difficult, it is nonetheless an important aspect of an approach in which Australia is supporting Indonesia's HIV response. The assessment of impact, and of the relative contribution from Australia, will be undertaken during the periodic reviews (conducted every two years) and during preparation of the program completion report. The periodic reviews are described in further detail below.

In addition to a focus on epidemiological data regarding HIV incidence estimates, new diagnoses/case reports and prevalence data, it may also be useful to compare prevalence data with the 'baseline scenario' projections from the HEMI Study (see Figure 5 in Section 2.2). A comparison of prevalence data against the HEMI projections will provide the basis for an assessment of the actual impact (as opposed to the relative success) of Indonesia's HIV response.

Purpose: Assessment of outcomes

HCPI's purpose is to support Indonesia to plan, develop and implement an effective and sustainable HIV response. Indicators that can help assess whether HCPI is achieving its purpose include:

- effective working groups on harm reduction, prisons and Papua and West Papua at national level
- strengthened coordination by KPA and cooperation among KPA members in implementing the National Strategy and Action Plan
- extent to which HCPI is building the capacity of government and non-government agencies and promoting sustainable approaches that can be implemented by those agencies in the future
- extent to which HCPI is building the capacity of government and non-government agencies to integrate gender equality within the planning and implementation of HIV/AIDS programs and activities
- effective harmonisation with other donors and alignment with GOI programs (including the extent to which the annual planning process has been integrated within GOI systems and processes)
- one M&E framework as the single instrument used by all partners, including HCPI, and
- the level of funds (and relative contribution) provided by GOI for HIV/AIDS activities.

HCPI may need to develop a measure to help assess the capacity of Indonesian agencies to plan and implement activities. One possibility is to assign a score for each activity undertaken with HCPI support that reflects the proportion of planning and implementation completed by the

Indonesian partner. For example:

5 Indonesian partner responsible for all planning and implementation of the activity (no HCPI input required other than financial support)
4 Indonesian partner responsible for the majority of planning and implementation with HCPI providing only periodic guidance or advice
3 Indonesian partner and HCPI jointly planned and implemented the activity (working together on a regular basis)
2 HCPI required to play the lead role in planning and implementation of the activity
1 HCPI responsible for the vast majority of planning and implementation

To reduce subjectivity, scores would be assigned through consultation between HCPI and the relevant partner.

The extent to which HCPI is contributing to the purpose statement will be assessed as part of an annual component review. The assessment will be most beneficial if it is undertaken by GOI agencies, and if the results are used to inform program planning and delivery in the following year (thereby establishing a continuous learning process that benefits both GOI agencies and HCPI). The annual component review is described in detail further below.

The periodic reviews should also have a particular focus on the success of HCPI in supporting Indonesia to plan, develop and implement an effective and sustainable HIV response. This is expected to be one of the critical points on which a decision is made to extend HCPI for an additional three years (following the initial five-year period) or to redesign the program.

Although the National Strategy does not have a specific indicator that reflects the capacity of Indonesian agencies or donor harmonisation, UNAIDS has recently introduced a 'country harmonisation and alignment tool' (CHAT) which encompasses these aspects and is in the process of being incorporated into the plan. There may be an opportunity to combine the annual component review with data collection activities required to measure Indonesian capacity, as part of the National Strategy and Action Plan. This will be explored once implementation of HCPI commences.

Component 1 – Leadership: Assessment of outcomes

The leadership component has an objective that is not dissimilar to the purpose statement. However, specific activities to be undertaken under Component 1 will be identified during the annual planning process and indicators and targets specified in annual plans. Indicators that could be used to assess the outcome of Component 1 include:

- working groups functioning effectively in provinces where HCPI is working
- Tim Asistensi functioning effectively at national level and in provinces where HCPI is working
- development and implementation of local strategies and plans that support the National Strategy and Action Plan
- collection and use of relevant data in planning and monitoring implementation of local strategies and plans
- development and adoption of conducive regulatory frameworks
- national and local leaders serving as key advocates on HIV messages
- degree to which the program has advanced GOI capacity to promote gender equality in response to HIV
- formation of CSO alliances or consortia with clear strategies and policy positions, and
- participation of people living with HIV or AIDS in planning bodies and decision-making forums and committees.

While the Managing Contractor will assemble information on the selected indicators for Component 1, it will be preferable to have KPA play the lead role in conducting the annual component review. Key aspects of the review will include an assessment of the outcomes (based on the list of indicators prepared during the annual planning process) and recommendations to improve the support provided through Component 1 in subsequent years.

Baseline data. Baseline data for Component 1 will be confirmed in consultation with KPA and other key stakeholders during the initial annual planning process (once indicators have been finalised). It would not be difficult, for example, to undertake a brief qualitative assessment of the above indicators (during the annual planning process) in each province where HCPI works.

Component 2 – Papua and West Papua: Assessment of outcomes

The Papua HIV/AIDS Strategic Plan sets an extensive list of targets. HCPI should adopt, as much as practicable, indicators and targets that are specified in the plan. For example, one target is to communicate HIV messages to 100 per cent of adults between 15 and 29 years of age by 2011. HCPI could adopt this target.

The National Strategy and Action Plan also has a number of 'results indicators' that are directly relevant to HCPI's work in Papua and West Papua. As shown in Table 5, these include:

- % of high-risk populations that tested for HIV and received results in past 12 months
- % of MSM that report using condoms during the last sexual relations with male partners
- % of high-risk populations that understand methods of transmission and reject misconceptions of how HIV is transmitted
- % of female and male sex workers who report using condoms with current partners
- % of schools with teachers trained in life skills education
- % of companies with HIV and AIDS policies for the workplace, and
- % of teens aged 15–24 who can correctly identify wrong perceptions of HIV sexual transmission.

During the initial annual planning phase, HCPI will need to compare these national indicators with those specified in the Papua HIV/AIDS Strategic Plan. This will allow HCPI to finalise a list of indicators that will effectively report on the outcomes (or results) achieved in Papua and West Papua while simultaneously contributing towards a unified national monitoring and evaluation system. The process for data collection (including timing and responsibility) will also need to be specified. Data will wherever possible be gender disaggregated to enable monitoring, reporting and targeted action for both men and women, and for boys and girls, where appropriate. It is recommended that an additional indicator be included to help ensure sufficient focus on gender:

- The degree to which the program has advanced gender equality in responding to the different needs of men and women and in access to services

There will be strong integration between Components 1 and 2 in Papua and West Papua. Examples of indicators from the Papua HIV/AIDS Strategic Plan that may apply to Component 1, and which will be essential for the success of both Component 2 and HCPI overall in Papua and West Papua, include:

- 100 per cent of districts and kota (municipalities) have a functioning KPAD by 2011
- agreements between BNN and the KPAPs
- coordination and cooperation between government agencies
- coordination and cooperation between donors
- local regulations on the prevention response

- development of work programs to implement the strategic plan.

Additional indicators, specific to West Papua, may include:

- a functioning KPAP for West Papua
- an HIV/AIDS strategic plan for West Papua.

In addition, the government budget allocation (in both Papua and West Papua) should be an indicator on which to assess the adequacy of the HIV response in both provinces. This is also an indicator that has been specified in the National Strategy and Action Plan (see first input indicator in Table 5).

HCPI will need to liaise with the KPAPs in Papua and West Papua to finalise indicators that reflect Papua's and West Papua's capacity to lead, plan and manage an effective and sustainable HIV response. This will be undertaken during the initial annual planning process. It is envisaged that the KPAPs in Papua and West Papua will also play a lead role in assessing the support provided by HCPI, particularly in terms of the above indicators.

Baseline data. Baseline data for Component 2 should be available from existing sources, including the 2006 IBBS study (see Section 2.2). As an example, the survey indicated that 47 per cent of the Papuan/West Papuan population had not heard of HIV. This and other data from the survey (and data from other available sources) could establish a baseline for the Papua HIV/AIDS Strategic Plan (and therefore for Component 2 of HCPI). Building on lessons learned through IHPCP (see Section 2.4), it will be important to avoid a focus on further data collection where such data already exist. However, given the scale of the epidemic in Papua and West Papua, follow-up bio-behavioural surveys may be required on a periodic basis to assess the overall response to the epidemic in Papua and West Papua, including the relative success of the prevention activities supported by HCPI. Funding of such surveys would need to be discussed with the governments and donors in Papua and West Papua with a joint effort envisaged.

Component 3 – injecting drug use: Assessment of outcomes

As shown in Table 5, the draft National Action Plan specifies a range of indicators that can be used to assess the effectiveness of Indonesia's HIV response in relation to IDUs and their sexual partners. Indicators that could be adopted by HCPI include:

Goal:	Prevalence of HIV among IDUs and their sexual partners
	Number of IDUs provided with CST, and the quality of these services
Purpose:	Capacity of Indonesian agencies to provide services to IDUs
	The level of funds (and relative contribution) provided by GOI for HIV/AIDS activities (specifically for IDU activities)
Component:	% of high-risk populations covered by prevention programs
	% of IDUs applying behaviour that can reduce the risk of HIV transmission through using sterile injecting equipment and using condoms in the last two months

In addition to these indicators, HCPI will develop a range of other supporting indicators that reflect the specific activities undertaken from year to year. These activities, and indicators on which the outcome or achievement will be assessed, will be identified during the annual planning process. Some of these indicators are expected to support Regulation 02/07, for example:

- supporting DepKes to develop standards, guidelines and operational instructions for IDU harm reduction services
- supporting local governments and KPAD on the financing and location of comprehensive IDU harm reduction services

- supporting the Harm Reduction Working Group and other partners on the development of local laws, regulations and policies to ensure an enabling regulatory framework, and
- supporting integrated data collection and monitoring and evaluation.

It is recommended that an indicator be included to help ensure sufficient focus on gender:

- The degree to which the program has advanced gender equality in responding to the different needs of men and women and in access to services.

Another important indicator will be the absolute amount and proportion of funds provided by GOI for IDU activities. As HCPI will be supporting activities that assist GOI achieve its targets under the National Strategy and Action Plan, its targets will be the same as those of GOI:

- For NSP: an increase in coverage from 10 per cent of IDUs in 2006 to 70 per cent by 2010
- For MMT: an increase from approximately 600 clients at present to 154 000 clients by 2010
- For CST: establish 20 puskesmas-based comprehensive programs (NSP, MMT, VCT, CST and antiretroviral therapy) and 75 prevention-focused puskesmas programs for IDUs.

For each of the above indicators, performance will be assessed in terms of HCPI's achievements in each of the locations in which it works, and the relative contribution from HCPI in terms of the overall Indonesian response.

Baseline data. Baseline data for Component 3 should be available from existing sources. For example, available data indicate that 8 per cent to 10 per cent of IDU access harm reduction services, the target is 80 per cent. IHPCP conducted a rapid assessment and response study in 15 cities in West Java that are proposed sites, which will provide additional baseline data. A gap analysis of epidemiologically indicated need will be required each two to three years to inform HCPI's technical focus and geographical location. GOA will support GOI's universal access reporting in 2008 and 2010 to the UN, with a review in 2011, which will further inform HCPI's annual planning and monitoring and evaluation.

Component 4 – Prisons: Assessment of outcomes

Indicators will be derived from the National Strategy and Action Plan and the National Prison Strategy, which has three main pillars:

- law enforcement and legal counselling – to prevent an increase in drug abuse in correctional facilities
- rehabilitation and social services – to inmates and detainees who are drug users, IDUs or HIV infected, and
- prevention and care – for inmates and detainees with HIV/AIDS.

Under the three pillars, the following are proposed:

- education programs for corrections personnel, medical and non-medical – HIV and drug information, behaviour change communication training, training in PEP (post-exposure prophylaxis), VCT and CST training
- medical service programs – provision of HIV prevention packages (condoms, bleach, IEC), provision of MMT, VCT and CST, treatment for inmates with Hepatitis B and C, TB, STIs and other opportunistic infections, treatment of the same standard as received by the general public, and
- referral programs – people living with HIV or AIDS referred to local hospitals and to ongoing drug treatment as needed.

The key indicators for Component 4 are:

- % of high-risk populations (prisoners) covered by prevention programs
- % of IDUs in prisons and other closed settings applying behaviour that can reduce the risk of HIV transmission
- development of standards, guidelines, operational instructions, local laws, regulations, etc. for IDU harm reduction services in prisons/closed settings
- increase in coverage of comprehensive MMT
- increase in CST services for IDUs in prisons/closed settings
- increases in the absolute amount and proportion of funds provided by GOI for IDU activities in prisons/closed settings, and
- degree to which the needs of men and women have been adequately addressed in prisons and other closed settings.

Baseline data. There are limited baseline data for Component 4 including from DepHukHam (prisons mapping of number and location of most at-risk inmates), KPA estimates (November 2006) and DepKes (September 2004). IHPCP and FHI/ASA also have data. UNODC will be an important partner in identifying data sources and negotiating access. While data is scarce and inconsistent, there will be sufficient information to establish some baseline data, and gaps can be analysed for a targeted approach to filling them. HIV data in prisons is not always easy to extract, and it may be that a more robust 'baseline' data will need to be developed iteratively over the first two to three years, with data continuing to be built for the life of the program. HCPI must avoid, however, a focus on gathering additional baseline data in the first year of activities *to the exclusion* of developing relationships, partnerships and supporting the increased momentum in GOI HIV prison activities.

Component 5 – Management: Assessment of performance

The program management component includes a limited number of indicators chosen to monitor specific management tasks and evaluate the performance of HCPI in line with AusAID's proposed quality reporting system for aid initiatives:[89]

- effective support provided to the PCC
- effective communication with all stakeholders
- alignment of support to GOI systems and processes
- effective use of technical advisers and technical advice
- level of local program ownership and participation
- development of approaches which are appropriate, innovative and sustainable
- provision of physical and financial data to enable AusAID, KPA and other key stakeholders to effectively monitor progress and evaluate performance and impact
- effective treatment of risks
- demonstration of continuous learning
- donor harmonisation
- promotion of gender equality and effective treatment of gender issues, and
- sufficient emphasis given to capacity building.

It is recommended that the Managing Contractor's performance be assessed on these indicators by AusAID Jakarta (possibly utilising independent technical advisers) on an annual basis and during the periodic reviews (every two years). Modifications to and/or additional indicators – focusing on the guiding principles outlined in Section 3.5 – could also be

[89] Derived from the Consultants Information Briefing – Aid Effectiveness and Performance Assessment, 20 March 2007.

considered and agreed during the assessments.

Assessments should be undertaken and discussed with the Managing Contractor and other key stakeholders (in particular KPA, DepKes, DepHukHam and provincial representatives in provinces where HCPI is working). It is recommended that a score be assigned to each indicator, as follows:[90]

Satisfactory:

1 Very high quality; needs ongoing management and monitoring only
2 Good quality initiative; needs minor work to improve in some areas
3 Adequate quality initiative; needs some work to improve

Less than satisfactory:

4 Less than adequate quality initiative; needs work to improve in core areas
5 Poor quality initiative; needs major work to improve
6 Very poor quality initiative; needs major overhaul

The annual assessment could be used as the basis for performance-related payments to the Managing Contractor. The Managing Contractor would be required to specifically address any areas judged to be less than satisfactory. Strategies for improvement would be outlined in the annual plan for the following year.

Gender

HCPI will help strengthen the capacity of partners, including government agencies, to collect sex disaggregated data, analyse the different impacts of HIV policies and program activities on women and men, and develop gender-sensitive strategies and activities to prevent HIV. Indicators have been included in the preliminary M&E framework (see Attachment 10) to help ensure gender is effectively incorporated throughout the program.

It will be important for the Managing Contractor to ensure that adequate information is available to:

- determine whether the needs and interests of both men and women are adequately addressed and remain valid
- determine whether gender inequality issues are constraining aspects of the program or the GOI's ability to deliver an effective and sustainable HIV response, and
- identify constraints that may restrict women's or men's participation and access to benefits.

At the purpose level, HCPI will be assessed in terms of the extent to which it is building capacity of government and non-government agencies to integrate gender equality within the planning and implementation of HIV/AIDS programs and activities. This will be assessed during the annual component reviews and periodic reviews.

As shown in the preliminary M&E framework (see Attachment 10), gender-specific indicators have also been included in Components 2, 3, 4 and 5. The indicator for Component 5 is an assessment of the Managing Contractor's performance in promoting gender equality and the effective treatment of gender issues across the program. This assessment will also consider the capacity of HCPI staff and technical advisers to promote gender equality and develop gender-sensitive approaches.

[90] Based on the six-point rating scale used by the World Bank and others (derived from the Consultants Information Briefing – Aid Effectiveness and Performance Assessment, 20 March 2007).

Evaluation of program performance

Program evaluation will focus on the goal, purpose and component objectives. Indicators presented in the preliminary M&E framework (see Attachment 10), and where available, baseline data and annual targets, are based on those specified within the National Strategy and Action Plan and other Indonesian HIV strategy documents. The M&E framework will be finalised in consultation with KPA during the preparation of the first annual plan (February/March 2008).

Evaluation mechanisms are outlined below:

- An annual component review will be undertaken by HCPI in collaboration with the lead agency for each component[91] and the KPA. A report will be prepared that outlines in detail the substantive progress and issues related to each component. The report will be geared towards providing the national authorities with an overview of the policy and strategic issues and implications of HCPI's work, with a view to exploring the integration and institutionalisation of selected activities into national and local systems (including budgets). The report is expected to be submitted for consideration at the PCC meeting, and should therefore include policy recommendations that are beyond the boundaries of HCPI. KPA could also bring the report to the attention to the KPA's Executive Team, if appropriate.
- A detailed periodic review will be conducted every two years. The periodic review will assess progress across both AIPH and HCPI, and in Year 4 will provide recommendations specific to HCPI in regard to whether (i) it is appropriate to continue with the approach taken, and (ii) the contract with the Managing Contractor is to be extended for a further three years or the program re-designed.
- The Managing Contractor will be required to complete a program completion report in either Year 5 (if the contract is not extended) or Year 8 (if it is). The report will include a comparison of targets and achievements (both in terms of outputs and outcomes), an assessment of likely impact, significant constraints, lessons learned and recommendations for further support.

Independent technical advisers may be contracted to undertake periodic assessments of progress (in addition to periodic reviews), as directed by the Senior Program Coordinator (HIV). These assessments may have a specific focus or provide general program-wide assessment.

In addition, every two years the GOI will report on progress in achieving its Millennium Development Goal as part of its commitment to the 2006 UNGASS Declaration. These reports will not identify contributions by HCPI, but will provide national-level data that will help assess Indonesia's HIV response, and help identify the relative contribution made by HCPI.

Monitoring of progress

Indicators and targets for activities identified during the annual planning process will be specified in annual plans and will focus on specific outputs. The Managing Contractor will report on progress in achieving annual targets twice each year, although much of the information will be provided directly by the partners contracted to implement particular activities. The outputs and associated indicators, along with the monitoring and reporting requirements (including specification of gender disaggregated data) will be specified in partner agreements.

While outputs and indicators for monitoring progress in achieving those outputs have not been specified, they are expected to reflect and contribute to the indicators presented in the

[91] Component 1: KPA, 2: DepKes, 3: Papua and West Papua KPAPs, 4: DepHukHam.

preliminary M&E framework, presented as Attachment 10. HCPI performance will therefore be assessed in terms of achieving specific outputs (developed during the annual planning process), and the contribution these make in meeting the goal, purpose and complement level objectives.

Reporting requirements

Reporting requirements are summarised in Table 6. In addition to the reports indicated, it is expected that the Managing Contractor will present other brief reports and visual presentations to a wide range of agencies in the normal course of the work. Short-term advisers engaged by the Managing Contactor will be expected to present brief mission reports following each input. The independent technical advisers will be expected to complete brief reports following each input.

6. Sustainability, risk and feasibility

6.1 Sustainability

The program design incorporates several strategies to encourage local ownership and local participation, and enhance sustainability:

- The program directly supports Indonesian priorities by contributing towards the objectives and targets specified in the National Strategy and Action Plan (and other sectoral or geographically focused strategy documents).
- The program will build the capacity of Indonesian systems by specifically working with the KPA (as the main coordinating agency), DepKes and DepHukHam and their equivalents at provincial/district levels (as the main agencies responsible for harm reduction among IDUs and their partners) and BAPPEDA, as the main planning agency at sub-national levels of government.
- Building capacity of Indonesian systems and personnel will be integrated across all components, in addition to Component 1, which specifically aims to contribute to Indonesian capacity.
- Coordinating activities at a senior level with KPA, DepKes and DepHukHam will help ensure the program is effectively integrated within Indonesia's HIV response, and information and lessons learned are shared between HCPI, the lead agencies and other stakeholders.
- HCPI is committed to supporting the Papua HIV/AIDS Strategy and working with other donors in Papua and West Papua to effectively coordinate the HIV response.
- Adopting a cost-sharing principle for assistance will help all stakeholders focus on approaches that are financially viable and will encourage GOI agencies to increasingly fund, from their own resources, the HIV response.

The mix of technical experts within the team and available to AusAID will help ensure the program is developing approaches that are best practice. Strong linkages with Indonesian agencies and the provision of assistance for a period of eight years will help ensure practices are appropriate within the Indonesian context. This timeframe enables a more thorough opportunity to build Indonesian capacity and integrate approaches within Indonesian systems and budget processes.

