

**USAID/INDONESIA
HIV/AIDS EXPANDED RESPONSE STRATEGY
2002-2007**

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ACRONYMS AND ABBREVIATIONS

ABC	Abstinence, Be Faithful and Condom Use
AIDS	Acquired immune deficiency syndrome
ANC	Antenatal Care
ART	Anti Retro-viral Therapy
ASA	<i>Aksi Stop AIDS</i>
ASEAN	Association of Southeast Asian Nations
AusAID	Australian Agency for International Development
BKKBN	National Family Planning Board
BP	BP PLC
BPS	Central Bureau of Statistics
BSS	Behavior Surveillance Survey
CA	Cooperating Agency
CCM	Country Coordinating Mechanism
CSM	Condom Social Marketing
CDC & EH	Communicable Disease Control and Environmental Health
CUP	100% Condom Use Programs
DKT	DKT International
DOTS	Directly Observed Treatment, Short Course
DPR	National Parliament
DPRD	Provincial or District level People's Representative Council
ELISA	Enzyme-Linked Immuno-sorbent Assay
FHI	Family Health International
FSW	Female Sex Worker(s)
Gardunas	National Integrated Movement to Control Tuberculosis
GDA	Global Development Alliance
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GOI	Government of Indonesia
HAPP	HIV/AIDS Prevention Project
HIV	Human Immunodeficiency Virus
IBRD	International Bank for Reconstruction and Development
ICCM	Indonesian Consortium of Condom Manufacturers
IDHS	Indonesia Demographic Health Survey
IDP	Internally Displaced Person(s)
IDU	Injecting Drug User(s)
IEC	Information, Education and Communication
ILO	International Labor Organization
KfW	Kreditanstalt fur Wiederaufbau
KNCV	Royal Dutch Tuberculosis Association
KPA	National AIDS Commission
KPAD	Provincial/District AIDS Commission
LitBangKes	National Institute for Health Research and Development
Lokalisasi	Brothel Complexes
LNG	Liquefied Natural Gas
M&E	Monitoring and Evaluation
Menko Kesra	Coordinating Ministry for People's Welfare
MCH	Maternal and Child Health
MOH	Ministry of Health
MSM	Males Who Have Sex With Males
MSW	Male Sex Worker(s)
MTCT	Mother to Child Transmission
NGO	Non-Government Organization
NTB	West Nusa Tenggara
NTT	East Nusa Tenggara

PKBI	Indonesian Family Planning Association
PLWHA	Person Living With HIV/AIDS
PMI	Indonesian Red Cross
PMP	Performance Monitoring Plan
PNG	Papua New Guinea
PROPENAS	National Development Program
Rp.	Rupiah
RSCM	Cipto Mangunkusumo Hospital
RSKO	Drug Rehabilitation Hospital
SGS	Second Generation Surveillance
SO	Strategic Objective
SOAG	Strategic Objective Agreement Grant
STI	Sexually Transmitted Infection
SW	Sex Worker(s)
TB	Tuberculosis
TIP	Trafficking in Persons Report
TKI	Indonesian Export Workers
TNI	Indonesia's Armed Forces
UNAIDS	United Nations Joint Programme on AIDS
UNDCP	United Nations Drug Control Program
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on AIDS
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteers
UP	Universal Precautions
USA	United States of America
USAID	U.S. Agency for International Development
VCT	Voluntary Counseling and Testing
VSO	Volunteer Service Organization
Waria	Transvestite(s)
WB	Western Blot
WHO	World Health Organization
YARHS	Youth and Reproductive Health Survey
YKB	Yayasan Kusuma Buana

I. EXECUTIVE SUMMARY

USAID/Indonesia has supported Government of Indonesia (GOI) and community efforts to address HIV/AIDS since 1993. Indonesia's rapid economic growth of over a decade was abruptly reversed by the economic and political crises of 1997-98. As Indonesia struggles to regain its economic and political footing, many formerly lower-middle class Indonesians now find themselves without jobs and economic security, and with income levels at poverty scale levels. For a variety of reasons, many Indonesians are adopting coping behaviors that put themselves increasingly at risk to HIV/AIDS.

USAID/Indonesia's multi-sector responses to these broad crises are embodied in its 2000-2004 Country Strategy, "Transition to a Prospering and Democratic Indonesia". The health component of this strategy, "Health of Women and Children Improved", is supported through a Strategic Objective Agreement Grant (SOAG) between the GOI and USAID, and includes a major effort to address HIV/AIDS.