Table 6: HCPI reporting requirements

Report	Brief description	Timing	Responsibility
Partner Agency Progress Reports	Describes the progress of implementation (and expenditure) in comparison to the agreed partner contract. Reports cover the periods January-June and July-December. Additional details are expected to be included in any activity that has ended during the reporting period. These reports will be presented to the Contractor and should inform the Contractor's own Six Monthly Progress Reports.	Reports required by the end of January (1) and July (1).	Implementing Partners Agencies
Annual Plan	Will include a preliminary review of progress over the previous year (as this will be undertaken in more detail in the above report), and a detailed description of activities for the next calendar year (including implementation arrangements, roles and responsibilities of key stakeholders, indicators for each activity, responsibility for collecting data and detailed cost estimates).	To be submitted to PCC by 15 October each year.	Contractor, with technical oversight by the Senior Program Coordinator (HIV)
Six Monthly Progress Report	A report summarising progress and expenditure against targets, outputs, budgets and the strategic direction of the program as agreed in the Annual Plan.	To be submitted to AusAID three weeks prior to the March (1) and September (1) PCC meetings.	Contractor
Annual Component Review	A report outlining in detail the substantive progress and issues related to each component, including progress against objectives as required by AusAID for reporting against Quality at Implementation criteria. Reporting should particularly focus on gender indicators and success against gender based objectives.	Report to be submitted 1 February for the March PCC meeting	Prepared by HCPI in collaboration with the lead agencies and KPA.
Periodic Reviews	Reviews to analyse the effectiveness of Australia's support to Indonesia's HIV response (AIPH and HCPI). The Year 4 review will contain recommendations for the future of HCPI, including whether an extension should be provided to the Managing Contractor or the Program re-designed.	Year 2 and Year 4	Team assembled by AusAID (possibly including external consultants)
Completion Report	A report on program effectiveness, efficiency, impact and sustainability, relevance, and lessons learnt over the life of HCPI.	Required three months prior to the Program End Date.	Contractor

6.2 Risk management

There are a number of risks that may reduce the effectiveness of the program in achieving the goal, purpose and component objectives. Foremost among these is the overall level of funding for HIV and AIDS programs.

A summary of the main risks, and strategies for their mitigation, is presented in the following table. A detailed analysis, including suggested responsibility for mitigation, is presented as Attachment 12.

Table 7: Risk summary

Risk	Mitigation
Risks to achieving the goal: > Failure to increase the level of support before a generalised epidemic occurs, either from the GOI or donors (e.g. GFATM and DFID)	> All stakeholders must continue to raise awareness of the need to scale up the HIV response > Target the response towards areas of greatest need (flexibility is therefore important)
Risks to achieving the purpose: > A lack of planning and implementation capacity, particularly within lower levels of government > Ineffective use of resources due to a lack of cooperation and coordination between GOI, donors, civil society and the private sector	> Support and strengthen GOI systems and processes at all times > All stakeholders must be willing to work together and learn from each other. Sharing information and lessons learned will be important
Risks to achieving the Component 1 objective: > Lack of ability to lead and foster inter-institutional collaboration	> Intensive support to KPA and lead agencies, particularly at the beginning of the program, by fostering frequent communication and collaboration
Risks to achieving the Component 2 objective: > Failure to improve health services > Failure to change behaviour among high-risk groups and the general population	> Lobby support for additional resources for Papua's and West Papua's health services > Develop materials/techniques that are applicable to the local population (drawing on experience from PNG), including local language materials, the use of local theatre groups, and use of high-profile people such as sport and rock stars
Risks to achieving the Component 3 objective: > Loss of support for a sustained and comprehensive approach to address the needs of IDUs	> Strengthen awareness of the need for a comprehensive approach, work in locations that have political support and strong leadership, and ensure information is collected to provide (in the longer term) evidence of impact
Risks to achieving the Component 4 objective: > Lack of access to prisons and ability to provide comprehensive services	> Liaise closely with senior officials in DepHukHam and work collaboratively with KanWilHukHam and prison officers, and other key stakeholders in the province and prison
Risks to achieving the Component 5 objective: > Failure to plan and implement activities within the GOI planning cycle	> Place staff in GOI agencies, enter agreements at provincial level which specify collaborative planning

Risk	Mitigation
	and the cost-sharing principle > Prepare 'shadow plans' in anticipation of planning delays within government. In addition, provide flexibility in HCPI funding to help minimise disruption from GOI funding delays

There are a number of program design features that aim to reduce risk, including promoting partner ownership (by working closely with and supporting GOI systems and processes), placing more emphasis on institutional strengthening and capacity building, providing flexibility, allowing for technical and strategic advice at relevant times, maximising the opportunities to benefit from lessons learned (by working with lead agencies for each component), and continuing to support a comprehensive and evidence-based approach.

Transition risks

In addition to the risks facing HCPI, it is worth mentioning the risks prior to implementation, and in particular, the risks associated with the transition from IHPCP to HCPI. Changes of the magnitude proposed are seldom easy. To help avoid these problems:

- A Transition Strategy will be prepared by the end of April 2007, describing all IHPCP activities between July 2007 and February 2008.
- Partner grants that are to be continued under HCPI (from March 2008 onwards) will be negotiated to extend from July 2007 to December 2008.
- The new Managing Contractor will have a one-month overlap with key staff from the current IHPCP team.
- The HIV/AIDS Coordinator in AusAID Jakarta will oversee the transition period, working closely with KPA and the managing contractors for both IHPCP and HCPI.
- The new Managing Contractor will hold an inception workshop in March 2008 to discuss with a range of stakeholders, plans for the remainder of 2008.

Additional details of the transition are presented in Attachment 7.

6.3 Feasibility

There should be no illusion that Indonesia faces a tremendous challenge in its attempt to avoid a generalised HIV epidemic. Such an epidemic would have serious social and economic consequences, particularly in rural communities in Papua and West Papua. As discussed in Section 2.2, unless the current response is substantially increased the number of deaths in Indonesia resulting from AIDS and related illnesses is estimated at 1.5 million by 2025. Indonesia must not only allocate far more resources, but employ a comprehensive response that includes adequate coverage and effective, sustainable approaches.

HCPI is a shift in direction from previous Australian support. No longer is the main challenge raising awareness among political leaders and the general population, or developing appropriate approaches, or revising policies to enable appropriate approaches to be implemented. While tremendous progress has been made in each of these areas, in part through the work of IHPCP, the rapid and progressive nature of HIV in Indonesia means that the main challenges now are increasing the overall level of resources available, increasing the effectiveness and impact of these resources, and increasing the capacity of Indonesian systems and agencies. Only with increased resources and enhanced Indonesian capacity will the response be scaled up to the magnitude required.

The primary focus of HCPI therefore is to work in partnership with, and build the capacity of, Indonesian agencies. By working with existing agencies and within existing processes, HCPI

will:

- facilitate the strengthening of Indonesia's role in leading the HIV response
- help ensure effective coordination of HCPI activities at each level of government
- provide an opportunity for successful HCPI interventions to be highlighted among policy makers and therefore replicated on a wider scale, and
- promote donor harmonisation.

Consistent with the aim of integration of program activity into Indonesian systems, HCPI will progressively support and strengthen GOI structures rather than relying on parallel infrastructure and personnel. This approach will be integrated throughout HCPI. To facilitate this approach, HCPI will (i) synchronise its activities with those of the concerned institution; (ii) gradually integrate activities and responsibilities for these activities into the concerned institution's systems, processes and budgets; and (iii) include effective monitoring.

Within this context, the approaches to be employed by HCPI and the inputs to be provided appear to be appropriate, strategic and well targeted, technically and institutionally feasible, and cost effective. However, success in achieving the ultimate goal is far from certain. Nevertheless, the goal is common to both the National Strategy and Action Plan and Indonesia's millennium development commitments (MDG #6). It is therefore a goal that the GOI and the donor community have accepted, along with the timeframe that the spread of HIV will be reversed by 2015.

7. Attachments

Attachment 1: Design mission terms of reference

(Condensed version)

1. Background

1.1 These terms of reference are for the design of the Indonesia HIV/AIDS Prevention and Care Program 2007–2012.

1.2 In Indonesia, despite the response of the Government of Indonesia (GOI), community groups and the international community, the number of people living with HIV continues to rise. IDU in Java and the epidemic in Papua-Irian Jaya Barat are both of particular concern. IDU accounts for around 50 per cent of HIV transmission in Indonesia and currently Papua has the highest known prevalence in any one provincial location. Transmission in Papua is primarily through heterosexual sex (following patterns similar to those in PNG). Poor health and education services, high rates of STIs and behavioural factors including low levels of consistent condom use are contributing to vulnerability and to the risk of a generalised epidemic. AusAID-commissioned research undertaken in 2006 concluded that unless Indonesia and its donors scale up efforts to contain the epidemic in Indonesia there could be as many as 1.95 million people living with HIV in Indonesia by 2025 with 145 000 of these in Papua.

1.3 AusAID has funded HIV/AIDS support to Indonesia for more than ten years, mainly through two successive projects: The Indonesia HIV/AIDS Prevention and Care Project (IHPCP) Phase 1 (funding A$20 million; duration September 1995 – June 2001; operated in Bali, South Sulawesi, East Nusa Tenggara), and IHPCP Phase 2 (funding A$37 million, duration September 2002 – August 2007, operated in Bali, South Sulawesi, NTT, Java Barat, Papua and DKI Jakarta. There were criticisms of the loss of momentum during the transition between the two projects and consequently lessons learned on the importance of a smooth transition from the current Project to the new Program. AusAID recently engaged an HIV/AIDS Coordinator, based in the Embassy in Jakarta, to further strengthen support to Indonesia.

1.4 Aside from Australia, the other major bilateral donor with significant direct involvement in HIV/AIDS in Indonesia is the USA. The USAID contractor, Family Health International (FHI), delivers the $60 million five-year Aksi Stop Aids Project (ASA). This project operates in ten provinces, building capacity in local governments and NGOs, and targets major transportation hubs; it promotes harm reduction, treatment and care, and encourages private companies to be actively involved in HIV prevention.

1.5 Australia has played a leadership role in the establishment of the Indonesia Partnership Fund for HIV/AIDS (IPF). The IPF was established with a three-year funding commitment of 25 million pounds from DFID as a mechanism for Indonesia and its external partners to jointly resource and monitor Indonesia's HIV/AIDS Strategy under a single operational framework. IPF funds have been used to strengthen the capacity of AIDS Commissions at all levels (with technical assistance provided by the United Nations) and scaling up of the current two largest bilateral HIV/AIDS projects (AusAID and USAID) to decrease transmission rates and to help Indonesia in achieving the Millennium Development Goals (MDGs) in HIV/AIDS. The IPF has committed up to US$8 million over two years to the AusAID-funded

Indonesia HIV Prevention and Care Project.

1.6 Indonesia has received significant additional funding from the GFATM (to date, Round One: US$7,062,548 and Round Four: US$16,023,871). However, far lower amounts have been disbursed due to absorptive capacity constraints and performance problems. Indonesia's submissions for Round 2 and 3 were not successful. The submission for Round 6 funding focusing on prevention of mother to child transmission of HIV was also not successful.

1.7 The Development Banks are increasing their involvement in the region's HIV response. The World Bank commenced a program of epidemiological, social and behavioural research and analysis on HIV in Indonesia in 2006, with a focus on Prisons and IDU, Papua and Harm Reduction. The ADB is also making funds available to support the region's HIV responses through the Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific.

1.8 AusAID intends to maintain a significant long-term program to assist Indonesia in combating HIV/AIDS and the Indonesia HIV/AIDS Prevention and Care Program 2007–2012 reflects this intention. A Concept Paper for future support to Indonesia for HIV/AIDS provided the platform for these terms of reference. The November 2006 Concept Paper contains a detailed situational analysis of the HIV/AIDS situation in Indonesia and includes a recommendation for a seamless transition to the new Program.

1.9 It is expected that the design mission will be undertaken in February 2007, with the design document appraised and peer reviewed before tendering.

2. Rationale for the design mission

2.1 The response to the epidemic by the Government of Indonesia, community groups, and the international community over the last decade, whilst far from comprehensive, has laid some foundations for preventing an expanded epidemic. It is clear though that the support of the international community is essential for continuing the response to HIV/AIDS. Maintaining the required effort in the absence of donor funding would make challenging demands on the GOI budget given the level of allocations available for health.

2.2 The MOH national sentinel surveillance program, which commenced in the early 1990s, weakened following decentralisation in 2001 and efforts are being made for its strengthening. However, available data and expert opinion confirm that Indonesia is experiencing three different escalating HIV epidemic patterns: concentrated epidemics in (i) IDUs and (ii) sex workers and their clients (iii) a generalised epidemic in Papua/Irian Jaya Barat. All three epidemics are expanding and further delay in mounting an escalated response will exacerbate the social and economic consequences and create a heavy burden on the health sector.

2.3 A transition to a generalised epidemic by 2025 is predicted in Indonesia without an increased response, with 300 000 deaths from the HIV epidemic by 2010 and 1.5 million by 2025.[92] Drivers of these HIV epidemics include injecting drug use including in prisons, poverty, gender inequality, mobile men with money who use sex work services, sex workers and their mobility.[93] In Papua-West Papua sexual transmission is also thought to be exacerbated by low levels of circumcision, high STI rates,

[92] Australian Government. AusAID. The HEMI Report. 2006.
[93] Republic of Indonesia. National AIDS Commission. Reporting Period 2004–2005. pp. 16–17

behavioural factors and alcohol misuse.[94]

2.4 AusAID support through the current Indonesia HIV/AIDS Prevention and Care Project has made an important contribution. The Project has been a major player in assisting the GOI response to HIV/AIDS in Indonesia. A number of innovative responses have been developed and strong relationships with partners in the government, non-government and community sectors have been established upon which the new Program can build.

2.5 There is a dynamic environment for strengthened HIV/AIDS responses in Indonesia. The National AIDS Commission (NAC) has been revitalised following a 2006 Presidential Regulation, provincial and district AIDS commissions are being strengthened, as are their monitoring requirements to NAC. There is continued emphasis on the 'Three Ones', and a 2007–10 National HIV/AIDS Strategy and costed National Action Plan are being developed.

2.6 From a cost benefit perspective HIV/AIDS deserves special attention. Failure to control the epidemic at this early stage will result in more damaging and costly consequences in the future. It takes six to ten years, on average, for an HIV infected adult to develop AIDS. Regardless of future changes in mode of transmission, the number of people with AIDS will continue to increase over the next few years in Indonesia. Currently the GOI is unable to comprehensively respond to the increase without continuing support. Current expenditure on AIDS prevention is inadequate and Indonesia's response to AIDS is reliant on international support. As AusAID is one of the largest bilateral donors in this sector, withdrawal of support would leave a large gap and leave the effectiveness of Indonesia's HIV/AIDS response at risk.

2.7 The economic impact per case of AIDS is greater than for other prevalent diseases such as malaria: HIV mainly affects adults in their most productive years. Consequent infections lead to heavy demand for expensive health care, the lack of workforce participation carries a cost, and the social costs to families and communities through illness and death are high. As there is no cure for AIDS, prevention is key.

3. Australia's Overseas Aid Program – HIV/AIDS

3.1 Australia has an international strategic leadership role including through its board memberships of UNAIDS and the GFATM, its initiation of the pre-eminent leadership group on HIV in the region (the Asia Pacific Leadership Forum on HIV/AIDS) and its work with the business community to establish the Asia–Pacific Business Coalition on HIV/AIDS. Australia has also signed a five-year agreement with the Clinton Foundation to treat people living with AIDS. In April 2006, Australia appointed an Ambassador for HIV/AIDS (Ms Annmaree O'Keeffe). The focus of this position is to encourage political, business and community leaders in the Asia Pacific region to provide the direction and support needed to meet the HIV/AIDS threat. Australia has committed $1 billion over the ten years from 2000 to 2010 to global HIV/AIDS initiatives.

3.2 Policy drivers of future HIV/AIDS support to Indonesia include (i) the White Paper *Australian Aid: Promoting Growth and Stability* (2006) and AusAID Health Policy (2006), which emphasise health systems, women and children's health, gender equality, and leadership on HIV/AIDS, (ii) AusAID's Indonesia Country Strategy, (iii) Australia's International HIV/AIDS Strategy (2004), (iv) commitments under UN HIV/AIDS Declarations (2001 and 2006), (iv) MDGs, (v) the 'Three Ones' principles,

[94] ibid.

and (vi) the recommendations of the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors (2005).

4. Australia's Overseas Aid Program – HIV/AIDS in the Indonesia Program

4.1 Australia's policy drivers on HIV/AIDS (see above) are reflected in the Indonesia Country Program. As well as other support to the health sector (maternal and child health projects, family planning and reproductive health services, malarial research and GOI's national tuberculosis program, health system development), there has been support for HIV/AIDS for a decade. This support has been of great assistance and highly valued. However, it has been spread too thinly for maximum impact on containing the epidemic. For the new IHPCP, even greater return on investment is sought through a geographical and technical focus on areas of greatest need (Java for harm reduction in IDUs, Papua-Irian Jaya Barat for a comprehensive response, and prisons nationally).

5. Objectives

5.1 The objectives of the design mission are: To design and cost a new Indonesia HIV/AIDS Program 2007–2012 which has its geographical and technical focus on Java and possibly Bali for harm reduction in IDU, Papua-Irian Jaya Barat for a comprehensive response, and the national prisons program building on the current prisons IHPCP model in Bali. The program will aim to assist Indonesia in containing the HIV/AIDS epidemic. In order to achieve this, the design team will produce a document that:

- Provides for a flexible design ensuring a seamless transition, with no gaps, between the current Project and the new Program, and which will be aligned with the 2007–10 National HIV/AIDS Strategy and costed National Action Plan, and incorporates donor harmonisation where feasible. The design needs to enable the Program to be proactive, responsive to, and accommodating towards, GOI, NGOs and emerging HIV/AIDS issues and high-risk groups.
- Ensures the design builds on achievements of the current Project, lessons learned and the achievements and lessons learned from other GOI activities, other donor support and activities in Indonesia, and relevant regional and global initiatives.
- Outlines management arrangements, developed in consultation with AusAID, for the Program and AusAID's proposed high-level policy and technical HIV/AIDS leadership role. These will articulate roles for personnel within AusAID Jakarta, including existing staff and new program management positions recommended in the program design, as well as positions within the new Program.
- Incorporates in the design technical and any other relevant linkages with other AusAID HIV/AIDS activities elsewhere (e.g. Asia regional, PNG) as mooted in the Concept Paper.
- Articulates a draft design for the new Program; the team will present this to AusAID for approval and to a peer review panel for assessment.

6. Program approach and strategy

6.1 The Concept Paper preceding this design mission contains a rigorous HIV/AIDS situational analysis which will inform the design mission. A number of other situational analyses and issues papers on the current state of the HIV/AIDS epidemic in Indonesia have been produced and most are cited in the Concept Paper. The design team will familiarise themselves with these and other relevant documents and the social, political, cultural and economic context of Indonesia's response to the

HIV/AIDS epidemic.

6.2 For the design process, it is proposed that the design mission spend approximately four weeks in Indonesia. The design mission will consult further with key stakeholders in Jakarta as appropriate, and with key stakeholders in Java, Papua-Irian Jaya Barat using participatory meetings, focus groups and other appropriate processes. The design mission will collaborate with and participate in a multi-donor review of the response to HIV/AIDS in Indonesia to be undertaken in February. The design mission will draw on findings of this review to inform development of Australia's new HIV/AIDS program.

6.3 The team will be presented an Aide Memoire, containing key elements for use in the design of a Program of assistance, before departure from Indonesia using a workshop format with key stakeholders. It will include clear descriptions of institutional and management arrangements for the proposed Program, and address social, gender and economic factors. It will include details of Australia's proposed financial contribution to the IPF.

6.4 Key stakeholders will include representation from community groups and, if possible, high-risk groups, as well as relevant ministries within GOI at national level, other donors, and the IHPCP. Gender balance will be ensured.

6.5 The team will observe the following guidelines. They will:

- Ensure the design is aligned with the 2007–10 National HIV/AIDS Strategy and costed National Action Plan (once completed) and donor programs where feasible.
- Ensure the design reflects a program approach to ensure a more coherent and strategic approach amongst AusAID's various HIV/AIDS activities as presented in the Concept Paper.
- Ensure the design reflects areas of Australia's comparative advantage, has increased coverage of effective interventions, and that guiding principles articulated in the Concept Paper are applied.
- Ensure that Program interventions are linked to, and can be implemented in collaboration with, other relevant activities (e.g. AusAID's health system development activities, USAID's FHI, IPF, GFATM).
- Link funding during the implementation phase to the achievement of specific objectives and specify these links in the Program design.
- Provide for strategic and operational linkages of the Program with GFATM and IPF, including enabling its access to these funds for leverage.
- Provide for an AusAID contribution to IPF.
- Ensure there is no gap between the current IHPCP finishing and the new Program commencing.
- Adopt or refine the Guiding Principles contained in the Concept Paper.
- Adopt or refine the proposed goal in the Concept Paper.
- Consult with key stakeholders in high-risk groups, across GOI ministries at subdistrict, district, provincial and central levels, within the non-government sector, religious and community-based organisations, and other donors and their agencies.

7. Scope of services

7.1 The design team shall consider the following elements:

- Prevalence and other data
  Determine the need to incorporate broad or localised surveillance activity in the

design of the project, or other means of data collection and monitoring.

- Research
  Incorporate mechanisms in the design to accommodate behavioural, biomedical and epidemiological research. The design should provide for sufficient flexibility to accommodate research findings.
- National approach
  Include NAC and MOH as key counterparts.
- Transition
  Provide for mechanisms for current locally engaged staff to be engaged on the new Program if found suitable by the successful tenderer, given their relative scarcity and possible loss to other areas if the transition is not well designed or managed. Provide for mechanisms for ongoing funding of key NGOs to prevent their collapse during the transition phase.
- Interventions
  Utilise lessons learned and build on current IHPCP achievements in designing interventions, and on other relevant activities/lessons learned.
- NGOs
  Incorporate NGOs in the design to provide a conduit and leadership in the community setting.
- Management of project
  Ensure the design should minimise the complexity of program management, providing for efficiency in delivery, and strong links to the policy and technical role of AusAID.
- Key counterpart capacity
  Ensure the design responds to and supports further development of the capacity of key counterparts.
- Cross cutting issues
  Identify cross cutting issues, particularly support for gender equity, and ensure appropriate support for these issues.
- Mainstreaming
  Identify options to enhance mainstreaming HIV in the design, implementation and evaluation of all AusAID activities.

7.2 At the conclusion of this work, the team will have produced the following outputs:

- An Aide Memoire, presented to GOI, AusAID Jakarta and other key stakeholders as appropriate.
- A detailed Program Design.

Attachment 2: Persons consulted during design

Name	Institution	Title
Jamie Uhlrig	DFID	HIV/AIDS Adviser
Michael O Dwyer	DFID	Regional Adviser
Bob Magnani	Family Health International	Country Director
James Johnson	Family Health International	Deputy Director
Chawalit Natpratan	Family Health International	Director for Technical Support
Dr Nafsiah Mboi	National AIDS Commission	Secretary
Dr I Nyoman Kandun	Ministry of Health	Director General of Communicable Disease Control and Environmental Sanitation
Dr Diah	Ministry of Health	Staff of AIDS and STD Sub Directorate
Daniel Hazman	Clinton Foundation – Indonesia	Country Representative
Tim Mackay	IHPCP	Team Leader
Abby Ruddick	IHPCP	Deputy Team Leader
Celia Greening	GRM International	Project Manager
Jane Wilson	UNAIDS	Country Coordinator
Edna Oppenheimer	UNODC	HIV Adviser
Chris Purdy	DKT International	Country Director
Lynn Kruegar	USAID	Director – Health Office
Karen Klimowski	USAID	Deputy Director – Health Office
Ratna Kurniawati	USAID	Public Health Specialist
Bernadette Whitelum	AusAID	Deputy Senior Representative – Aceh Reconstruction and Health Unit
Michelle Vizard	AusAID	First Secretary – Health
David Dunlop	AusAID	Health Adviser
Dr Arum Atmawikarta	BAPPENAS	Director for Health and Community Nutrition
Dadang Rizki Ratman	BAPPENAS	
Round table discussion with People living with HIV or AIDS organisations		
Anto Eko Sudaryanto	Rumah Cemara (NGO)	Representative
Hertin Setyowaty	Spiritia (NGO)	Representative
Husein Habsyi	Yayasan Pelita Ilmu	Representative
Sunarsih	Ikatan Perempuan Positif Indonesia	Representative
Rico Gustav	Yayasan Permata Hati Kita	Representative
Kurniawan Rachnadi	Pokdisus AIDS	Representative
Arie Rahadi	Ikatan Napza Indonesia	Representative
Yogyakarta		
HE Sri Paku Alam IX	Yokyakarta Province	Vice Governor
Dr Bondan SMPH	Provincial Health Dept	Head
Dr Elvy Effendie, MSi	Provincial Health Dept	Pharmacist
Dr Andung	Gracia Mental Hospital	Director
Dr Juwono	Provincial Health Dept	Staff
Dr Susy	Provincial Health Dept	Staff
Dr Yanri Wijayanti Subronto, PhD	Sardjito Hospital	HIV/AIDS Program Coordinator
Ana Yuliastanti	Provincial AIDS Commission	Secretary

Name	Institution	Title
Slamet Riyadi	Yogya Institute of Research, Education and Publications	Assistant Director
Vinolia	KEBAYA (Yokyakarta Waria Association)	Coordinator
Primarendra	CD – Bethesda Yokyakarta	Staff
Ika Harmawati	Yayasan Kembang Yokyakarta	Director
Papua and West Papua		
Unnamed official	Wamena District Government Office	Secondary Assistant
Unnamed official	Health Office	Chief
Unnamed official	Health Office	Staff
Unnamed official	Wamena District Government Office	
Unnamed official	Department of Social Welfare	Staff
Unnamed official	District Police Office	Vice President
Unnamed official	Bina Mitra	Staff
Dr Viviana M.P	District Hospital	Director
Dr Charles Ratulangi	District Hospital	Hospitalisation Installation Chief
Mr Agus	District Hospital	Phlebotomist
Dr Taha	District Hospital	Clinician
Penina	Yasukogo Foundation	Representative
Sex workers	Sex worker 'village'	
Pdt Y Meage	Christian Community	
Jeffrey F Pelamonia	FHI/ASA	Programme Manager, Jayapura
Frans Wanggau	Universiti Negari Papua	Resource Management
Yan Peiter Karafir	Universiti Negari Papua	Fakultis Ekonomi
Various	Universiti Negari Papua	Faculty Heads and other staff
Benjamin Johns	WHO, Jakarta	Technical Officer
Pak Leanda	Department of Workforce, Sorong	
Pak Sihombing	Sorong City Health Office	Chief Executive Officer
Ibu Mina	Sorong Hospital	VCT Program Manager
Pak Dickie	YSA St Augustus Foundation, Sorong	
Ibu Barista	YSA St Augustus Foundation, Sorong	CST Manager
Dr Sita	YSA Sorong	
Pak Petrus	YSA St Augustus Foundation, Sorong	Laboratory Technician
Dr Ferhat	RS Sele B Solu Sorong	
Dr Englebert, Pak Inda and others	District Heads of Revenue, Economic Development, Culture and Tourism, Information, Social Affairs, Cooperation Office	
Dr Rahimin Katjong	Government of West Papua	Mayor of Sorong and Acting Vice Governor
John Toisuta	Sorong Municipality	KPAD
Dr Ferdinand	Sorong Hospital	RSUD Kabupaten Sorong
Mien Arfayan	Raja Ampat KPAD	

Name	Institution	Title
Pak Indah Arfan	Raja Ampat KPAD	
Pak Tigor Silaban	Papua DinKes	Chief Health Officer
Dr Tunggul	DepKes, Jakarta	
Pak Constant Karma	Provincial AIDS Commission	
Various	Roundtable with DinKes	
Wamena District AIDS Commission – Mini Workshop		
Suparman	Bina Mitra	Representative
Joko Maryono	Labour Office	Representative
Maslim Rajab	Jayawijaya AIDS Commission	Representative
Ramlia Salim	Jayawijaya AIDS Commission	Representative
Tinggal Wusono	Wamena AIDS Commission	Representative
Daud Lolo	Wamena AIDS Commission	Representative
Lekius Yikwa	Wamena AIDS Commission	Representative
Daulat Marlia	Wamena AIDS Commission	Representative
Dr Charles Ratulangi	District Hospital	Hospitalisation Installation Chief
Dr Viviana MP	District Hospital	Director
Supriyagung	Police Office	Head (Kompol)
Eli Tabuni	World Vision	Representative
Penina	Yasukogo Foundation	Representative
Yoram Yogobi	Yasukogo Foundation	Representative
Magdalena Tenalu	GOW	Representative
Yan Huby	Health Office	Representative
Supriyono	Radio of Republic of Indonesia	Representative
Etty Wira	Health Office	Representative
Benyamin Ariensi, MSi	District Government	Staff
Pelemon Matuan , SSos	P2K	Representative
Merauke		
Dr Mala Hayati	WHO Indonesia for Merauke	Focal points
Dr Merlin Ranoko	District Hospital	Working Group
Dr Neville Muskita	District Health Office	Staff
Ibu Manurung	Mopah Health Centre	Midwife and Counsellor
Unnamed Official	Mopah Health Centre	Doctor/Director
	Kupik Health Centre	Staff
Various	The 'Bel Rusak' Localisation	Madam and sex workers
	Yobar Localisation	Madam
	Bei Rusak and Yobar Localisation	Dinas Social Office
HIV/AIDS Working Group – Merauke District Hospital		
Herlina Fonataba	YASANTO – St Antonius Foundation	Counsellor
Priest Steve Lobwaer	Cendrawasih Bersatu Merauke/Merauke United Cendrawasih (CSO – PLWHA)	Chief and Counsellor
Dr Paul JS Kalalo	District Hospital – Tranfusion Unit	Chief
Priest Ronald Imkotta	YAMIKARI – Christian Society	Chief
Merauke District Health Office – Mine Workshop		

Name	Institution	Title
Various	Merauke	Local Government, Police Office, teacher, village leader, villagers and public health office staff
WHO Health Review Team		
Dr Sabine Flessenkaemper	WHO Indonesia	
Kurniawan Rahmadi	POKDISUS/RSCM	
Dr Dicky Budiman	DepKes	
Dr Ainurrofiq	AIDS and STI sub unit – DepKes	
Anne Bergstrom	UNICEF East Asia & Pacific Regional Office	Timika/Jayapura Review Team Leader
Ratna Kurniawati	USAID	Review Team Member
Dr Grace Munthe		Review Team Member
Dr Priskila R. Noviane	WHO Indonesia	
Marni Radini	Depkes	Review Team Member
KPA – Prisons Working Group Round Table Discussions		
Dr Nafsiah Mboi	National AIDS Commission	Secretary
Edna Oppenheimer	UNODC	HIV Adviser
Pak Enang	KPA	Harm Reduction Adviser
Pak Henry	FHI	Harm Reduction Adviser
Ibu Cindy	Dept of Justice and Human Rights	
Pak Wim	Dept of Justice and Human Rights	
Pak Hendra	Dept of Justice and Human Rights	
Ibu Ratna	DepKes	Head of HIV Working Group
Various	Manokwari Provincial Health Office	

Attachment 3: Documents reviewed

1. ADB. Proposed Technical Assistance for Fighting HIV/AIDS in Asia and the Pacific. (Financed by Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific). 2006
2. Australian Government. AusAID. Australian Aid: Promoting Growth and Stability. A White Paper on the Australian Government's Overseas Aid Program. 2006
3. Australian Government. AusAID. AusAID 2010: Director General's Blueprint. February 2007
4. Australian Government. AusAID. Consultants Information Briefing – Aid Effectiveness and Performance Assessment. Presentation by the Office of Development Effectiveness, AusAID. 20 March 2007.
5. Australian Government. AusAID. Gender equality in Australia's aid program – why and how. March 2007.
6. Australian Government. AusAID. Summary of Australia's Overseas Aid Program 2006–2007
7. Australian Government. AusAID. Helping health systems deliver. A Policy for Australian Development Assistance in Health. 2006
8. Australian Government. AusAID. HIV/AIDS in the Asia Pacific Region. Analytical Report for the White Paper on Australia's Aid Program. 2005
9. Australian Government. AusAID. Impact of HIV/AIDS 2005–2025 in Papua New Guinea, Indonesia and East Timor. Final Report of HIV Epidemiological Modelling and Impact Study. 2006
10. Australian Government. AusAID. Impact of HIV/AIDS 2005–2025 in Papua New Guinea, Indonesia and East Timor. Synopsis Report of the HIV Epidemiological Modelling and Impact Study. 2006
11. Australian Government. AusAID. Australia Indonesia Partnership (AIP) Organisation Chart. 2006
12. Australian Government. AusAID. Design Framework Report for a 'Program of Assistance to Maternal and Neonatal Health in Nusa Tengarra Timur'. 2006
13. Australian Government. AusAID. Regional Collaboration Indonesia, East Timor, PNG. (Slide presentation. Linette Collins. AusAID Post Indonesia.) 2006
14. Australian Government. AusAID. Indonesia HIV/AIDS Donor Harmonisation (AusAID Team Leaders' Meeting). 2006
15. Australian Government. AusAID. Australian Aid to Indonesia. Summary of Programs. 2006
16. Australian Government. AusAID. Australia's Strategy to Support PNG Response to HIV/AIDS 2006–2010. 2006
17. Australian Government. AusAID. Papua New Guinea–Australia HIV and AIDS Program. Program Implementation Framework. 2006
18. Australian Government. AusAID. Through the looking glass. HIV and the White Paper on Australian Aid. (John Godwin, AusAID HIV Adviser.) 2006
19. Australian Government. AusAID. SHARP. Outline of possible management and communication structure (draft). 2006
20. Australian Government. AusAID. Mainstreaming HIV into AusAID's Development Portfolio in Papua New Guinea (Kate Butcher). 2005
21. Australian Government. AusAID. Strategy for AusAID's Regional Programs 2005–09: an approach to regional engagement with East Asia. 2005
22. Australian Government. AusAID. Indonesia: HIV/AIDS Country Profile. 2004

23. Australian Government. AusAID. Indonesia HIV/AIDS Prevention and Care Project (IHPCP) – Phase 2. Review of Stage 1. Final Report. 2004

24. Devaney, M, Reid, G & Baldwin, S. Situational analysis of illicit drug issues and responses in the Asia–Pacific region. ANCD Research Paper 12, 2006.

25. DFID. Annual Review. Partnership Programme for HIV and AIDS in Indonesia. 2006

26. DKT. Research Briefing. Family Planning. Knowledge, Behaviour, Attitude and Practices of the Midwife. 2006

27. DKT. Research Briefing. Family Planning, Knowledge, Behaviour, Attitude and Practices of the Acceptor. 2006

28. DKT. Research Briefing. Youth Sexual Behaviour Study in Four Cities in Indonesia. 2005

29. DKT. Ringkasan Riset. Studi Mengenai Perilaku Seksual Kawula Muda di Empat Kota Besar Indonesia. 2005

30. England, R. Coordinating HIV control efforts. What to do with the national AIDS commissions. Lancet. May 2006; 367(9524):1786–9.

31. FHI/ASA. Year One Workplan (October 2005 – September 2006)

32. FHI/ASA. Third Quarterly Report (April – June 2006)

33. Gani, A. District Health Financing Reform in the Decentralisation. Excerpt from paper. 2006

34. GFATM. Situation Analysis and Proposed Solutions to Address Factors Identified as Impeding the Implementation of Round 1 and Round 4 Global Fund Grants for HIV/AIDS. Final Report of the Problem Solving Ad Hoc Task Team CCM GFATM Indonesia. 2006

35. GFATM. Use of Multiple PRs to Implement GFATM Programs (Vivikka Molldren; prepared for Indonesia GFATM CCM Team for HIV/AIDS). 2006

36. Godwin, P et al. Five Myths about the HIV Epidemic in Asia. 10.1371/joutnal.pmed.0030426. 2006

37. Hudiono, E. Women and HIV/AIDS in Indonesia. Monitoring Ten Years of ICPD Implementation: The Way Forward to 2015: Asian Country Reports. Asian–Pacific Resource and Research Centre for Women. Chapter 5. 2005

38. IHPCP. Discussion Notes (draft) (Tim Mackay, ATL). Priorities and options for technical and geographic focus and delivery mechanisms for AusAID support for the national response to HIV in Indonesia after August 2007

39. IHPCP. Brief notes against main agenda items for AusAID/IHPCP meeting. (Tim MacKay, ATL). 2006

40. IHPCP. Supporting the Indonesia Response to HIV (slide presentation). 2006

41. IHPCP. The field based comprehensive feedback for AusAID. (Esthie Hudiona, Surabaya). 2006

42. IHPCP. Nurlan Silitonga. Perawatan, Dukungan dan Pengobatan (CST). 2006

43. IHPCP. Capacity Building-Institution Strengthening: what are we doing (slide presentation). 2006 IHPCP. Institutional Strengthening for National Provincial and District KPAs (slide presentation). 2006

44. IHPCP. Perawatan, Dukungan dan Pengobatan (Care, Support, and Treatment). (slide presentation). 2006

45. IHPCP Phase 2. Internal evaluation report. 2006

46. IHPCP Phase 2. Annual Plan. July 2006 – August 2007

47. IHPCP Phase 2: Annual Plan July 2005 – June 2006

48. IHPCP Phase 2. Six monthly report. January – June 2006

49. IHPCP Phase 2. Six monthly report July – December 2005

50. IHPCP. Capacity Building of Key Referral Centres. Proposal for Extension to Component 4.5 (Strategies implemented to increase the capacity of health care services to provide quality HIV-related care, support and treatment, in selected sites). 2005

51. IHPCP. Tabulasi Hasil. 2004

52. Irawati, I et al. Indonesia Sets up Prison Methadone Maintenance Treatment. Addiction, Vol 101, Issue 10, pp 1525–1527: News and Notes. 2006

53. MAP Report 2005. Drug Injecting and HIV/AIDS in Asia

54. OECD. Development Assistance Committee. Review of gender and evaluation. Hunt, J and Brouwers, R. OECD DAC Evaluation Series. Paris. 2005

55. Perusahaan Peduli AIDS Indonesia. HIV/AIDS Awards. 2006

56. Republic of Indonesia. Papua. Bureaucratic Reform in Papua Province. 2006

57. Republic of Indonesia. Regulation of the President of the Republic of Indonesia. Number 75 Year 2006 on the National AIDS Commission.

58. Republic of Indonesia. KPA Nasional. Rencana Aksi Nasional Penanggulangan HIV 2007–2010. (slide presentation). 2006

59. Republic of Indonesia. KPA Nasional. Scale up plan for HR intervention for injecting drug user (draft). 2006

60. Republic of Indonesia. National AIDS Commission. Country Report on the Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS). Reporting period 2004–2005.

61. Republic of Indonesia. Coordinating Ministry for People's Welfare and National AIDS Commission. National Guideline on Monitoring, Evaluation & Reporting of HIV & AIDS. Edition 1. 2006

62. Republic of Indonesia. KPA Nasional. The Indonesia Partnership Fund for HIV/AIDS. 2005

63. Republic of Indonesia. KPA Nasional. National HIV/AIDS Action Framework: 2005–2007. 2005

64. Republic of Indonesia. Ministry of Justice and Human Rights of Indonesia. National Strategy for Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centres, for the period 2005–2009 (Jakarta, Indonesia). 2005

65. Republic of Indonesia. National Estimates. 2004

66. Republic of Indonesia. National Strategy: Prevention and Control HIV/AIDS and Drugs Abuse in Indonesian Correction and Detention Centres 2005–2009. Ministry of Law and Human Rights of Republic of Indonesia. Directorate General Correction. 2005

67. Riono, P. Could the Modelling Guide the National Policy? Indonesia. 2006

68. Spiritia Yayasan. Self Empowerment to Face HIV/AIDS in Indonesia. 2005

69. Synthesis Team. A Multistakeholder Synthesis of the Development Situation in Papua. A cooperation between UNDP, the local Government and multistakeholders in Papua. May 2005

70. UN Joint Action Programme on HIV/AIDS Indonesia 2003–2007. Unified Workplan and Budget.

71. UNAIDS and WB. Country Harmonization and Alignment Tool (CHAT). Draft Version (for review and pilot testing only). Version 3.1. 2006

72. UNAIDS. Improving AIDS harmonization and alignment of the national response: A review of implementation of Global Task Team Recommendations in Indonesia (draft). 2006

73. UNAIDS & NAC. A Review of Vulnerable Populations to HIV and AIDS in Indonesia. 2006

74. UNAIDS. HIV/AIDS programmes in Indonesia. Status of National Response. 2005

75. UNDP and Australian Government. Agreement between UNDP and AusAID on IPF. Support to the National Action Framework 2005–2007 of the National HIV/AIDS Strategy 2003–2007. 2005

76. UNDP Indonesia. Indonesia Human Development Report 2004: The Economics of Democracy: Financing Human Development in Indonesia.see: http://www.undp.or.id/pubs/ihdr2004/index.asp

77. UNICEF. Country Programme Action Plan (CPAP). 2006–2010. 2006

78. UNODC. A Review of the NGO Program in the Indonesian Prison System. Jakarta. February 2007

79. USAID. Stock Taking Study on Indonesia's Recent Decentralization Reforms: Summary of Findings. 2006. Unpublished.

80. World Bank. Evaluation of the World Bank's Assistance in Responding to the AIDS Epidemic: Indonesia Case Study. (Elemdorf, A et al.) 2005

81. World Bank. Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance. An OED Evaluation of the World Bank's Assistance for HIV/AIDS Control. 2005

82. World Bank. Draft Indonesia HIV Concept Note. Human Development Sector Unit. East Asia and Pacific Region (EAP). 2005

83. Yayasan Sadar Hati. Presentation on Prevention Program HIV/AIDS among IDUs in Malang. 2006

84. XVI International AIDS Conference. Abstract Book Volume 1. Toronto, Canada. 2005

85. 17th International Conference on the Reduction of Drug Related Harm. Vancouver, Canada. Abstracts. 2006

Attachment 4: Aide Memoire

This Aide Memoire reflects the views of the Design Team[95] only, rather than those of the governments of Australia or Indonesia. The Aide Memoire outlines the background to and conduct of the design mission, and summarises the Design Team's main findings and recommendations, which are made to both governments. The Design Team expresses our gratitude for the cooperation received from all agencies and individuals consulted during the course of the mission.