The HIV/AIDS strategy focuses on prevention and surveillance interventions for core-transmitter and bridge populations in ten priority geographic sites. The goal of the strategy is to keep HIV prevalence low in these populations at high risk, thereby preventing and delaying the spread of HIV throughout the vast Indonesian archipelago. This strategy fully supports the Government of Indonesia's National AIDS Strategy and is designed to complement other donor activities.

Recent epidemiological and behavioral surveillance data indicate that the incidence of HIV/AIDS is growing in Indonesia at a more rapid pace than previously seen. The number of new HIV cases in 1999 more than doubled those reported in 1995 and the cases reported in 2000 doubled the 1999 cases. Although surveillance data have not been widely available, it is clear that the epidemic is well established in several areas of Indonesia among specific key vulnerable groups -- sex workers (SW) and their clients, males who have sex with males (MSM), and more recently rapidly growing numbers of young, injecting drug users (IDUs). In Papua due to a variety of factors, including the absence of circumcision, the multiplicity of tribal-based cultural and sexual patterns, rapid modernization and extremely high migration and mobility, the epidemic has the greatest probability of rapidly moving into the general population than elsewhere in Indonesia. An expanded government, donor, and community response is warranted to prevent and delay the further spread of HIV throughout Indonesia.

This revised strategy for the period 2002-2007 is designed to provide the programmatic structure for an expanded USAID response to the HIV/AIDS epidemic in Indonesia. It takes into account a significant number of challenges that currently face Indonesia:

- A nation with vast geographic scope and diversity;
- A highly mobile population, including large numbers of mobile men with money working in the shipping and transport industries, in extractive industries, in export processing zones, in the military, and as tourists;
- The aftermath of a major economic crisis, including women in search of survival or opportunity, and increasing numbers of children living and working on the streets;
- A low perception of risk among the Indonesia population, including very low levels of condom use and lack of knowledge/misperceptions on how to treat sexually transmitted infections (STIs);
- Increasing unemployment among youth and an expanding injecting drug problem, especially among young, underemployed men in major cities;
- Low levels of investment in HIV/AIDS by the GOI (at the central, provincial and district levels) and limited donor participation and funding;
- A scarcity of laboratory testing and surveillance capacity;
- Relatively young and inexperienced non-government organizations (NGOs);
- Limited human resource capacity among both government and NGO staff; and

- A newly instituted, (and not fully defined), process of government decentralization of service delivery and revenue generation.

This strategy also takes account of a number of significant opportunities that positively affect the viability of an expanded USAID HIV/AIDS strategy:

- A growing awareness of the potential severity of the HIV/AIDS epidemic, especially among senior government leaders;
- An increased availability of condoms, including a functioning and expanding market for socially-marketed condoms;
- An HIV/AIDS response initiated relatively early in the epidemic;
- Lessons and program models from neighboring countries, such as Thailand, are available; and
- Decentralization provides an opportunity for effective locally designed and managed program initiatives.

The first phase (2000-2002) of USAID's activities focused on areas where local epidemics are clearly evident and expanding: Papua, DKI Jakarta, East Java (Surabaya/Malang), North Sulawesi (Manado/Bitung) and Riau (Pekanbaru and the Riau Islands). These programs will be expanded with the objective of 80% coverage of key vulnerable groups by 2007.

Five additional areas are identified for second-phase activities, which begin in 2002-2003: West Java (Bandung), North Sumatra (Medan), Central Java (Semarang), South Sumatra (Palembang), and the Maluku Islands (Ambon). The initial focus in these second-phase sites will be to start with surveillance and assessments of NGO and government program capacity. These programs will then expand to support focused interventions to reach selected most-at-risk groups, as well as complementary NGO and local KPAD capacity-building (provincial and district HIV/AIDS commissions), including the strengthening of government-supported services.

In these ten intervention sites, the Mission will have an excellent opportunity to meet USAID's expanded program goals: maintaining prevalence below 1% among 15-49 year olds and providing (in concert with other donors) a comprehensive package of prevention activities for 80% of the targeted population in 3-5 years.

A new element of this expanded strategy is a Care and Support component, linked to voluntary counseling and testing (VCT), which will be supported in all sites.

Papua province stands out as a region of Indonesia that deserves a somewhat different program strategy since it is at greatest risk of a more generalized HIV/AIDS epidemic.