A. Background

Australia has provided support to Indonesia for HIV since 1995. A key element of Australia's support since 1995 has been Phase 1 and 2 of the Indonesia HIV/AIDS Prevention and Care Project (IHPCP). Phase 2 of IHPCP is due to end in August 2007. The current project has worked across six geographically dispersed provinces (DKI Jakarta, Java Barat, South Sulawesi, NTT, Bali and Tanah Papua), and has trialled, modelled and demonstrated a variety of different approaches to prevention, care, support and treatment of HIV. It has also worked to strengthen the capacity of key players including NGOs and the AIDS Commissions at national (KPA), provincial and district levels (KPADs) and DepKes at national and provincial levels. Contributions from the Indonesia Partnership Fund (IPF) and local governments have enabled scaling up of IHPCP activities over the past two years, particularly in Java Barat and Tanah Papua. IHPCP has been widely recognised as making many positive contributions to Indonesia's response to HIV. Particular successes of IHPCP have been its work addressing HIV associated with injecting drug use (IDU) using a harm reduction approach, and increasingly, the integration of IHPCP's work within Indonesian systems.

In 2006 the White Paper on the Australian aid program emphasised Australia's ongoing commitment in the region on HIV. In addition, AusAID's Health Policy (2006) emphasises work on health system strengthening, maternal and child health and communicable diseases, including HIV and Avian Influenza. The Government of Indonesia (GOI) has requested a continuation of Australian involvement in HIV in Indonesia.

In September/October 2006 a Scoping Mission made recommendations regarding a new program that would commence once IHPCP ends, and which would focus on Java, Tanah Papua[96] and prisons nationally. To design the new program a mission was mobilised in February 2007.

B. Method

The design mission was in Indonesia from 3 February to 2 March 2007. Members of the Design Team visited Jakarta, Surabaya, Yogyakarta and Tanah Papua (Jayapura, Manokwari, Sorong, Raja Ampat, Merauke, Wamena and Timika). The Team met with a wide range of government and non-government agencies including government agencies at national, provincial and district levels, NGOs, civil society organisations (CSO) including religious groups, people living with HIV, the private sector, IHPCP staff, UN agencies and other donors and development partners. The Team also reviewed a wide range of documents.

Members of the Design Team also participated in the external review of the health sector response to the HIV/AIDS epidemic in Indonesia[97] (during the design phase and in Tanah

[95] The Team comprised Linette Collins (Team Leader), Bona Siahaan, Mike Finlayson, Gillian Biscoe, John Godwin, Bron Nicholas, Fahmia Badib (Interpreter) , Ria Nuri Dharmawan (Interpreter).

[96] Tanah Papua comprises the provinces of Papua and Papua Barat (West Papua). Discussions are ongoing regarding creation of a new province of South Papua.

[97] Joint review by WHO Regional Office for South East Asia and MoH Indonesia, 5–17 February 2007

Papua).

C. Findings and key aspects of the design

All development partners consulted strongly supported the principles of harmonisation and alignment. The Team took into account updated surveillance data which reinforced views of a concentrated epidemic among IDU and sex workers and their clients, and a generalised epidemic in Tanah Papua.[98] The Team also acknowledges recent developments in the institutional and policy context including:

- The Presidential Regulation 75/2006, which has strengthened the KPA and KPADs;
- New KPA leadership, which has created optimism for achievement of the 'Three Ones' and accelerated progress in impacting the HIV epidemic;
- The 2007–2010 National HIV/AIDS Strategy and costed National Action Plan, which are currently being finalised;
- The New Papua Development Strategy 2006–2011 and the preparation of a Provincial HIV/AIDS Plan for Papua (although it is not clear how these apply to Irian Jaya Barat); and
- Ministerial Regulation 02/per/menko/kesra/1/2007 and MOU between KPA and BNN, 1/12/06, confirming a national harm reduction approach to HIV and drug use.

The new Partnership will be informed by the following principles:

- Align with and support GOI HIV strategies and priorities at all levels;
- Work with all levels of government (in accordance with decentralisation) and continue to work with and strengthen civil society engagement to underpin an effective response;
- Ensure a new program has the flexibility to respond to changing circumstances, including changes in the epidemic and changes in levels of support provided by GOI and other development partners;
- Increase Australia's higher level engagement with the GOI on policy and strategy;
- Cooperate with GOI in areas in which Australia has a comparative advantage and build on the achievements of IHPCP (including the pioneering work on IDU and prisons, and the strengthening of NGOs and KPA/KPADs);
- Increase the focus on populations with greatest need (e.g. Tanah Papua, IDU in Java);
- Provide a longer term commitment (eight years) to enhance impact and sustainability;
- Facilitate multiplier effects by demonstrating and promoting the most effective responses;
- Leverage additional resources, by providing strategic investments that attract additional investments from other sources;
- Harmonise with other donors and development partners;
- Promote evidence informed responses, as indicated by epidemiological, social and economic data and research; and
- Accord special consideration to gender throughout activities of the Partnership.

D. Description of the Partnership

[98] Surveillance by GOI occurred in Tanah Papua in 2006. In February 2007 WHO reported in excess of 2 per cent prevalence in the general adult population in Tanah Papua.

All Australian HIV activities in Indonesia will be framed within a new Partnership, the Australia–Indonesia Partnership for HIV (AIPH). The Partnership will commence in February 2008 and extend until the end of 2015. The goal of the Partnership mirrors the GOI goal in the National HIV/AIDS Strategy 2007–2010, which is to prevent the spread of HIV, improve the quality of life of people living with HIV, and alleviate socio-economic impact. The Partnership supports GOI to achieve the MDG target of halting and reversing the spread of HIV by 2015.

As shown in Figure 1, the Partnership will comprise:

- A new program, the HIV Cooperation Program for Indonesia (HCPI), described in Section E below; and
- A range of other activities which may include research, health systems strengthening, child and maternal health, mainstreaming of HIV into AusAID's work in other sectors, the NGO Cooperation Program, activities implemented by other GOA agencies in Indonesia, AusAID's regional partnerships with the Asia Pacific Business Coalition on HIV/AIDS and the Clinton Foundation HIV/AIDS Initiative, AusAID's HIV/AIDS Regional Capacity Development Program, Australian Development Scholarships (ADS), Australian Leadership Awards Program and the Indonesian Australia Specialised Training Program (IASTP).

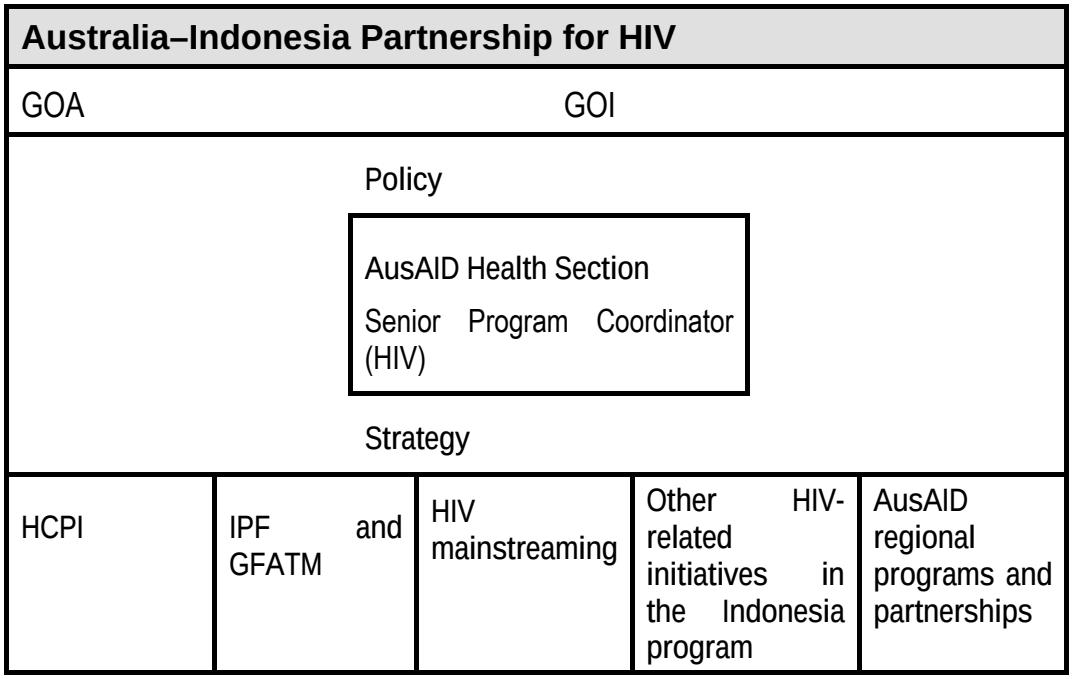


Figure 1: Elements of the Australia-Indonesia Partnership for HIV

The approach of AIPH and HCPI in particular is a new one. The program of assistance will feature a progressive reduction of a direct implementation role. It will feature an increase in the provision of technical support to GOI and other key stakeholders to lead, plan, manage and increasingly fund the HIV response. This change management approach to funding and engagement with partners in Indonesia is adopted with the aim of integrated programming and builds on IHPCP experiences of integration of programming with Indonesian systems.

The role of the Senior Program Coordinator (HIV) will include technical oversight and assistance in stakeholder coordination. This may include areas such as AIPH policy and strategy inputs, Global Fund for AIDS, TB and Malaria (GFATM), Indonesia Partnership Fund (IPF) and other donor cooperation. The Coordinator will work within the AusAID Health Section, based in Jakarta.

E. Description of HIV Cooperation Program for Indonesia (HCPI)

HCPI will be an eight-year program and will share the same goal of the AIPH. The objectives and components are illustrated in Figure 2.

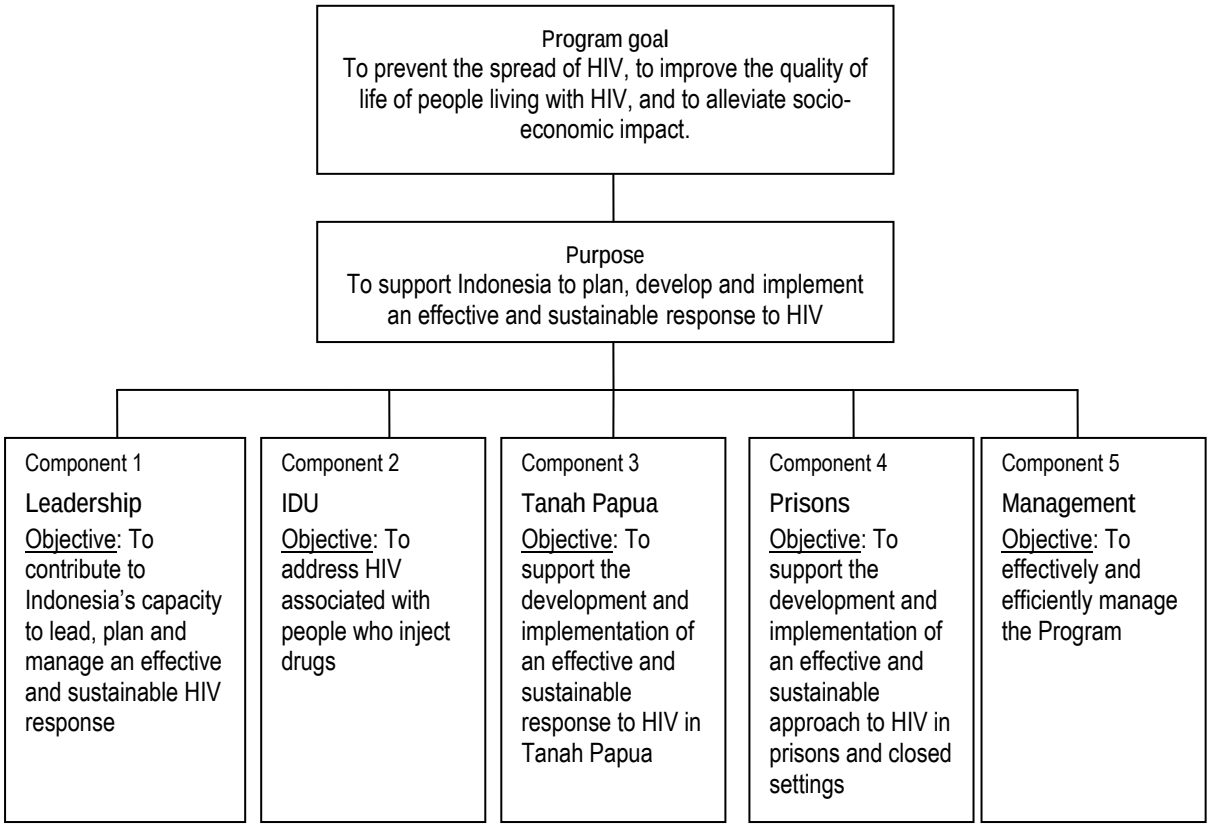


Figure 2: HCPI goal, purpose, components and component objectives

A brief description of the main activities within each component follows:

Component 1: Leadership

HCPI will provide assistance to government (at all levels), civil society and the private sector, to build Indonesia's capacity to lead, plan and manage an effective and sustainable HIV response. This could entail a range of activities, including for example, support for strengthened leadership and management capacity, advice on policy and legal frameworks, support for strategy development, planning and coordination, identifying and supporting national and local champions, strengthening implementation systems, M&E support, and promoting evidence informed approaches including through support for surveillance and research. The work under component 1, as well as providing input to national initiatives will be integral to the work of components 2, 3 and 4.

Component 2: IDU

HCPI will support implementation of GOI plans that address the HIV needs of IDUs and their sexual partners. It is anticipated that this will primarily involve support for delivery of services through GOI public health systems as well as engagement of civil society. Emphasis will be given to piloting and promoting a comprehensive response to IDU and their partners in priority locations. Consistent with GOI policy, the comprehensive response will adopt a harm reduction approach and may include: needle and syringe programs (NSP), substitution therapies and other effective drug treatments, peer education and outreach, VCT, STI and HIV treatment (including antiretroviral therapy and treatment for opportunistic infections). The initial focus will be locations in Java where IHPCP has ongoing activities, with a view to expanding support to other locations in Java or elsewhere if supported by evidence of need.

Component 3: Tanah Papua

Activities will support the provincial development strategies for Papua and Irian Jaya Barat in relation to HIV. While supporting a comprehensive approach in both provinces, the initial focus will be on developing more effective behaviour change approaches. This work will have a strong primary prevention element, as well as addressing health promotion for people living with HIV. This will build on the IEC and behaviour change communication work of IHPCP, FHI/ASA and others over the last two years. This initial focus recognises the importance of a strong prevention response to an expanding generalised epidemic, and that care, support and treatment needs are being supported by other donors and GOI budgets. It is also anticipated that HIV treatment services in Tanah Papua may benefit from other Australian inputs that fall within AIPH but will be managed outside of HCPI, such as AusAID's programs on maternal and child health and HIV regional capacity development, and partnership with the Clinton Foundation. Some HCPI staff will be based initially in Jayapura.

Component 4: Prisons and other closed settings

Activities will support the GOI in developing and implementing effective policy and program responses to HIV prevention, care support and treatment needs in relation to prisons and other closed settings such as drug treatment facilities. This may include harm reduction approaches such as methadone, education and information, VCT, antiretroviral/opportunistic treatment programs, and will include support to NGOs for outreach to closed settings. Initial activities will include policy and strategy support at the national level, continuing the work at the Bali prison, and continuing the activities at other specific sites currently supported by IHPCP.

Component 5: Management

The management component includes the establishment and operation of HCPI offices (where necessary), the planning and coordination of activities, and the monitoring and evaluation of activities and the Program as a whole. Consistent with the aim of integration of activity into Indonesian systems HCPI will progressively support and strengthen GOI structures rather than relying on parallel infrastructure and personnel.

Within each technical component, HCPI will program its activities on an annual basis, working collaboratively with counterparts and other development partners to ensure alignment and harmonisation. The annual planning process will provide the flexibility to support current GOI priorities and needs.

F. Cooperation and implementation arrangements

The Program Coordination Committee (PCC) will be the key decision-making body for the Program and will have prime responsibility for (i) the approval of annual plans, (ii) ensuring HCPI remains strategically focused, (iii) providing oversight of program outcomes and quality; and (iv) resolving (when possible) any significant implementation problems. The KPA and AusAID will be responsible for oversight and coordination of HCPI. In partnership with AusAID, KPA, Departemen Kesehatan (DepKes), Departemen Hukum dan Hak Azasi Manusia (DepHukHam) and Papua/Irian Jaya Barat KPAP will oversight the implementation of activities under the respective components.

At provincial level, the main counterparts will be the KPAP, Office of the Governor, DinKes, KanWilHukHam, BAPPEDA and other relevant agencies. At district level, the main counterparts will be the Bupati, KPAD, DinKes, BAPPEDA and other local agencies.

Collaborating partners for planning and implementation include the above agencies and legislators, professional, NGO and community-based organisations, people living with HIV, faith-based organisations, traditional and village leaders, women's groups, and the private sector.

The institutional arrangements are illustrated in Figure 3.

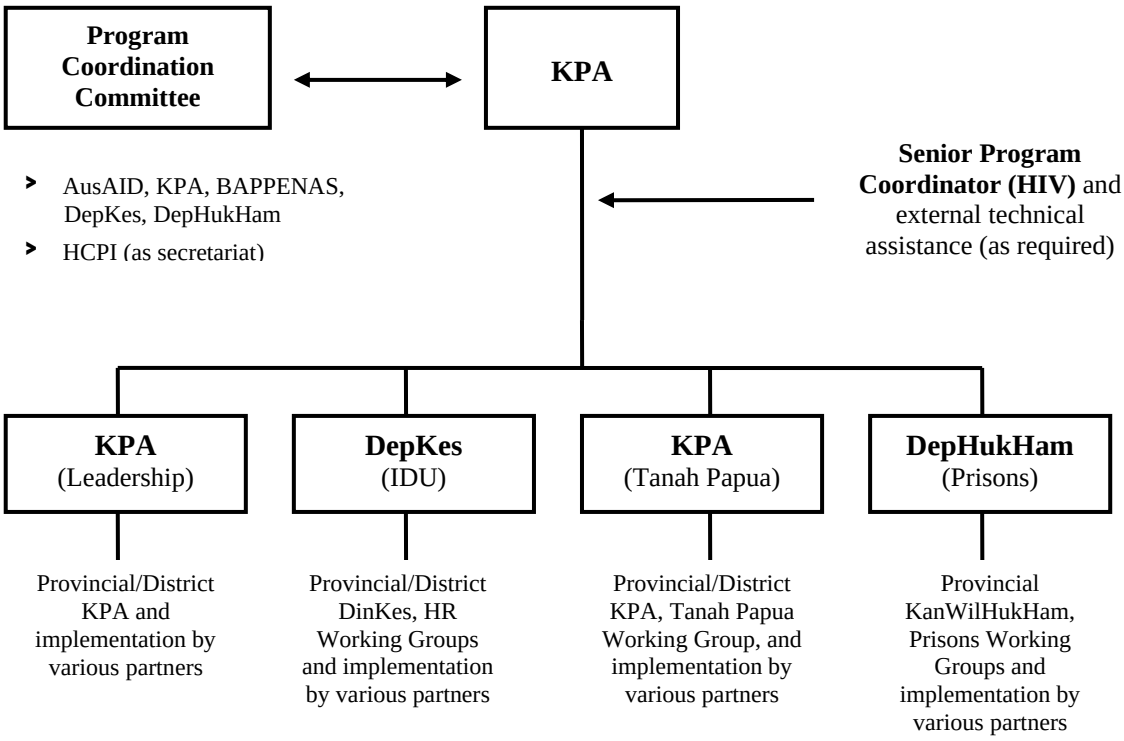


Figure 3: HCPI cooperation arrangements[99]

A contractor will be engaged to provide technical expertise, work collaboratively with and support the above stakeholders and manage inputs to each component within HCPI. A five-year contract is proposed with an option for a three-year extension. The contractor will report to AusAID Jakarta, with technical oversight provided by the Senior Program Coordinator (HIV). The Senior Program Coordinator (HIV) will be able to access external technical assistance to provide an independent assessment of progress (when required), and provide technical and managerial advice and support on a periodic basis. It is recommended that KPA and the contractor develop a program title or brand in Bahasa Indonesia.

HCPI will have an office in Jakarta, some staff based in Tanah Papua and some staff based in other provinces (as needed) but the number and duration of other offices and staff will be limited. This is in line with the guiding principle of progressive integration of AusAID resources within Indonesian national structures.

G. Transition strategy

IHPCP is due to end in August 2007. [100] It is recommended that IHPCP be extended – to enable a targeted program of support for selected activities and a period of handover to HCPI – until end of February 2008, with reduced staffing during the period of extension. It is also recommended that HCPI commences at the start of February 2008, providing a one-month overlap with key staff from IHPCP.

IHPCP's activities from July 2007 to the end of February 2008 – including support to selected partners – will be outlined in an annual plan that will double as a plan for the transition between IHPCP and HCPI.

[99] Options for Tanah Papua representation on the PCC have not yet been determined.
[100] All current partner agreements end in June 2007.

To help ensure a smooth transition between IHPCP and HCPI, it is recommended that:

- In locations that HCPI will not work, other than in relation to closed settings (South Sulawesi, NTT and Bali), new agreements will be negotiated with selected partners for an extension of their activities for a period up to eight months (subject to available funding). This will provide an opportunity for KPAP/KPAD and these partners to seek alternative funds. IHPCP staff will manage these activities.
- In locations that HCPI will work during this period (DKI Jakarta, Java Barat, Tanah Papua and prisons currently served nationally), new agreements will be negotiated with selected partners for the continuation of their activities. These agreements will be negotiated for an 18-month period (July 2007 to December 2008) and will be managed by HCPI from 1 March 2008. This will provide the basis of the activities implemented in Components 2, 3 and 4 in Year 1 of HCPI.

The above transition arrangements will be negotiated between IHPCP, AusAID Jakarta and KPA, as appropriate, and a detailed, fully costed transition strategy/annual plan (1/7/07 – 29/2/08) prepared during March/April 2007.

Another element of the transition relates to the Senior Program Coordinator (HIV). It is recommended that the current Indonesia HIV/AIDS Coordinator will fill this position until June 2008 (when the current contract ends). This will provide consistency and continuity during the transition period. The Senior Program Coordinator (HIV) will be appointed in June 2008.

H. Funding

The budget for the AIPH is tentatively estimated at A$ 9 million per annum from July 2007 onwards.[101] From this, approximately A$ 6.7 million will be allocated to HCPI annually, other than in the first year of implementation, in which the transition costs will be attributed to IHPCP and are estimated at approximately A$ 5 million (between July 2007 and February 2008).

Australia intends to fund a number of other activities from the A$ 9 million budget, including a financial contribution to IPF of A$ 1 million. This will be allocated to IPF in the 2007–08[102] financial year. The design team recommends Australia makes future contributions to the IPF. In addition to the above budget estimate, HCPI may source additional funds from the IPF, GFATM or other, as yet unidentified sources. Similarly, AIPH may derive funds from other sources.

I. Next Steps

The Design Team will prepare a draft Partnership and Program Design Document before the end of March 2007. This will be circulated to GOI agencies and AusAID and comments and suggestions will be considered and incorporated as appropriate into a final Design Document. This will be submitted to AusAID in April 2007.

It is envisaged that AIPH and HCPI will commence in February 2008 (following a tendering process to appoint a managing contractor). Both AIPH and HCPI will end in December 2015.

J. Risks

- Transition – Changes of the nature proposed in this Aide Memoire are seldom easy. A transition strategy/annual plan (1/7/07 – 29/2/08) will be prepared by IHPCP under direction of AusAID and KPA to ensure the continuity of priority activities between the end of IHPCP and the start of HCPI.
- IPF and GFATM – IHPCP has used IPF funds to scale up its activities. There are uncertainties regarding future funding for HIV via IPF and GFATM. This has both direct and indirect significance for AIPH, as currently IHPCP, GOI and other partners receive

[101] The annual allocation is expected to be indexed to retain its current purchasing power.
[102] July 07 – June 08.

substantial support from these funds. Interruption to or loss of funding may affect the national response and have widespread ramifications for development partners.

- Dynamic environment – there are great opportunities but also uncertainties associated with working through GOI systems and structures in a period of decentralisation and other significant and rapid change.

The annual planning process will provide the flexibility to respond to risks such as these. Closer alignment with GOI structures should also better position AusAID to be aware of and work collaboratively on areas of risk.

Attachment 5: Needle and syringe and drug treatment programs

This attachment contains a description of the Indonesian response to HIV among people who inject drugs for 2006.[103]

A. Needle and syringe programs (NSPs)

In December 2006 there were 115 NSPs operating in Indonesia. NSP activity was occurring in DKI Jakarta, Java Barat, East Java, South Sulawesi, Bali, Riau, Yogyakarta, NTT and North Sumatra (refer Table 1).

Table 1. NSP and MMT by province, kabupaten and kota

Province	Kabupaten/kota	Program type	Program source
Bali	K Badung	NSP, MMT	IHPCP
	K Tabanan	NSP	IHPCP
	K Buleleng	NSP	IHPCP
	K Jemberana	NSP	IHPCP
	K Gianyar	NSP	IHPCP
South Sulawesi	Kota Makassar	NSP	IHPCP
Java Barat	Kota Bandung	NSP	IHPCP
	Kota Sukabumi	NSP	IHPCP
	K Cianjur	NSP	IHPCP
	K Cimahi	NSP	IHPCP
	Kota Bandung	NSP	FHI/ASA
	Kota Bogor	NSP	FHI/ASA
	K Karawang	NSP	FHI/ASA
	K Banding and Subang	NSP	FHI/ASA
	Kota and K Tasikmalaya	NSP	FHI/ASA
	Kota and K Bekasi	NSP	FHI/ASA
	Kota and K Semarang	NSP	FHI/ASA
	Kota and K Surkarta	NSP	FHI/ASA
	K Banymas and Cilacap	NSP	FHI/ASA
	Kota/K Malang and Pasuran	NSP	FHI/ASA
	Kota Malang	NSP	FHI/ASA
	Kota/K Surabaya and Sidoarjo	NSP	FHI/ASA
	Kota Surabaya and K Gresik	NSP	FHI/ASA
	Kota and K Madium	NSP	FHI/ASA
	K Banyuwangi	NSP	FHI/ASA
	Kota Bandung (& other sites) x 9	NSP	Gov of Java Barat
Jakarta DKI	Central Jakarta	NSP	IHPCP
	West Jakarta	NSP	IHPCP
	South Jakarta	NSP, MMT	IHPCP
	North Jakarta	NSP, MMT	IHPCP
	East Jakarta	NSP, MMT	IHPCP
	East Jakarta	NSP	FHI/ASA

[103] Mesquita F, Winarso I et al. Public health the leading force of the Indonesian response to HIV/AIDS crises among the people who inject drugs. Harm Reduction Journal 2007. pp. 4–9.

Province	Kabupaten/kota	Program type	Program source
	North and West Jakarta	NSP	FHI/ASA
	South Jakarta and Kotip Depok	NSP	FHI/ASA
	North Jakarta	NSP	FHI/ASA
	Central Jakarta	NSP	FHI/ASA
NTT	Kota Kupang	NSP	IHPCP
North Sumatra	Kota Medan	NSP	FHI/ASA
	K Deli Serdang	NSP	FHI/ASA
	K Serdang Bedagai	NSP	FHI/ASA
	K Pematang Santar	NSP	FHI/ASA
	K Simalungun	NSP	FHI/ASA
Riau	Kota Batam	NSP	FHI/ASA

NGOs. 41 NGOs were working in the field of harm reduction. Of these:

- 16 were conducting NSP projects targeting 4 500 IDU/month. 15 were supported by IHPCP. These were located in DKI Jakarta, Java Barat, NTT, Yogyakarta and Bali.
- 25 NGOs started NSP in mid 2006, supported by FHI/ASA with funding from IPF and GFATM. These were located in DKI Jakarta, East Java, Java Barat, Central Java, Riau and North Sumatra.

Puskesmas. 65 puskesmas in DKI Jakarta, Java Barat and South Sulawesi were involved in harm reduction activities, including NSP. IHPCP and local KPA (IPF funds) were co-funding these for 12 months with commitment that future costs would be borne by GOI.

Nine NSP in puskesmas were opened in Bandung City. These were funded by City of Bandung Public Health Department. IHPCP provided technical support for planning and staff capacity building.

The puskesmas target of IHPCP is to reach 23 000 IDU. From 2005 IHPCP has aimed to shift the interventions with IDU from primarily NSP to a comprehensive prevention approach including NSP, condoms, alcohol swabs, IEC material. Activity is conducted mainly on an outreach basis with a referral to the puskesmas for basic health care, drug treatment (mainly MMT) and support and treatment for IDU at risk of HIV.

B. Drug treatment

Methadone maintenance therapy (MMT). The number of registered and active MMT patients is summarised in Table 2.

MMT services are located in four hospitals (South Jakarta, Bali, Bandung Java Barat, Surabaya East Java), four puskesmas (Central, East and North Jakarta, Bali) two prisons (East Jakarta and Bali) and one detention centre (East Jakarta).

The target of the Draft National Action Plan is to increase the number of IDU treated with methadone to 53 000 by 2009 (38,810 [17%] IDU and 14, 913 [15%] prisoners).

Buprenorphine. 300 doctors are certified to prescribe Buprenorphine. It is reported to be expensive and not widely available. Anecdotal reports from IDU in Bali and Java Barat suggest illicit use and injection of Buprenorphine may be a problem associated with scarcity of heroin.

Table 2: Total patients registered and active patients up to December 2006 in MMT

No	Name and location of MMT institution	Start of activation	Patients registered	Active patients	Patients registered	Active patients	Patients registered	Active patients
			End of Jun 2006		End of Sep 2006		End of Dec 2006	
1	RSKO (Sth Jakarta)	27-Jan-03	198	172	203	197	540	221
2	RSU Sanglah Denpasar (Bali)	17-Feb-03	218	99	240	106	343	105
3	LP Kerobokan Denpasar (Bali)	1-Aug-05	41	30	57	38	73	39
4	RSU Dr. Soetomo Surabaya (East Java)	7-Feb-06	49	47	149	80	163	93
5	PKM Kec. Tanjung Priok (Nth Jakarta)	24-Apr-06	35	35	95	89	128	118
6	RSU Hasan Sadikin Bandung (West Java)	15-May-06	41	31	71	45	88	52
7	PKM Kuta I Bali	1-Sep-06			14	13	25	17
8	LP Narkotika Cipinang (East Jakarta)	1-Dec-06					38	36
9	PKM Kec. Gambir (Central Jakarta)	14-Dec-06					143	66
10	PKM Kec. Jatinegara (East Jakarta)	28-Dec-06					4	3
11	RUTAN Pondok Bambu (East Jakarta)	29-Dec-06					3	2
	Total		**582**	**414**	**829**	**568**	**1 546**	**752**

Note: RS = hospitals, PKM = puskesmas, LP = prison, RUTAN = detention centre
Source: Briefing Paper Prepared for the External Review of the Health Sector Response to the HIV/AIDS Epidemic in Indonesia, 5–17 February 2007

Table 3: Indicators for coverage for methadone program

IDU								
Population estimate	219 000		223 000		227 000		231 000	
Indicator	Baseline 2006		Target 2007		Target 2008		Target 2009	
% of IDU that receive MMT	1 085	0.5%	8 030	4%	217 090	10%	38 810	17%
Prisoners								
Population estimate	96 210		97 268		98 338		99 420	
Indicator	Baseline 2006		Target 2007		Target 2008		Target 2009	
% of prisoners that receive MMT	0	0%	2 918	3%	9 834	10%	14 913	15%

Source: Attachment E M&E indicators, draft National Action Plan, KPA 26/4/07

Attachment 6: Transition arrangements

IHPCP has been extended from late August 2007 until the end of February 2008. This extension will enable a targeted program of support for selected activities and provide a period of handover to HCPI, on the basis that HCPI commences on 1 February 2008.

IHPCP's activities from July 2007 to the end of February 2008 – including support to selected partners – will be outlined in a plan for the transition between IHPCP and HCPI. As all partner contracts under IHPCP end in June 2007, it is recommended that:

- In locations where HCPI will continue to support activities initiated by IHPCP (e.g. DKI Jakarta, West Java, Papua, West Papua and selected prisons), new agreements be negotiated with selected partners for the continuation of their activities. These agreements will be negotiated for an 18-month period (July 2007 to December 2008) and will be managed by HCPI from 1 March 2008. This will provide the basis of the activities implemented in Components 2, 3 and 4 in Year 1 of HCPI.
- In locations where HCPI will not work, other than in relation to closed settings (e.g. South Sulawesi, NTT and Bali), new agreements be negotiated with selected partners for an extension of their activities for a period up to eight months. This will provide an opportunity for KPAP/KPAD and these partners to seek alternative funds. IHPCP staff will manage these activities.

The first step will be for IHPCP, AusAID and KPA to categorise current partners, as follows:

- Partners that must continue their activities without delay and which will be included in Year 1 of HCPI (under Components 2, 3 and 4).
- Partners that implement activities that are a high priority (generally providing an essential service) but will not be funded under HCPI.
- Partners that:
    - have a reasonable probability of sourcing alternative funds
    - are implementing activities that, while beneficial, are not providing an essential service, and
    - may be funded under HCPI, but will not be adversely affected by a disruption in the funding. This could, for example, apply to several of the mass media prevention initiatives (such as television and radio messages) funded in Papua.

The level of funding available to IHPCP from 1 July 2007 to 29 February 2008 is limited to approximately $5.4 million (for both partner grants and all other costs), and must be taken into consideration when current partners are placed in the above categories.

Transition plan

A transition plan will be prepared for the period July 2007 to February 2008 and will include:

- a brief introduction to IHPCP and the purpose of the transition plan (referencing HCPI as appropriate)
- an overview of achievements during the previous year
- a description of the main priorities and main activities between July 2007 and February 2008
- a summary of the process used to identify which partners will receive grants from July 2007 onwards, a description of the grants proposed, the period of funding, and their cost
- a description of the plan to phase out selected activities in NTT, South Sulawesi and

Bali, including a clear statement in regard to staff, office facilities, asset management and provision of ongoing support/monitoring of partner grants

- a description of the plan for locations that are not being phased out, in regard to staff, office facilities, asset management and ongoing support/monitoring of partner grants
- an outline of the proposed methodology for the program completion report (including timeframe), the proposed contents and the resources required
- a description of proposed staffing changes, for example, to include additional resources to help partners seek alternative funds
- a description of proposed staffing levels during the eight-month period, including specification of when key staff will take outstanding leave entitlements, and which staff will be available to work with the new Managing Contractor during the handover period in February 2008
- a detailed description of the handover activities (and scheduling) during February 2008
- a detailed list of all assets and the proposed transfer of these assets to HCPI, various Indonesian agencies, or alternative disposal, and
- a cost summary.

The transition plan will be prepared by IHPCP in consultation with KPA and AusAID Jakarta during March/April 2007.

Role of AusAID Jakarta

AusAID Jakarta will support the transition arrangements by:

- providing guidance to IHPCP, in consultation with KPA, on the selection of partner grants that will be funded from July 2007 onwards
- providing guidance to IHPCP, in consultation with KPA, on the contents and preparation of the transition plan
- providing guidance to IHPCP, in consultation with KPA, on the contents of the program completion report
- liaising with senior officials from Papua and West Papua, Java, South Sulawesi, NTT and Bali, in association with KPA, over the transition arrangements
- socialising the new program within KPA, DepKes, DepHukHam, BAPPENAS, Papua and West Papua and Java, particularly as it relates to the approach of supporting GOI priorities and systems, planning in consultation with GOI agencies (including BAPPEDA), and progressively adopting cost-sharing arrangements
- monitoring IHPCP during the transition phase
- briefing the new Managing Contractor on arrival and assisting in introductions to senior officials in KPA, DepKes, DepHukHam, Papua and West Papua and Java, and
- overseeing the activities during the handover in February 2008.

Inputs from AusAID Jakarta will be shared with the HIV Coordinator and AusAID's Health Section. The current AusAID HIV/AIDS Coordinator will remain in post and oversee the transition to AIPH/HCPI until the contract expires in June 2008, when the Senior Program Coordinator (HIV) will be appointed. This will provide consistency and continuity during the transition period. The Senior Program Coordinator (HIV) will preferably have a short overlap with the current coordinator.

During the transition period, the HIV/AIDS Coordinator will undertake the following:

- oversee the preparation of the transition plan and ensure the transition arrangements are satisfactory and within budget

- provide support to the AusAID Health Section, as required, during the preparation of a contract extension for IHPCP
- promote HCPI among GOI and other stakeholders, in particular, the new focus on supporting and strengthening GOI systems and processes and, where applicable, the proposed cost-sharing principles
- identify and/or initiate activities to be included in AIPH (subject to available funding)
- ensure the Managing Contractor for IHPCP prepares a program of activities for February 2008 that will enable a smooth transition between IHPCP and HCPI, and ensure that both IHPCP and HCPI have suitable staff available for proposed transition activities in February
- brief HCPI staff on arrival and provide introductions to key stakeholders, as appropriate
- with KPA, provide direction or guidance to HCPI staff in February/March 2008 as they prepare their inaugural annual plan (for the period April to December 2008)
- with KPA, confirm PCC membership and provide an overview to the concerned agencies and/or individual PCC members on the roles and responsibilities of the PCC, and
- help identify organisations or individuals that could provide technical and strategic advice to AIPH and HCPI, and establish a database of suitable advisers to facilitate their inputs if and when required.

Role of GRM International Pty Ltd

GRM, as the managing contractor for IHPCP, is expected to continue its support for a smooth transition. Continued support will entail a willingness to vary from the current design and a willingness to lay the groundwork for a new contractor. This may include, for example, maintaining positive relationships with partners and effectively managing (and hopefully retaining) key staff. Both may be difficult, as it will not be possible for GRM to provide any certainty beyond February 2008 (other than the partner agreements that run for a period of 18 months).

GRM will be expected to:

- prepare a schedule of handover activities during February 2008 (in consultation with AusAID Jakarta) and schedule key staff to work with the new Managing Contractor during this period
- provide a comprehensive briefing to the new Managing Contractor
- assist in introductions to counterparts, partners and others (as appropriate)
- provide a detailed list of all assets being transferred to HCPI and arrange for an appropriate transfer prior to the end of February 2008
- provide to the new Managing Contractor:
  - a list of all partners and other stakeholders, and their contact details
  - all training, promotional and other materials
  - available data on IHPCP activities, progress, performance and impact
  - information for each grant (including both completed and ongoing grants)
- novate ongoing partner agreements and contracts to the new Managing Contractor, and
- finalise the program completion report by the end of January 2008 and provide a thorough briefing to AusAID Jakarta, KPA, the new Managing Contractor and others (as appropriate) in February 2008. AusAID Jakarta will, in consultation with KPA, provide direction to GRM on the content of the program completion report prior to its

preparation.

GRM may also assist by socialising the new program within various counterparts, particularly as it relates to the approach of supporting GOI priorities and systems, planning in consultation with GOI agencies (including BAPPEDA), and progressively adopting cost-sharing arrangements.

Although a one-month handover will occur, GRM will be expected to fund the office and operational costs for IHPCP until the end of February 2008. The new contractor will only be responsible for the cost of HCPI staff during this period, and any additional costs they incur.

Role of the new Managing Contractor

The new Managing Contractor is expected to be identified in late 2007. The Managing Contractor will commence work in Indonesia in early February 2008 and will:

- ensure appropriate staff are available to participate in briefings and planned handover activities
- ensure continuous support for those partners implementing agreed activities, without disruption to financial payments
- finalise office and staffing plans (in consultation with IHPCP staff, as appropriate)
- fund HCPI staff during the handover period, along with any additional costs incurred, and
- undertake any other tasks as required under the contract.

The partner agreements will also be novated to the new Managing Contractor in February 2008.

In addition, the new Managing Contractor will prepare an annual plan in February/March for the period April–December 2008. It will not be possible to follow the proposed annual planning process for Year 1. However, it may be feasible to hold a workshop in March, as part of the initial planning process, to discuss various plans and options for 2008 with a range of stakeholders. It may also be beneficial to review the findings of the program completion report for IHPCP during the workshop.

It may also be possible for a representative of the new Managing Contractor to review the transition plan and provide input to the final months of its implementation (in particular, providing input to the proposed handover work plan, the transfer of assets, etc.).

IHPCP assets

GRM will include in the transition plan a detailed asset disposal plan, giving due consideration to assets that may be useful to HCPI. The asset disposal plan will be reviewed by AusAID Jakarta during the finalisation of the transition plan.