Highest priorities in the expanded Indonesia strategy include:

- The development of effective surveillance systems in all ten sites.
- The finalization of the HIV/AIDS test kit analysis, the establishment of national test procedures, and support for VCT testing in each intervention area.
- The initiation of IDU interventions in priority urban sites to address the rapid expansion of injecting drug use among urban youth and young adults.
- Significant expansion of capacity development efforts for local NGOs and KPADs.
- Continued support for phased Mass Media Campaigns and initiatives including the design and implementation of sub-campaigns appropriate for the Papua and Riau areas.
- Increased efforts to encourage advocacy and participation in HIV/AIDS issues, activities and dialogue among senior-level government officials, nationally known personalities and respected religious leaders.

Budget and Management Support:

The pace of progress and expansion of USAID/Indonesia's 2000-2002 HIV/AIDS activity has been constrained by limited funds. With the availability of additional expanded program funding, the Mission will need to ensure sufficient staff resources for expanded program supervision responsibilities, donor collaboration, and increased HIV/AIDS advocacy among Indonesian leadership and other international donors. The management and technical capacity of the Mission's principal program implementing agency will also need to be carefully monitored, reviewed and expanded as is necessary to ensure that technical, capacity-building and policy areas are adequately addressed.

II. SITUATIONAL ANALYSIS

a. Introduction

Today Indonesia, the world's fourth most populous nation with over 210 million people, stands at a critical crossroads in the global transmission of HIV/AIDS. Like a number of its Asian neighbors, Indonesia maintained a very low HIV population prevalence through the late 1990s. Almost overnight, this situation is changing. Since the economic crisis of 1997 that devastated Indonesia's economy, and the fall of the Soeharto New Order government in 1998, Indonesia has begun to experience a national development challenge – a serious HIV/AIDS epidemic that is affecting key economic sectors and young populations across the archipelago. Over the last four years, massive political and economic disruption has produced dramatic changes in Indonesia's national-risk environment. Indonesia is now experiencing new, rapidly developing sub-epidemics of HIV in several provinces and communities. If Indonesia is to regain its status and footing as an ASEAN leader, the nation must strategically confront HIV/AIDS as a serious threat to Indonesia's national development and prosperity.

b. Changing HIV Infection Trends

The HIV epidemic gained a firm foothold in Thailand and India in the early 1990s, but remained an insignificant public health concern in Indonesia. Prevalence of HIV among Indonesia's most-at-risk population groups, including female, brothel-based sex workers and *waria* (transvestites) remained less than 1%. As of the mid-1990s there were limited numbers of HIV infections reported by the Ministry of Health. Since 1998 however, HIV prevalence rates in Indonesia have exhibited remarkable change. The number of new HIV cases reported in 1999 more than doubled those reported in 1995. In 2000, the number of new cases again more than doubled, and in 2001 the number of new HIV cases jumped by 82%. As of September 2002, 3,374 cases of HIV/AIDS have been reported in Indonesia (2,417 HIV cases and 957 AIDS cases). At the present time the largest number of *reported* HIV infections are found in urban Jakarta (DKI Jakarta), followed by Papua in the east and Riau province in the west. In September 2002 a national estimation workshop was convened by the MOH with wide representation of government, non-government, university and community sectors, in addition to donor technical assistance from USAID/ASA, WHO and UNAIDS. The new national estimates developed as a result of the consensus of all participating parties estimates a low of 90,000 and a high of 130,000 HIV/AIDS cases.

Despite Ministry of Health (MOH) efforts to implement routine sentinel surveillance monitoring of HIV and STIs in its 314 districts nationwide, Indonesia's Communicable Disease Control directorate is unable to provide comprehensive HIV/STI reporting of key population groups. As a result, Indonesia must rely on incomplete reporting when preparing annual HIV and STI prevalence reports.

Through the late 1990s Indonesia's HIV surveillance reports showed prevalence rates at less than 1% in most sentinel sites. As of 1998 and 2000 this situation began to show increased prevalence rate change in a number of sites in Papua (Eastern Indonesia) and Riau (Western Indonesia).

Indonesia's most recent surveillance data present a rapidly changing HIV environment. The 2000-2001 HIV infection rates range from 8.0% among female sex workers (FSW) in Tanjung Batu, a port city in Riau province (near Singapore/Malaysia) to 7.03% in Kotim in Central Kalimantan to 26.5% among brothel-based FSWs in the Papua port city of Merauke (bordering Papua New Guinea). In addition to FSWs the 2000-2001 data show rapid HIV infections among male-dominated subgroups including *waria*, clients and IDUs. In a study of *waria* working on Batam Island in Riau province a prevalence rate of 6.38% was found, and a newly completed study (August 2002) of *waria* in urban Jakarta shows a prevalence rate of 22.7 percent. In Wamena, Papua, an HIV prevalence rate of 3.0% was identified among male clients. Indonesia's most disturbing HIV prevalence data are that of the nation's newest risk group – an urban-based population of young, injecting drug users. HIV prevalence rates among this group of young adults have reached 48% in greater Jakarta and 45% in West Java in 2002, and 53% (2001) in Bali.