Tendering and transition timeframe

Date	Activity	Prime responsibility
April 2007	HCPI design finalised and approved following peer review	AusAID (design team)
March/April 2007	Transition plan finalised	IHPCP (with AusAID/KPA)
May/June 2007	New contracts finalised for selected partners from July 2007 onwards	IHPCP
July 2007	New partner agreements commence	IHPCP
August 2007	First stage of tender for new contractor	AusAID
October 2007	New contractor selected	AusAID
November 2007	Contract finalised	AusAID/new contractor
1 February 2008	HCPI commences	AusAID/BAPPENAS
March 2008	HCPI holds an inception workshop which includes a discussion on priority activities for 2008	HCPI
31 March 2008	Annual plan for remainder of 2008 finalised	HCPI

Attachment 7: Logical framework matrix

Narrative description	Indicators	Means of verification	Assumptions
AIPH			
Goal: To prevent and limit the spread of HIV, to improve the quality of life of people living with HIV, and to alleviate the socio-economic impacts of HIV/AIDS	> Prevalence and incidence of HIV within high-risk groups > Comparison of HIV prevalence with baseline HEMI projections	GOI surveillance systems	> Levels of GOI funding for HIV/AIDS increases over time > Levels of funding from GFATM, DFID and USAID are maintained or increased over time > Medical supplies and medical supply chains are maintained and improved over time > Adequate data are collected by GOI agencies to monitor HIV prevalence and incidence and to help target HIV/AIDS programs and activities
	Prevalence of HIV in Papua and West Papua	Papua and West Papua surveillance systems	
	> % of PLWHA receiving CST > % of PLWHArequiring treatment who receive antiretroviral therapy	GOI surveillance systems	
	Quality of CST services provided	Periodic assessment by DepKes	
	Policies and practices which reduce discrimination, differentiate by gender, protect the rights of PLWHA, and minimise adverse socio-economic impacts	Documentation of policies and practices and associated research	
Objective 1: To combine Australia's support for HIV in Indonesia into a coherent partnership that benefits from synergies between each element	Clear and coherent annual plans	> AIPH annual plan endorsed by the PCC > Annual partnership summary prepared and circulated among key stakeholders	> Implementing agencies for activities supported by Australia are willing to collaborate (liaise during the planning of activities, share experiences, share data, etc.) > GFATM and IPF continue in Indonesia and seek ongoing support from Australia > Implementing agencies and AusAID sectors are responsive to HIV/AIDS mainstreaming inputs > Other HIV-related initiatives in the Indonesia program and AusAID regional programs and partnerships are relevant to and compatible with AIPH
	Effective linkages and synergies between: > HCPI > IPF and GFATM > HIV mainstreaming > Other HIV-related initiatives in the Indonesia program > AusAID regional programs and partnerships	Periodic review and assessment of individual activities	
	Satisfaction expressed by GOI agencies in the clarity and composition of Australia's support for Indonesia's HIV response	Periodic review and assessment of individual activities	
Objective 2: To strengthen GOI leadership and capacities to implement an effective and sustainable HIV response	Extent to which AIPH is building capacity of Indonesian agencies and promoting sustainable approaches that can be implemented by these agencies in the future Extent to which AIPH is promoting gender equality and equitable access to services	Periodic review and assessment of individual activities	> Implementing agencies for activities supported by Australia have access to senior GOI staff > Activities (other than HCPI) have an implementation period of sufficient duration to develop close relationships with counterparts and provide capacity building support

Narrative description	Indicators	Means of verification	Assumptions
HCPI			
> Goal: As for AIPH (see above)			
Purpose: To support Indonesia to plan, develop and implement an effective and sustainable response to HIV	Effective working groups on harm reduction, prisons and Papua and West Papua at the national level	Annual component review Periodic review Program completion report	> The costed Action Plan is finalised in 2007 > GOI agencies, NGOs, donors and the private sector can combine resources and coordinate activities in support of agreed priorities and plans > Strong support for HIV prevention and care programs is provided at all levels of government (national, provincial, municipal/district) > GOI agencies are willing to work and collaborate with NGOs and the private sector
	Strengthened coordination by KPA and cooperation among KPA members in implementing the National Strategy and Action Plan	Annual component review Periodic review Program completion report	
	Extent to which HCPI is building the capacity of government and non-government agencies and promoting sustainable approaches that can be implemented by those agencies in the future	Annual component review Periodic review Program completion report	
	Extent to which HCPI is building the capacity of government and non-government agencies to integrate gender equality within the planning and implementation of HIV/AIDS programs and activities	Annual component review Periodic review Program completion report	
	Effective harmonisation with other donors and alignment with GOI programs (including the extent to which the annual planning process has been integrated with GOI systems and processes)	Annual component review Periodic review Program completion report	
	One M&E framework as the single instrument used by all partners, including HCPI	Annual component review Periodic review Program completion report	
	The level of funds (and relative contribution) provided by GOI for HIV/AIDS activities.	GOI National Budget	
Component 1: Leadership Objective: To contribute to Indonesia's capacity to lead, plan and manage an effective and sustainable HIV response	Working groups functioning effectively in provinces where HCPI is working	Annual component review	> KPA has adequate budget for institutional strengthening activities > KPA continues to have strong leadership > Effective relationships can be developed between HCPI and KPAPs/KPADs in locations HCPI is providing assistance > Various agencies can work together and share data in an effort to develop a single HIV/AIDS M&E system for Indonesia
	Tim Asistensi functioning effectively at national level and in provinces where HCPI is working	Annual component review	
	Development and implementation of local strategies and plans that support the National Strategy and Action Plan	Annual component review	
	Collection and use of relevant data in planning and monitoring implementation of local strategies and plans	Annual component review	
	Development and adoption of conducive regulatory frameworks	Annual component review	
	National and local leaders serving as key advocates on	Annual component review	

Narrative description	Indicators	Means of verification	Assumptions
	HIV messages		
	Improvement in GOI capacity to implement a gender sensitive response to HIV	Annual component review	
	Formation of CSO alliances or consortia with clear strategies and policy positions	Annual component review	
	Participation of PLWHA in planning bodies and decision-making forums and committees	Annual component review	
Component 2: Papua and West Papua Objective: To support the development and implementation of an effective and sustainable response to HIV in Papua and West Papua	IEC: > % of female sex workers, MSM and waria who understand methods of transmission and reject misconceptions of how HIV is transmitted > % of teens aged 15 to 24 who can correctly identify wrong perceptions of HIV sexual transmission	Periodic behavioural survey	> Sufficient resources are available in both Papua and West Papua to implement HIV activities > Health services improve over time in terms of both coverage and quality > West Papua has a functioning KPAP no later than mid 2008 > GOI agencies, NGOs and/or donors (including HCPI) have access to companies involved in extractive industries (mining, petroleum, forestry, oil palm and fishing) and can implement prevention and CST programs for their employees and their families > GOI agencies, NGOs and/or donors are able to coordinate HIV prevention and care activities between Papua and PNG to provide adequate support for both legal and illegal border crosses > An effective supply of condoms is maintained and widely available in both Papua and West Papua > An increase in knowledge of HIV and HIV transmission does lead to behavioural change, and in particular, safe sexual practices
	Behaviour: > % of MSM that report using condoms during the last sexual relations with male partners > % of female and male sex workers who report using condoms with current partners	Periodic behavioural surveys	
	Services: > % of high-risk population that tested for HIV and received results in past 12 months > % of schools with teachers trained in life skills education > % of companies with HIV and AIDS policies for the workplace	Documentation of policies and practices and associated research	
	Local capacity: > Functioning KPAPs for Papua and West Papua > Strategic HIV/AIDS plan for West Papua > 100% of districts and kota (municipalities) have a functioning KPAD by 2011 > Agreements between BNN and KPAPs > Coordination and cooperation between government agencies > Coordination and cooperation between donors	> Details on membership and meetings held > Plan prepared and approved > Assessment by KPAPs and other key stakeholders > Signed agreements > Assessment by KPAPs and other key stakeholders > Documentation of policies and practices	

Narrative description	Indicators	Means of verification	Assumptions
	➢ Local regulations on the prevention response ➢ Development of work programs to implement the strategic plan		
	Degree to which the needs of men and women have been adequately addressed in HIV/AIDS activities in Papua and West Papua	Annual component review Periodic review	
	Increase in HIV activities funded by Papua and West Papua governments	Papua and West Papua Annual Budgets	
Component 3: Injecting drug use Objective: To strengthen programs addressing HIV associated with people who inject drugs	% of high-risk populations covered by prevention programs	GOI surveillance systems	➢ Bureaucratic requirements do not delay support for harm reduction activities (e.g. DepKes approval for each needle and syringe and methadone maintenance program) ➢ Effective coordination occurs at local level (involving, for example, DinKes, the police and local NGOs) ➢ Effective coordination and leadership is provided at national level, including data collection, policy review and implementation, and support for sub-national programs and activities ➢ Indonesian agencies have access to increased levels of funding over time ➢ No disruption in services is experienced between the transition from IHPCP to HCPI
	% of IDUs applying behaviours that can reduce the risk of HIV transmission through using sterile injecting equipment and using condoms in the last two months	Periodic behavioural surveys	
	Development of standards, guidelines, operational instructions, local laws, regulations, etc. for IDU harm reduction services	Documentation of policies and practices and associated research	
	Increase in coverage of NSPs	GOI surveillance data	
	Increase in coverage of comprehensive MMT	GOI surveillance data	
	Increase in CST services for IDU	GOI surveillance data	
	Increases in the absolute amount and proportion of funds provided by GOI for IDU activities	GOI National Budget and budgets for participating provinces/municipalities	
	Degree to which the needs of men and women have been adequately addressed in IDU activities	Annual component review Periodic review	
Component 4: Prisons Objective: To support the development and implementation of an effective and sustainable approach to HIV in prisons and closed settings	% of high-risk populations (prisoners) covered by prevention programs	GOI surveillance systems	➢ Effective coordination occurs between DepHukHam and prisons and local government agencies ➢ Indonesian agencies have access to increased levels of funding over time ➢ HCPI and implementing partners have adequate access to prisoners and prison staff ➢ HCPI and implementing partners have adequate access to prisoners following release from prison ➢ No disruption in services is experienced between the transition from IHPCP to HCPI
	% of IDUs in prisons and other closed settings applying behaviour that can reduce the risk of HIV transmission	Periodic behavioural surveys	
	Development of standards, guidelines, operational instructions, local laws, regulations ,etc for IDU harm reduction services in prisons/closed settings	Documentation of policies and practices and associated research	
	Increase in coverage of comprehensive MMT	GOI surveillance data	
	Increase in CST services for IDU in prisons/closed settings	GOI surveillance data	
	Increases in the absolute amount and proportion of funds provided by GOI for	GOI National Budget and budgets for participating prisons	

Narrative description	Indicators	Means of verification	Assumptions
	IDU activities in prisons/closed settings		
	Degree to which the needs of men and women have been adequately addressed in prisons and other closed settings	Annual component review Periodic review	
Component 5: Management Objective: To effectively and efficiently manage the program	Effective support provided to the PCC	Assessment by AusAID Jakarta (and possibly independent technical advisers) and the periodic reviews	The members of the PCC meet as and when required
	Effective communication with all stakeholders	As above	> The roles and responsibilities of all agencies and key individuals is clear from the outset > The Managing Contractor has access to senior staff in each of the lead agencies and to the various working groups, as required
	Alignment of support to GOI systems and processes	As above	The Managing Contractor can develop an effective process for planning activities at provincial and district/municipal levels which integrates HCPI assistance within Indonesian systems and processes
	Effective use of technical advisers and technical advice	As above	
	Level of local program ownership and participation	As above	> The roles and responsibilities of all agencies and key individuals is clear from the outset > Indonesian agencies have access to increasing levels of funding for HIV activities
	Development of approaches which are appropriate, innovative and sustainable	As above	
	Provision of physical and financial data to enable AusAID, KPA and other key stakeholders to effectively monitor progress and evaluate performance and impact	As above	
	Effective treatment of risks	As above	
	Demonstration of continuous learning	As above	Staff from the lead agencies are prepared to participate in annual component reviews and discuss findings/recommendations in working group or other relevant meetings
	Donor harmonisation	As above	The Managing Contractor is able to liaise effectively and coordinate activities with other donors, as required
	Promotion of gender equality and effective treatment of gender issues	As above	
	Sufficient emphasis given to	As above	

Narrative description	Indicators	Means of verification	Assumptions
	capacity building		

Attachment 8: Draft terms of reference for Senior Program Coordinator (HIV) and independent technical and strategic advisers

Position **Senior Program Coordinator (HIV)**

Location Jakarta Embassy or with other AusAID personnel elsewhere in Jakarta, with regular travel to other parts of Indonesia

Duration Three years with option of an additional two years (subject to extension of HCPI)

Responsibilities

The Senior Program Coordinator (HIV) will provide policy and program advice to AusAID, and advice on the integration and coordination of Australian-funded programs. In addition, the Senior Program Coordinator (HIV) will provide technical oversight of activities and provide assistance in stakeholder engagement and coordination.

The Senior Program Coordinator (HIV) will report to the Manager of AusAID's Health Section in Jakarta. The Senior Program Coordinator (HIV) may have locally engaged support staff.

Key relationships

Within GOI, the Senior Program Coordinator (HIV) will establish close working relationships with senior staff in KPA, DepKes, DepHukHam and BAPPENAS, and with senior representatives in selected provinces in Java, Papua and West Papua. The Senior Program Coordinator (HIV) will be the key contact point within AusAID for technical matters for HCPI. While overseeing HCPI from a technical perspective, the Senior Program Coordinator (HIV) is expected to provide support and guidance to HCPI.

The Senior Program Coordinator (HIV) will also develop close working relationships with UNAIDS, UNODC, USAID/FHI and other agencies that provide HIV/AIDS support to Indonesia, and with regional and global agencies and activities where linkages and synergies would benefit Indonesia's response to HIV/AIDS.

Duties

The Senior Program Coordinator (HIV) will:

For HCPI:

- Participate in PCC meetings and take the lead role in ensuring monitoring and evaluation and general oversight of HCPI activities on behalf of GOA
- Provide input to the annual planning process, including provision of forward budget estimates and articulating GOA development priorities, and reviewing and commenting on draft annual plans as they are developed
- Provide support to the AusAID Health Section for its contract management of HCPI, including oversight of planning and monitoring processes
- Lead the strategic thinking and preparations for monitoring and evaluation of HCPI including preparing terms of reference and tasking notes of independent and strategic technical advisers (in collaboration with, and approved by, the PCC)
- Provide recommendations to HCPI for the requirements and specific focus of the program completion report
- Promote linkages between HCPI and other Australian activities in Indonesia and the region, including for example, health sector reform programs in Indonesia, and HIV

activities in Papua New Guinea and Asia, including research, and

- Access resources though regional initiatives for capacity building in social and epidemiological research (training, mentoring etc.), participate in relevant multi-country research projects and provide guidance and direction to HCPI for its participation.

For AIPH:

- Maintain dialogue and build relationships with the GOI, other donors, NGOs and other stakeholders
- Keep abreast of global, regional, GOA and GOI policies and programs that may impact on, or provide opportunities for, HCPI or AIPH
- Liaise with team leaders/advisers from other GOA-funded activities in Indonesia and identify needs/opportunities for HIV mainstreaming and assist AusAID Jakarta to identify and organise inputs to meet these needs, as required
- Prepare a brief and costed annual plan for proposed AIPH activities (other than for HCPI) for each calendar year and present the plan to the PCC in November/December
- Assist AusAID Jakarta in the negotiation of funding agreements for AIPH activities (other than HCPI), including, for example, the overall objectives and timeframe, the roles and responsibilities of key stakeholders, indicators, the collection of baseline and performance data, the responsibility for data collection, and reporting requirements
- Provide support to the AusAID Health Section for monitoring AIPH activities
- Prepare brief six-monthly reports summarising AIPH activities and present these at PCC meetings
- Prepare tasking notes for any technical advisory inputs, if required, and following approval by the PCC, brief advisers and provide input/assistance during missions
- Help promote AIPH (including HCPI) in Australia and in Indonesia
- Participate in forums in HIV and related fields
- Manage locally engaged staff (if applicable)
- Act as an HIV resource within the Australian Embassy and to various GOA–funded activities in Indonesia, as appropriate, and
- Undertake any other activities agreed by AusAID that would add increase the impact of HCPI.

Experience required

(A) Essential

The position requires a competent and experienced person with the following attributes:

- Experience in the planning and management of HIV or public health programs at a senior level
- HIV technical knowledge
- Strong communication and interpersonal skills
- Capacity to develop and deliver a gender-sensitive HIV response
- Ability to work within and support Indonesian systems.

(B) Preferable

- Experience in international development
- Previous experience in Indonesia
- An understanding of AusAID policies and cross-cutting issues.

Generic terms of reference for independent technical and strategic advisers

Roles and responsibilities

Technical and strategic advice will in general be provided to the Senior Program Coordinator (HIV), in collaboration with KPA and other lead agencies (DepKes and DepHukHam). The technical and strategic advisers will also work closely with the Managing Contractor and implementing partners, and consult with the AusAID Health Section in Jakarta and other agencies (such as UNAIDS, UNODC and USAID/FHI) as appropriate. The advisers may be required to:

- Review annual plans, partner contracts and progress reports
- Review specific activities (for example, where new approaches are being trialled) in one or more locations
- Provide advice in terms of either gaps or opportunities within particular components or AIPH as a whole
- Outline experiences and lessons learned from other countries or regions, and
- Provide advice or comment to the PCC, the working groups, other agencies, members of the periodic review team or other review teams commissioned by AusAID or other agencies.

The technical and strategic advisers will in general be required to play a supportive role during implementation of AIPH, including HCPI, by providing advice and assistance, working with all partners to improve the activities being implemented, supporting GOI and HCPI priorities, building capacity and encouraging effective coordination.

Inputs

Technical and strategic advisers will generally provide inputs from one or two days (to review a report) to several weeks (to undertake a detailed review of a component). Terms of reference for each input will be prepared by the Senior Program Coordinator (HIV) and approved by the PCC. The terms of reference will outline the tasks to be undertaken, the inputs required (expressed in days), a draft work plan and itinerary, a list of proposed key contacts/appointments, the expertise required, and the expected output. The output will in general be a verbal presentation to AusAID and other agencies (e.g. KPA, DepKes, DepHukHam, HCPI), a written aide memoire and a succinct written report.

AusAID Jakarta, and specifically the Senior Program Coordinator (HIV), will be responsible for identifying, contracting and managing the advisers.

Skills required

Technical advisers will be expected to have sound technical knowledge in their respective area of specialisation and be aware of different approaches that have been or are being trialled in different parts of the world.

Technical and strategic advisers will be expected to have a sound understanding of program planning and management and performance assessment, and proven capacity to provide strategic advice at a senior level.

Technical and strategic advisers will be expected to have good interpersonal skills; proven report writing skills; and the ability to work with interpreters, if required.

Attachment 9: Draft terms of reference for HCPI advisers

The following positions should be considered only as indicative, and are included as a guide to the type of expertise required to support the activities outlined in each component and contribute to the achievement of the goal and purpose.

Position **Team Leader**

Location Jakarta, with regular travel to other parts of Indonesia

Duration Five years with option of an additional three years (subject to extension of HCPI)

Responsibilities

As the senior representative of the Managing Contractor, the Team Leader will have prime responsibility for the planning and delivery of assistance provided through HCPI. The Team Leader will oversee the annual planning process, ensuring HCPI supports Indonesian priorities and systems, has a strong capacity building focus, and progressively incorporates cost-sharing principles. The Team Leader will be the main contact with AusAID Jakarta, and will oversee financial, management and reporting systems.

Key relationships

The Team Leader will be expected to establish close working relationships with senior staff in KPA and develop good working relationships with a range of senior officials from DepKes, DepHukHam, BAPPENAS, Papua and West Papua and Java.

The Team Leader is expected to have close working relationships with staff in AusAID Jakarta and will liaise primarily with:

Senior Program Coordinator (HIV) – for technical matters, and

AusAID's HCPI Activity Manager – for contractual and operational matters.

The Team Leader is also expected to develop effective linkages with the donor community, including senior staff in UNAIDS, UNODC, USAID/FHI and other agencies that provide support to the sector.

Duties

The Team Leader will undertake the following:

- With support from the Managing Contractor, establish management and financial systems to ensure effective communication, adequate and timely reports, financial accountability, appropriate insurance cover, effective management and support for staff, etc.
- Conduct monitoring and evaluation
- Compile six monthly progress reports
- Represent HCPI in PCC meetings and other forums, as required
- Brief AusAID and KPA on any matters they should be aware of
- Liaise with and build relationships with senior government staff, AusAID and other donors
- Keep abreast of GOI policies and programs that may impact on, or provide opportunities for, HCPI
- Ensure the integration of gender equality throughout the program and all activities
- Promote HCPI and its achievements

- Oversee financial payments and the preparation of financial reports
- Brief all HCPI staff (including short-term consultants) on the objectives of the program, the approach utilised (supporting Indonesian systems and having a strong capacity building focus), relevant AusAID policies, and other matters as appropriate
- Brief AusAID staff on HCPI, as requested
- Provide information and advice to independent technical advisers and any other teams engaged by AusAID to provide advice on or review HCPI or other related activities
- Maintain dialogue with AIPH to ensure any local or multi-country research resources identified are applied to capacity building of GOI social researchers and surveillance systems in areas (i) that are priorities for KPA and national, sectoral and provincial plans and (ii) in which other donors (particularly FHI) are not offering support
- Effectively manage HCPI staff
- Liaise regularly with the Managing Contractor (head office), as required, and
- Any other activities agreed by AusAID and the Managing Contractor that would enhance the impact of HCPI.

Experience required

(A) Essential

The position requires a competent and experienced person with the following attributes:

- Experience in health planning and management at a senior level
- Project management experience
- Strong communication and interpersonal skills
- Ability to work within and support Indonesian systems
- Capacity to develop and deliver a gender-sensitive HIV response
- Experience in HIV-related policy development or program management.

(B) Preferable

- Experience in international development
- Previous experience in Indonesia
- An understanding of AusAID policies and cross-cutting issues.

Position	**HIV Adviser (IDU)**
Location	Jakarta, with regular travel to other parts of Indonesia
Duration	Three years with an option for an additional two years (subject to approval by the PCC in Year 3) and further inputs depending on the outcome of the periodic review in Year 4

Responsibilities

The HIV Adviser (IDU) will take the lead in planning and implementation of Components 3 (IDU) and 4 (Prisons), and ensure linkages with Component 1 (Leadership). The adviser will report to and support the Team Leader.

Key relationships:

The HIV Adviser (IDU) will establish good working relationships with senior staff in KPA, DepKes, DepHukHam and the provinces in which HCPI provides support under Components 3 and 4.

The adviser will establish a good working relationship with the Senior Program Coordinator (HIV) within AusAID, along with senior staff in a number of agencies such as UNAIDS, UNODC and USAID/FHI.

Duties

The HIV Adviser (IDU) will:

- Take the lead in planning activities with counterparts and implementing partners for Components 3 and 4, and ensure linkages with Component 1, including specification and costing of activities at provincial/municipal level, and aggregating these into component-level annual plans
- For Components 3 and 4, and Component 1 linkages, identify institutional strengthening and capacity building needs for implementing partners, in consultation with these agencies, and incorporate these in annual plans as appropriate
- Provide advice to KPA, DepKes and DepHukHam on technical matters (including policies, strategies and approaches) relating to harm reduction among IDUs and their partners
- Negotiate partner agreements for activities within Components 3 and 4 and Component 1 linkages, provide support for their implementation, and oversee the monitoring of these agreements
- Ensure adequate information is collected by HCPI to enable an assessment of progress, achievements and impact for Components 3 and 4 (including gender disaggregated data as appropriate)
- Manage and mentor other HCPI staff who contribute to Components 3 and 4
- For Components 3 and 4, provide input to six monthly progress reports and the review of progress included in annual plans
- Brief AusAID staff on HCPI, as requested
- Provide information and advice to independent technical and strategic advisers and any other teams engaged by AusAID to provide advice on or review HCPI or other related activities, and
- Any other duties as agreed by the Team Leader or reasonably requested by the Team Leader.

Experience required

(A) Essential

The position requires a competent and experienced person with the following attributes:

- Successful experience in the design and implementation of harm reduction approaches for IDUs and their partners (both in the general community and within closed settings)
- Successful project management experience
- Strong communication and interpersonal skills
- Capacity to develop and deliver a gender-sensitive HIV response
- Ability to work effectively within and support Indonesian systems.

(B) Preferable

- Developing country experience
- Previous experience in Indonesia.

Position: **HIV Adviser (Capacity Development)**

Location: Jayapura (initially), with regular travel to Jakarta and other parts of Indonesia

Duration: Three years with an option for an additional two years (subject to approval by the PCC in Year 3) and further inputs depending on the outcome of the periodic review in Year 4

Responsibilities

The HIV Adviser (Capacity Development) will take the lead in the planning and implementation of Components 1 (Leadership) and 2 (Papua and West Papua), working closely with the HIV Adviser (Prevention and Health Promotion) for Component 2 and ensuring linkages and cross cutting activities of Component 1 across all components. The HIV Adviser (Capacity Development) will report to and support the Team Leader.

Key relationships

The HIV Adviser (Capacity Development) will establish good working relationships with senior staff in KPA, DepKes, DepHukHam, BAPPENAS, Papua and West Papua and Java. In Papua and West Papua, these relationships are expected to include senior staff from the Office of the Governor, KPAP, BAPPEDA and DinKes.

The adviser is expected to have a good working relationship with the Senior Program Coordinator (HIV) within AusAID, along with senior staff in a number of agencies such as UNAIDS, UNODC and USAID/FHI.

Duties

The HIV Adviser (Capacity Development) will:

- Oversee the annual planning process for Components 1 and 2, ensuring Component 1 cross-cutting linkages with Components 3 and 4 (ensuring that HCPI supports Indonesian priorities and systems, has a strong capacity building focus, and progressively incorporates cost-sharing principles)
- Take the lead in planning activities with counterparts and implementing partners for Component 1 (Leadership), in close consultation with the HIV Adviser (Prevention & Health Promotion) for Papua activities, including specification and costing of activities at provincial/municipal level, and aggregating these into component-level annual plans
- As part of the annual planning process in Papua and West Papua, consider the specific need for supporting the KPAP in Manokwari and assisting in the preparation of an HIV/AIDS strategy for West Papua
- Identify institutional strengthening and capacity building needs for implementing partners, in consultation with these agencies, and incorporate these in annual plans as appropriate
- Provide advice to KPA, DepKes and DepHukHam on institutional strengthening matters (including policies, strategies and capacity building approaches)
- Keep abreast of GOI policies and programs that may impact on, or provide opportunities for, HCPI
- Ensure the integration of gender equality throughout the program and all activities
- Negotiate partner agreements for activities within Component 1 and oversee the monitoring of these agreements
- Ensure adequate information is collected by HCPI to enable an assessment of progress, achievements and impact for Component 1 (including gender disaggregated data as appropriate)
- Manage and mentor other HCPI staff who contribute to Component 1

- For Component 1 (and Component 2 to a lesser degree), provide input to six monthly progress reports and the review of progress included in annual plans
- Brief AusAID staff on HCPI, as requested, and
- Provide information and advice to independent technical advisers and any other teams engaged by AusAID to provide advice on or review HCPI or other related activities.

Experience required

(A) Essential

The position requires a competent and experienced person with the following attributes:

- Experience in institutional strengthening and change management
- Experience in planning and management of HIV or health related programs
- Strong communication and interpersonal skills
- Ability to work within and support Indonesian systems, including GOI budget and financial systems
- Ability to work in a relatively isolated and difficult environment
- Capacity to develop and deliver a gender-sensitive HIV response
- Strong commitment to capacity building.

(B) Preferable

- Developing country experience
- Previous experience in Indonesia.

Position: **HIV Adviser (Prevention & Health Promotion)**

Location: Jayapura, with occasional travel to Jakarta and other parts of Indonesia

Duration: Five years with option of an additional three years (subject to extension of HCPI)

Responsibilities

The HIV Adviser (Prevention & Health Promotion) will take the lead in developing appropriate approaches to prevent the spread of HIV and to promote the health of people living with HIV in Papua and West Papua. The adviser will report to and support the HIV Adviser (Capacity Development).

Key relationships

The HIV Adviser (Prevention & Health Promotion) is expected to establish good working relationships with staff within KPAP and DinKes in Papua and West Papua.

The adviser is expected to develop a good working relationship with the Senior Program Coordinator (HIV) within AusAID, along with staff in a number of agencies such as UNAIDS and USAID/FHI.

Duties

The HIV Adviser (Prevention & Health Promotion) will undertake the following:

- Review existing materials and approaches used by GOI, IHPCP, ASA/FHI and other agencies for HIV prevention and health promotion in Papua and West Papua
- Support KPAP, DinKes and other agencies (including civil society and the private sector) to refine/develop and implement appropriate HIV prevention and health promotion approaches in Papua and West Papua

- Support the technical and strategic adviser during the planning of activities for Component 2 (Papua and West Papua), including specification and costing of activities at provincial/municipal level
- Help identify institutional strengthening and capacity building needs for partner agencies in Papua and West Papua, in consultation with these agencies, and incorporate these in annual plans as appropriate
- Provide advice to the Papua/West Papua Working Group under KPA, on matters relating to HIV prevention and health promotion
- Ensure the integration of gender equality throughout the program and all activities in Papua and West Papua
- Negotiate partner agreements for activities within Component 2 and oversee the monitoring of these agreements
- Ensure adequate information is collected by HCPI to enable an assessment of progress, achievements and impact for Component 2 (including gender disaggregated data as appropriate)
- Manage and mentor other HCPI staff who contribute to Component 2
- For Component 2, provide input to six monthly progress reports and the review of progress included in annual plans
- Brief AusAID staff on HCPI, as requested
- Provide information and advice to independent technical advisers and any other teams engaged by AusAID to provide advice on or review HCPI or other related activities, and
- Any other duties as agreed by the Team Leader or reasonably requested by the Team Leader.

Experience required:

(A) Essential

The position requires a competent and experienced person with the following attributes:

- Successful experience in the design and implementation of HIV or other disease prevention programs
- Strong communication and interpersonal skills
- Previous experience in Indonesia
- Capacity to develop and deliver a gender-sensitive HIV response, and
- Ability to work effectively in a relatively isolated and difficult environment, including frequent travel within Papua and West Papua.

(B) Preferable

- Competency in Bahasa Indonesia.

Attachment 10: Preliminary M&E framework

For the goal, purpose and component objectives, the M&E framework includes indicators which are derived primarily from the draft National Action Plan for HIV and AIDS. These indicators need to be reviewed and finalised once the National Action Plan has been finalised and the program for 2008 prepared. This should be done as part of the inaugural annual planning process, in consultation with AusAID, KPA and the other key stakeholders.

Objective	Indicators	Means of verification	Baseline	Annual targets and achievements	Comments
AIPH					
Goal: To prevent and limit the spread of HIV, to improve the quality of life of people living with HIV, and to alleviate the socio-economic impacts of HIV/AIDS	> Prevalence of HIV within high-risk groups > Comparison of HIV prevalence with baseline HEMI projections	GOI surveillance systems	> Female sex workers: 6.2% (DKI, 2003) > IDU: 47.9% (DKI, 2001) > IDU: 42.9% (Java Barat, 2003) > Inmates: 19.7% (DKI, 2003) > Transgenders: 25.7% (DKI, 2004)	This column to be completed as part of (i) the annual planning process and (ii) negotiation of partner grants, and would preferably be split into two separate columns (targets and achievements)	Indicator and baseline data derived from the National HIV/AIDS Action Plan. A comparison with the HEMI projections will provide the basis for an assessment of the actual impact of Indonesia's HIV response Incidence data not currently available
	Prevalence of HIV in Papua and West Papua	Papua and West Papua surveillance systems	2.5% of the adult population is HIV positive		Baseline data derived from the FHI behavioural survey in 2007 Incidence data not yet available
	> % of PLWHA receiving CST > % of PLWHA who require treatment who receive antiretroviral therapy	GOI surveillance systems	See External Review of the Health Sector Response (March 2007)		
	Quality of CST services provided	Periodic assessment by DepKes	See External Review of the Health Sector Response (March 2007)		
	Policies and practices which reduce discrimination, differentiate by gender, protect the rights of PLWHA, and minimise adverse socio-economic impacts	Documentation of policies and practices and associated research			
Objective 1: To combine Australia's	Clear and coherent annual plans	AIPH annual plan endorsed by the PCC	There has not been a single, unified plan		

Objective	Indicators	Means of verification	Baseline	Annual targets and achievements	Comments
support for HIV in Indonesia into a coherent partnership that benefits from synergies between each element			before		
	Effective linkages and synergies between: > HCPI > IPF and GFATM > HIV mainstreaming > Other HIV-related initiatives in the Indonesia program > AusAID regional programs and partnerships	Periodic review and assessment of individual activities			
	Satisfaction expressed by GOI agencies in the clarity and composition of Australia's support for Indonesia's HIV response	Periodic review and assessment of individual activities			
Objective 2: To strengthen GOI leadership and capacities to implement an effective and sustainable HIV response	> Extent to which AIPH is building capacity of Indonesian agencies and promoting sustainable approaches that can be implemented by these agencies in the future > Extent to which AIPH has promoted gender equality and equitable access to services	Periodic review and assessment of individual activities			
HCPI					
Goal: As for AIPH (see above)					
Purpose: To support Indonesia to plan, develop and implement	Effective working groups on harm reduction, prisons, and Papua and West Papua at the	Annual component review Periodic review Program completion report	Papua and West Papua – meeting irregularly and not effective (2006) Harm reduction –		

Objective	Indicators	Means of verification	Baseline	Annual targets and achievements	Comments
an effective and sustainable HIV response	national level		to be confirmed Prisons – meeting irregularly and not effective (2006)		
	Strengthened coordination by KPA and cooperation among KPA members in implementing the National Strategy and Action Plan	Annual component review Periodic review Program completion report			This is the first unified national action plan for HIV in Indonesia
	Extent to which HCPI is building the capacity of government and non-government agencies and promoting sustainable approaches that can be implemented by those agencies in the future	Annual component review Periodic review Program completion report	Baseline to be derived from 2008 assessment of HCPI	Unified system in use by the end of 2008	HCPI could develop an indicator for Indonesian capacity, and assess the proportion of planning and implementation completed by Indonesian partners for each activity (using a simple 1 to 5 scoring system)
	Extent to which HCPI is building the capacity of government and non-government agencies to integrate gender equality within the planning and implementation of HIV/AIDS programs and activities	Annual component review Periodic review Program completion report	Baseline to be derived from 2008 assessment of HCPI		Monitoring needs to determine how successful HCPI has been in building GOI capacity to plan and implement a gender-sensitive response to HIV
	Effective harmonisation with other donors and alignment with GOI programs (including the extent to which the annual planning process has been integrated with GOI systems and processes)	Annual component review Periodic review Program completion report	> Limited donor harmonisation in the past > Cooperation with local government in the past, but not necessarily alignment with GOI programs		While IHPCP has cooperated at provincial and district levels, annual plans have not been prepared in tandem with GOI systems and processes
	One M&E framework as the single instrument used by all partners, including HCPI	Annual component review Periodic review Program completion report	At least 5 M&E systems used in the past		
	The level of funds (and relative contribution) provided by GOI	GOI National Budget	US$13 million (2005)		

Objective	Indicators	Means of verification	Baseline	Annual targets and achievements	Comments
	for HIV/AIDS activities				
Component 1: Leadership To contribute to Indonesia's capacity to lead, plan and manage an effective and sustainable HIV response	Working groups functioning effectively in provinces where HCPI is working	Annual component review	Baseline to be confirmed during annual planning		
	Tim Asistensi functioning effectively at national level and in provinces where HCPI is working	Annual component review	Baseline to be confirmed during annual planning		
	Development and implementation of local strategies and plans that support the National Strategy and Action Plan	Annual component review	Baseline to be confirmed during annual planning		
	Collection and use of relevant data in planning and monitoring implementation of local strategies and plans	Annual component review	Baseline to be confirmed during annual planning		
	Development and adoption of conducive regulatory frameworks	Annual component review	Baseline to be confirmed during annual planning		
	National and local leaders serving as key advocates on HIV messages	Annual component review	Baseline to be confirmed during annual planning		
	Improvement in GOI capacity to implement a response to HIV that promotes gender equality	Annual component review	Baseline to be derived from 2008 assessment of HCPI		
	Formation of CSO alliances or consortia with clear strategies and policy positions	Annual component review	Baseline to be confirmed during annual planning		
	Participation of PLWHA in planning bodies and decision-making forums and committees	Annual component review	Baseline to be confirmed during annual planning		
Component 2: Papua and West Papua To support the development and implementation of an effective and sustainable	IEC: > % of female sex workers, MSM and waria who understand methods of transmission and reject	Periodic behavioural surveys	47% of the people of Papua and West Papua had not heard of HIV (2007)		The Papua HIV/AIDS Strategy aims to communicate HIV messages to 100% of adults between 15 and 29 years of age by 2011

Objective	Indicators	Means of verification	Baseline	Annual targets and achievements	Comments
response to HIV in Papua and West Papua	misconceptions of how HIV is transmitted > % of teens aged 15 to 24 who can correctly identify wrong perceptions of HIV sexual transmission				
	Behaviour: > % of MSM that report using condoms during the last sexual relations with male partners > % of female and male sex workers who report using condoms with current partners	Periodic behavioural surveys			
	Services: > % of high-risk population that tested for HIV and received results in past 12 months > % of schools with teachers trained in life skills education > % of companies with HIV and AIDS policies for the workplace	Documentation of policies and practices and associated research			
	Local capacity: > Functioning KPAPs for Papua and West Papua > Strategic HIV/AIDS Plan for West Papua > 100% of districts and kota (municipalities) have a functioning KPAD by 2011 > Agreements between BNN	> Details on membership and meetings held > Plan prepared and approved > Assessment by KPAPs and other key stakeholders > Signed agreements > Assessment by KPAPs and other key stakeholders > Documentation of			

Objective	Indicators	Means of verification	Baseline	Annual targets and achievements	Comments
	and KPAPs > Coordination and cooperation between government agencies > Coordination and cooperation between donors > Local regulations on the prevention response > Development of work programs to implement the strategic plan	policies and practices			
	Extent to which HCPI has advanced gender equality Degree to which the needs of men and women have been adequately addressed in HIV/AIDS activities in Papua and West Papua	Annual component review Periodic review	Baseline to be derived from 2008 assessment of HCPI		Monitoring needs to determine if in responding to the differing needs of men and women the approach adopted promotes gender equality
	Increase in HIV activities funded by Papua and West Papua governments	Papua and West Papua Annual Budgets			
Component 3: Injecting drug use To strengthen programs addressing HIV associated with people who inject drugs	% of high-risk populations covered by prevention programs	GOI surveillance systems	To be completed when new prevalence data are officially released		
	% of IDUs applying behaviour that can reduce the risk of HIV transmission through using sterile injecting equipment and using condoms in the last two months	Periodic behavioural surveys			
	Development of standards, guidelines, operational instructions, local laws, regulations, etc. for IDU harm reduction services	Documentation of policies and practices and associated research			

Objective	Indicators	Means of verification	Baseline	Annual targets and achievements	Comments
	Increase in coverage of NSPs	GOI surveillance data	10% of IDUs in 2006	70% of IDUs by 2010	
	Increase in coverage of comprehensive MMT	GOI surveillance data	600 clients in 2006	53 000 clients by 2009	
	Increase in CST services for IDU	GOI surveillance data		20 puskesmas-based comprehensive programs and 75 puskesmas prevention programs	
	Increases in the absolute amount and proportion of funds provided by GOI for IDU activities	GOI National Budget and budgets for participating provinces/municipalities			
	Degree to which the needs of men and women have been adequately addressed in IDU activities	Annual component review Periodic review	Baseline to be derived from 2008 assessment of HCPI		
Component 4: Prisons To support the development and implementation of an effective and sustainable approach to HIV in prisons and closed settings	% of high-risk populations (prisoners) covered by prevention programs	GOI surveillance systems			
	% of IDUs in prisons and other closed settings applying behaviour that can reduce the risk of HIV transmission	Periodic behavioural surveys			
	Development of standards, guidelines, operational instructions, local laws, regulations, etc. for IDU harm reduction services in prisons/closed settings	Documentation of policies and practices and associated research			
	Increase in coverage of comprehensive MMT	GOI surveillance data			
	Increase in CST services for IDUs in prisons/closed settings	GOI surveillance data			
	Increases in the absolute amount and proportion of funds provided by GOI for IDU activities in prisons/closed	GOI National Budget and budgets for participating prisons			

Objective	Indicators	Means of verification	Baseline	Annual targets and achievements	Comments
	settings				
	Degree to which the needs of men and women have been adequately addressed in prisons and other closed settings	Annual component review Periodic review	Baseline to be derived from 2008 assessment of HCPI		
Component 5: Management To effectively and efficiently manage the program	Effective support provided to the PCC	Assessment by AusAID Jakarta (and possibly independent technical advisers) and the periodic reviews	NA		
	Effective communication with all stakeholders	As above	NA		
	Alignment of support to GOI systems and processes	As above	NA		
	Effective use of technical advisers and technical advice	As above	NA		
	Level of local program ownership and participation	As above	NA		
	Development of approaches which are appropriate, innovative and sustainable	As above	NA		
	Provision of physical and financial data to enable AusAID, KPA and other key stakeholders to effectively monitor progress and evaluate performance and impact	As above	NA		
	Effective treatment of risks	As above	NA		
	Demonstration of continuous learning	As above	NA		
	Donor harmonisation	As above	NA		
	Promotion of gender equality and effective treatment of gender issues	As above	NA		
	Sufficient emphasis given to capacity building	As above	NA		

Attachment 11: Risk matrix

Program area	Risk	Potential impact	L	C	R	Risk mitigation	Responsibility	Timing
Goal To prevent and limit the spread of HIV, to improve the quality of life of people living with HIV, and to alleviate the socio-economic impacts of HIV/AIDS	Reduction in funding from GFATM, DFID (IPF) and/or USAID (ASA/FHI)	As a high proportion of HIV funding is from external sources, any reduction in external funding may seriously reduce the effectiveness of Indonesia's overall HIV response	3	3	H	> All stakeholders must highlight the need to scale up the HIV response > The response (and resources) must be targeted to areas of greatest need	All stakeholders	Continuous
	Insufficient funding and strategic effort from GOI	Without a substantial increase in GOI funding for HIV and health services and strategies for health system strengthening, the prevalence and incidence of HIV and AIDS will continue to rise	4	5	E	Increase GOI funding for HIV activities (and funding and strategies for health service improvement) and allocate funds to areas of greatest need	GOI	Continuous
	Disruption of medical supplies (e.g. methadone, antiretrovirals)	Without a reliable supply of effective medicines the treatment programs will fail (resulting in relapse or loss of life). In addition, this could result in a loss of political support for a comprehensive approach	3	4	H	Medical supply and distribution channels need to be reliable and effective	DepKes	Continuous
Purpose To support Indonesia to plan, develop and implement an effective and sustainable HIV response	Limited awareness and capacity at provincial and lower levels (due in part to decentralisation)	Without strong support at provincial and district/kota levels, and the ability to coordinate and implement HIV activities effectively, the prevalence and incidence of HIV and AIDS will continue to rise	4	4	E	> Support and strengthen GOI systems and processes > Ensure stakeholder engagement at all levels and good communication	All stakeholders	Continuous
	Ineffective use of resources due to a lack of cooperation and coordination between GOI, donors, civil society and the private sector (including lack of alignment of donor activities with GOI systems and programs)	Given the limited resources available, there is a need to ensure that available resources are utilised effectively; otherwise the HIV response will have less success	3	3	H	> Donor alignment (with Indonesian systems) is crucial, as is donor harmonisation > Support to KPA > Support for implementation of national strategy and work plan	KPA and all other stakeholders including AIPH (and HCPI) support	Continuous
	Delays in finalising the costed	Although draft documents have been	4	3	H	Support to KPA to finalise these documents	KPA and all other	Early/mid

Program area	Risk	Potential impact	L	C	R	Risk mitigation	Responsibility	Timing
	Action Plan	prepared, delays in finalising these will inhibit effective coordination between GOI agencies and the donor community					stakeholders including HCPI support	2007
Component 1: Leadership	The budget available to the KPA for institutional strengthening programs is reduced	Reduction of capacity building activities at provincial and district/kota levels, which in turn would reduce the effectiveness of Indonesia's HIV response	3	3	H	Funding continuation will depend – in the short term – on funding from IPF. Support should be provided for this, with a gradual increase in GOI funding for the KPA's operational expenses	GOI, IPF and KPA ; GOA contribution to IPF; AIPH advocacy to other donors for IPF contributions	2007–08
	Change in KPA leadership reduces its effectiveness or capacity as the lead coordination agency	Without strong leadership the KPA will not be as effective in overall coordination	3	4	H	KPA needs to ensure senior staff have direct responsibilities and the capacity to play a leading role in the future	GOI/KPA	Continuous
	Effective relationships cannot be developed with the KPAP or other key agencies in provinces where HCPI is working	Activities are unlikely to be effective without strong local support	2	3	M	Strong local support – from the governor and/or bupatis, along with key agencies – should be a prerequisite for HCPI to work in a province	HCPI	Continuous
	Different GOI agencies will not work together or share data in an attempt to create and utilise a single HIV/AIDS M&E system for Indonesia	Detailed information may not be available on which to monitor and evaluate Indonesia's HIV response, or to effectively plan and prioritise future activities	3	3	M–H	Continue to lobby for a single M&E system and provide support to KPA and DepKes for its development	AIPH	2007–08
Component 2: Papua and West Papua	Limited resources (including GOI and donor support)	The funds required to scale up the response to the level required will not be achieved, and the prevalence and incidence of HIV in Papua and West Papua will continue to rise	4	5	E	Continue to lobby for more resources – and an effective, coordinated response – from the Papua and West Papua governments and the donor community	Governors and other local leaders; AIPH support	Continuous
	Health service coverage remains poor and the quality of health services provided remains low	Without substantial health system improvements, many people in Papua and West Papua will not have access to adequate counselling, testing, treatment or care, and the prevalence and incidence of	5	5	E	Continue to lobby for more resources, health system strengthening and improved health services	All stakeholders	Continuous

Program area	Risk	Potential impact	L	C	R	Risk mitigation	Responsibility	Timing
		sexually transmitted diseases including HIV and AIDS will continue to rise						
	Ineffective coordination and capacity, particularly in West Papua	Without effective coordination a comprehensive and effective response is unlikely (particularly in West Papua, which does not have a functioning KPAP, and many provincial governments where staff have limited experience)	4	4	E	Lobby for the establishment of the KPAP in West Papua, provide training and support for them, and assist (if required) in the preparation of an HIV/AIDS Strategy for West Papua	West Papua Governor, other local leaders and HCPI	2007–08
	Appropriate interventions are not taken to reduce HIV transmission as a result of legal and illegal border crossers	Without adequate consultation between Indonesia and PNG (and coordinated activities in Papua, Sandaun and Western Province) HIV transmission could continue to escalate and reduce the impact of programs in either country	4	3	H	Effective coordination is required between agencies on either side of the border, along with coordinated prevention and care programs	Indonesia and PNG Border Liaison Committees and health agencies in Papua, Sandaun and Western Provinces	Continuous
	High wage levels and mobility arising from employment in extractive and rural industries	Unless staff within Papua's and West Papua's extractive and rural industries (mining, petroleum, forestry, oil palm, fishing and pearling) change their behaviour, HIV transmission will continue to rise	4	4	E	HCPI can support partnerships with the private sector to implement prevention programs and integrate awareness activities as part of the recruitment process	Private sector representatives, KPAP, HCPI	Continuous
	The needs and interests of both men and women are not adequately addressed	Failure to plan and implement a gender-sensitive HIV response will jeopardise the overall effectiveness of the response	3	4	H	HCPI needs to promote gender equality, involve both men and women in the planning and implementation of activities, develop gender-sensitive approaches and build GOI capacity to implement gender-sensitive responses	HCPI	Continuous
	Logistical challenges result in a lack of awareness and services in remote areas	Many people in Papua and West Papua will not have access to adequate counselling, testing, treatment or care, and the prevalence and incidence of HIV and AIDS will continue to rise	4	4	E	Continue to lobby for more resources and improve health services	All stakeholders	Continuous
	Disruption of condom supplies	Without reliable supply, the effectiveness of condom use will be negligible and the	4	2	H	> Promote condom use	KPAP, DinKes, HCPI	Continuous

Program area	Risk	Potential impact	L	C	R	Risk mitigation	Responsibility	Timing
		prevalence and incidence of HIV will rise, particularly among sex workers and their clients				> Avoid government interventions that reduce the incentive for private supplies (e.g. distributing free condoms in main centres)		
	Sexual behaviour does not change despite increased knowledge on HIV and HIV transmission	If sexual behaviour does not change despite increased knowledge, the prevalence and incidence of HIV will continue to rise	4	4	E	Develop materials/techniques that are applicable to the local population (drawing on experience from PNG), including local language materials, the use of local theatre groups, and use of high profile people such as sport and rock stars	KPAP, HCPI	Continuous
Component 3: Injecting drug use	Bureaucratic requirements (e.g. DepKes approval for each needle and syringe and methadone maintenance program) may delay support for harm reduction activities	Delays in the provision of the full range of services to IDUs and their partners could reduce the effectiveness of the response, and HIV transmission may increase	3	3	H	HCPI to continually promote the need for comprehensive and adequately resourced programs that will – over time – be able to demonstrate benefits	DepKes, HCPI	Continuous
	Lack of coordination at local level	Without effective local coordination a comprehensive response is unlikely and HIV transmission may increase	3	4	H	Gain support from governors, bupatis, walikotas, KPAP and other agencies during initial discussions, and build on these relationships during the annual planning process	KPA, HCPI	Continuous
	Lack of coordination at national level	Without effective coordination at national level Indonesia is unlikely to develop a conducive policy environment, collect uniform data to help prioritise activities, or replicate successful approaches	3	4	H	> High-level liaison with GOI by HIV/AIDS Coordinator or other AusAID officers > HCPI will provide support to assist DepKes in its coordination role for IDU activities	GOI/AusAID DepKes, HCPI	Continuous
	Limited resources	The ability to scale up the response in areas with concentrated IDU populations will not be sufficient to prevent an increase in HIV transmission among or from IDUs	4	4	E	> Continue to lobby for more resources from GOI and the donor community. AIPH advocacy > HCPI to support Indonesia by supporting comprehensive approaches and ensuring the collection of data to demonstrate the	DepKes, AIPH HCPI	Continuous

Program area	Risk	Potential impact	L	C	R	Risk mitigation	Responsibility	Timing
						benefits and impact		
	Lack of continuity from IHPCP (including funding constraints imposed on IHPCP or a delay in HCPI commencing)	Contact with IDUs could be lost if resources are reduced during the IHPCP extension or services are temporarily discontinued (if HCPI is delayed), which could lead to an increase in HIV transmission, the collapse of some local NGOs, and a loss of support from participating GOI agencies (DinKes and the police)	2	4	H	> AusAID and GOI agreement for transition arrangements > Contracts for key partners will be negotiated by IHPCP, providing for continuous support from July 2007 to December 2008	GOI, GOA IHPCP, HCPI	IHPCP - Apr/May 2007 HCPI – Feb/Mar 2008
Component 4: Prisons	Limited support for harm reduction activities in prisons and other closed settings	It may not be possible to provide a full range of services to IDUs in prison, and HIV transmission may increase	3	4	H	> Policy and strategy dialogue between GOI and AIPH > HCPI should continually promote the need for comprehensive and adequately resourced programs that will – over time – be able to demonstrate benefits	GOI, AIPH DepHukHam, HCPI	Continuous
	Limited support for ex-IDUs after leaving prison	Without continued support, ex-IDUs could relapse and the spread of HIV increase	3	3	H	> Policy and strategy dialogue between GOI and AIPH > Services need to be provided to prisoners following release from prison, which may require coordination between partners at the prison and other partners or NGOs where the person returns to	GOI, AIPH HCPI partners and other NGOs	Continuous
	Lack of coordination at national level	Without effective coordination at national level Indonesia is unlikely to develop a conducive policy environment, collect uniform data to help prioritise activities, or replicate successful approaches	3	4	H	> Policy and strategy dialogue between GOI and AIPH > HCPI will provide support to assist DepHukHam in its coordination role	GOI, AIPH DepHukHam, HCPI	Continuous
	Continued increase in size of prison population	With an increased prison population, the program may be unable to achieve effective coverage	3	4	H	> Policy and strategy dialogue between GOI, AIPH and HCPI regarding prison diversion programs and drug law reform	GOI, AIPH, HCPI, DepHukHam	Continuous
	Limited resources	With resources limited, the ability to scale	4	4	E	> Policy and strategy dialogue between GOI	GOI, AIPH	Continuous

Program area	Risk	Potential impact	L	C	R	Risk mitigation	Responsibility	Timing
		up the response in Indonesian prisons (and other closed settings) will be reduced and HIV transmission may not be reduced				and AIPH > Continue to lobby for more resources from GOI and the donor community. HCPI can support Indonesia by supporting comprehensive approaches and ensuring the collection of data to demonstrate the benefits and impact	DepHukHam, HCPI	
	Lack of continuity from IHPCP (including funding constraints imposed on IHPCP or a delay in HCPI commencing)	Contact with prisoners could be lost if resources are reduced during the IHPCP extension or services are temporarily discontinued (if HCPI is delayed), which could lead to an increase in HIV transmission, the collapse of some local NGOs, and a loss of support from participating prisons	2	4	H	> AusAID and GOI agreement for transition arrangements > Contracts for key partners will be negotiated by IHPCP, providing for continuous support from July 2007 to December 2008	GOI, GOA IHPCP, HCPI	IHPCP - Apr/May 2007 HCPI – Feb/Mar 2008
Component 5: Management	The PCC fails to meet or does not contain senior staff from the agencies represented or is ineffective when it does meet, no matter the membership	The effectiveness of the program could suffer from not gaining strategic direction, not having high-level support for proposed activities, or not having high-level linkages across agencies	3	4	H	Providing the PCC with an important, strategic role	KPA, AusAID and BAPPENAS	2007–08
	Failure to plan and implement activities within the GOI planning cycle	This could reduce the ability of HCPI to align its activities with those of Indonesian agencies, and reduce capacity building activities	3	4	H	> Place staff in GOI agencies, enter MOUs at provincial level which specify collaborative planning, and continually promote the cost-sharing principle > Prepare 'shadow plans' in anticipation of planning delays within government. Provide flexibility in HCPI funding to help minimise disruption from GOI funding delays	HCPI AusAID, HCPI	Continuous
	Confusion exists between the role of KPA, the Senior Program Coordinator (HIV) and	Lack of clarity on the roles and responsibilities could impact negatively on HCPI's ability to plan and implement	2	4	H	> Outline clearly the role and responsibility of KPA, AusAID and HCPI > Ensure regular meetings between KPA,	KPA, AusAID, HCPI	Continuous

Program area	Risk	Potential impact	L	C	R	Risk mitigation	Responsibility	Timing
	HCPI staff	activities				AusAID and HCPI > Prepare clear duty statements for the Senior Program Coordinator (HIV) and HCPI staff		
	Poor relationships between any of the key players (KPA, the Senior Program Coordinator [HIV] and HCPI staff)	Dysfunctional relationships could create mistrust and contribute to lack of strategic focus and momentum	3	3	M–H	> Regular formal meetings; regular informal dialogue; 'dealing direct' with each other to clarify assumptions and issues; raising early any issues which may have a positive impact on progress	KPA, Senior Program Coordinator (HIV) and HCPI staff	Continuous

The risk management matrix contains an assessment of risk based on the following criteria:

L = Likelihood of occurrence (1=Rare, 2=Unlikely, 3=Possible, 4=Likely, 5=Almost certain)
C = Consequence of occurring (1=Negligible, 2=Minor, 3=Moderate, 4=Major, 5=Severe)
R = Risk level – a combination of the above two assessments (E=Extreme, H=High, M=Medium, L=Low)

Further details relating to the likelihood and consequence scores, and resulting assessment of risk level are provided in AusGUIDElines (see www.ausaid.gov.au/publications - Ausguide

Attachment 12: Options considered and rationale for design approach

Technical and geographic focus

During the design process an option considered was to continue support for a comprehensive response (as provided by IHPCP) across six geographically dispersed provinces. This was rejected as spreading resources and expertise too thinly.

Another option considered was to retain national reach of the new program by scaling down project activities in Bali, South Sulawesi and NTT. It was decided that national reach can be achieved through benefits of national policy support, health sector strengthening and capacity building programs, rather than specific project work at district level.

Australia has a long history of support to HIV responses in Bali and the response has gained a strong reputation in the region as best practice. Bali's HIV response is supported by local leadership and there are opportunities to source support from other donors. Bali's prison pilot, however, requires continued support as a national and regional model. Recent data indicate that while injecting remains a significant factor driving the epidemic in Bali, the epidemic has evolved and the majority of new cases are caused by sexual transmission.

Surveillance and HDI data indicate that HIV-related needs in Papua and West Papua are the highest in Indonesia. Papua and West Papua should be accorded a clear priority for Australian support because of the unmet need resulting in potentially devastating and destabilising social and economic impacts of the generalised epidemic, and the proximity of Papua and West Papua to Australia. An additional factor is the similarity of the HIV epidemic in PNG to that of Papua and West Papua. Australia is the lead donor in the PNG HIV response and lessons learned from PNG can inform the Papua and West Papua response and vice versa, and Papua and West Papua can be supported by Australia's expertise in a comprehensive response developed over a long period of time.

Outside of Papua and West Papua, to maximise impact with limited resources, the program will focus on Australia's areas of comparative advantage, which are IDUs and prisons, guided by evidence of need. Evidence of need includes data on IDU populations, which clearly indicates that the majority of Indonesia's IDUs are in Java. Halting the rise of the epidemic in IDUs is crucial because of the role of IDUs in introducing HIV into new sexual networks and the efficiency with which HIV is transmitted via injecting.

Australia's focus should be informed by Australia's expertise (in Indonesia and Asia more broadly) in effective responses to IDU prevention, treatment and care needs including in prisons. IHPCP has pioneered a comprehensive prison response in the Bali prison, which is the first prison in Asia to offer a methadone program and which is being rolled out to other prisons in Indonesia.

It is anticipated that there will be significant resources for prisons available from GFATM, IPF, UNODC and DepHukHam and therefore AusAID's investment needs to be selective and highly strategic including a focus on policy and strategy support, planning and quality assurance in service delivery. The specific strategy for the Bali prison is to plan for a shift in funding responsibility to GOI authorities, while simultaneously maintaining an interest and promoting the prison as a best practice example for wider replication in Indonesia.

Aid modality

Options considered included continuing to implement through a traditional project model, placing an increased emphasis on policy and strategy inputs, and programmatic options

including GOI sectoral budget support or using donor pool approaches including IPF. The major models considered were:

(i) Re-tender IHPCP for a further five-year Phase 3 project with predetermined outputs and a planning process managed between the Managing Contractor and AusAID. This would have the advantage of retaining a distinct AusAID contribution to the HIV response and allow AusAID to maximise direct control of priorities and directions in a sometimes uncertain environment. However a project approach was considered too rigid and risks entrenching parallel systems. It was thought likely to constrain opportunities for donor harmonisation and may create 'donor dependency' in some localities in key technical areas, thus impeding long-term efforts to build GOI systems capacity for a sustainable approach.

(ii) A program approach (or HIV sector-wide approach) where most funds are directed to GOI budget support and/or a donor pool approach at provincial and district levels. AusAID's role in this model beyond financial contributions would be restricted to joint monitoring and technical assistance as requested. Such an approach was considered not to be a strategic use of available funds, risky in terms of uncertainty of other future key donor inputs especially GFATM, USAID and DFID through IPF, and premature given the low level of GOI and civil society systems capacity in planning, managing, accounting and delivering in key technical areas and decentralised localities, particularly in Papua and West Papua provinces.

(iii) An approach that focuses on KPA leadership and donor harmonisation. This would imply providing the bulk of Australian assistance directly to the IPF, while also funding some high-level policy and strategy inputs to support donor harmonisation and strengthen GOI management of IPF and GFATM processes. Under this model, AusAID would not predetermine areas of technical or geographic focus but rather allow decisions to be made collaboratively under KPA leadership through the IPF. In addition, services currently funded by Australia (e.g. outreach to IDUs and prevention activities in Papua and West Papua) would essentially cease, as KPA is a coordinating rather than service delivery body.

(iv) A hybrid approach tailored to current realties and which enables maximisation of impact and sufficient flexibility to adapt to a changing context.

Consideration was also given to tendering separate IDU/prison and Papua and West Papua projects rather than combining them under one program. It was decided, however, that there are distinct advantages of having a combined program due to the needed interaction between the capacity building component and both IDU/prisons and Papua and West Papua, and best practice could be highlighted more effectively at national level under a single program (particularly in relation to activities in Papua and West Papua).

Preferred approach and rationale

HCPI will focus on:

- supporting Indonesian leadership capacities
- a comprehensive response in Papua and West Papua, with initial emphasis on primary prevention, as well as health promotion to people who are HIV positive
- IDUs in localities with the highest levels of injecting drug use and highest prevalence of HIV, with priority accorded to Java, and
- prisons nationally.

The design is a hybrid project/program approach that supports progression towards a more fully programmatic approach as GOI advances in technical capacities and system strengths. There were a number of reasons for continuing with the project approach in the short to medium term, including: the low implementation capacity of GOI counterpart agencies, the need to oversight funding to NGOs as a delivery mechanism, the relatively low transaction costs for GOI due to a small number of donors focusing on HIV, and the need to strengthen

systems and capacity before moving to a programmatic approach. It was considered essential to build in flexibility and responsiveness to changes in the epidemic and institutional environment through annual planning processes.

There is a need to move to a programmatic approach in the longer term, as the capacity of GOI counterparts (in particular the KPA) increases. With the implementation of the new National Strategy and Action Plan, GOI will over time have a well-defined sectoral policy and strategy in place supported by public expenditure management, performance monitoring systems, access to funding through GFATM and other sources, and experience in implementing a sectoral response through government agencies. Furthermore, the need to work through government systems and coordinate with other donors upholds the 'Three Ones' principles, to which Australia and Indonesia are committed, and is consistent with commitments made in the *Paris Declaration on Aid Effectiveness* (OECD DAC 2005) and the *AusAID 2010* vision.

Other design aspects

A partnership combining Australian support

AusAID Jakarta asked the scoping mission to focus on improving coordination between the work of IHPCP and various other elements of Australian support to Indonesia's HIV response. These include engagement on policy and strategy issues including the GFATM and IPF, mainstreaming of HIV into AusAID's non-HIV programs, research, scholarships and capacity-building partnerships.

The design team supported the recommendation of the 2006 scoping mission that all elements of Australian support, including the new contracted program, be framed within a partnership structure. The partnership, to be known as the Australia–Indonesia Partnership for HIV (AIPH), will be a first step towards a programmatic approach and will support the gradual move towards GOI implementation. It will help GOA play a strategic role in supporting the implementation of partner government strategies and develop collaborative relationships based on specific policy objectives.

Another option considered was to support this partnership with three senior staff (as suggested in the Concept Paper) to be located in a Health Section (Program Director, Harm Reduction Technical Director and Comprehensive Response Technical Director). However this option was rejected as being too costly given available resources and the fact that technical expertise could be sourced by appointment of advisory staff by the contractor of the new program. The recommended option is the appointment of a Senior Program Coordinator, along with local support staff, who will work with senior GOI officials to oversee all elements of the Partnership and to bring coherence and strategic direction to its work. The Senior Program Coordinator (HIV) is to be located within the Health Section in AusAID Jakarta.

Duration

A partnership that is of eight years duration was decided upon as a long-term strategy aimed at achieving impact and building Indonesian capacity, particularly in areas with severely underdeveloped health systems such as the remote areas of Papua and West Papua provinces.

Program offices

It is recommended that HCPI establish its main office in Jakarta, preferably close to the KPA. This office will function as the hub of overall planning, management, and liaison between the program and KPA, provincial offices/components, and AusAID Jakarta. Another office will be established in Jayapura within the premises of the KPAP. Rather than establish separate offices in other provinces in which HCPI provides support, advisers will be placed within counterpart offices where and when possible. This will help build relationships between HCPI staff and counterparts, avoid the establishment and cost of separate offices (and support staff), and thereby contribute to the development of sustainable responses and increased local

capacity. Other than offices in Jakarta and Jayapura, it is therefore recommended that office facilities and support staff be kept to an absolute minimum, and that those that are initially required be phased out as soon as possible.