Indonesia maintains good reporting of donated blood to the Indonesian Red Cross. These data are considered to be one of the best markers of HIV prevalence among the general adult population in Indonesia. Since the onset of the economic crisis, the HIV prevalence rate has sharply increased in donated blood supplies. Between 2000-2001 and 1997-98 the HIV prevalence among this group increased forty-seven fold from .00148% to .06906%. From January – August 2002 the HIV prevalence rate among Red Cross donors shows a further spike to 0.1501%.

While the national HIV prevalence rate among Indonesia's adult population remains less than 1.0%, it is evident that the low prevalence rate among Indonesia's general population (210 million) masks the rapidly increasing new HIV sub-epidemics within groups of core transmitters. In Indonesia, as in any concentrated epidemic, accurate estimates of the size and distribution of HIV and related risk depend on accurate estimates of the size and distribution of the populations engaging in specific risk behaviors. As in most other countries, accurate estimates are conspicuous by their absence. In Indonesia the challenge of developing accurate estimates is complicated by a number of factors:

- ***The sheer size of the population.*** In a country of 210 million people, the fourth largest in the world, many of the estimation techniques that are feasible in smaller countries are simply not manageable.
- ***The geographic diversity of the country.*** Indonesia spans a distance of 4,688 miles from east to west, is home to more than 100 different ethnic groups with different cultural practices. Even if accurate estimates are available for one urban area, they cannot necessarily be used in other urban areas, and certainly can not be extrapolated to rural areas.
- ***Active migration.*** Millions of Indonesians move internally every year, and mobility is particularly high in many of the populations at highest risk for HIV. This is a challenge for prevention interventions, but it also complicates the process of estimating how many people are at risk at any given time
- ***Decentralization.*** Some agencies collect data that could contribute significantly to good estimates of population size for some populations at risk for HIV. However, because of recent decentralization laws, these data are very often not reported to a central or even provincial level. This is a significant obstacle to producing national estimates of HIV infection or risk.
- ***The politics of denial.*** Indonesia's democracy is young and fragile. Formal and informal coalitions are the rule at every level, and religious-backed parties are critical to maintaining those coalitions in the most important provinces. Religious leaders have not been quick to embrace the challenges of HIV prevention in Indonesia, and many continue to take a punitive approach to risk behavior. The political incentive at all levels is often, therefore, to deny the existence of such behaviors. This limits the support for developing accurate estimates of populations at risk for HIV at the local level, a level which is critical in this diverse and decentralizing country.

There have been numerous efforts centrally and provincially to develop correct estimates of at-risk populations and HIV estimations over the past decade. The results have proved to not be useful from the both the political or public health perspective. An April 2002 donor-initiated workshop to strengthen population size estimates yielded a new GOI commitment to move forward with a formal process to develop serious HIV estimates for Indonesia. In September 2002 the Ministry of Health convened a national HIV/AIDS estimation workshop involving key sectors as well as local, national and regional experts. The new national estimates, developed as a result of a consensus of the participating parties, estimated a low of 90,000 and a high of 130,000 HIV/AIDS cases for 2002. For the first time in Indonesia, population and HIV estimation exercises were developed for a variety of subpopulations exposed to HIV thorough their behavior or that of their sex partners. The exposure groups included in the estimate exercises were: IDU, Non-injecting partners of IDU, Female sex workers, Clients of female sex workers, Male sex workers, Regular female partners of male sex workers, *Waria*, Clients of *waria*, Regular male partners of *waria*, Prisoners, and Street children. Results of the 2002 National Estimation meeting are presented in Annex 1 (2002 National HIV Infection Estimates) and Annex 2 (2002 Provincial HIV Infection Estimates for USAID Intervention Areas).

Despite the lack of national HIV surveillance data in Indonesia, with the support of USAID and AusAID, beginning in the mid-1990's, several rounds of quality behavioral surveillance surveys have been conducted in Jakarta, Surabaya and Manado (USAID/ HAPP) as well as Bali, South Sulawesi and NTB (AusAID). These studies have yielded rich behavioral data on both client and sex worker sexual behaviors. Surveillance data from male clients of FSWs from Jakarta, Surabaya and Manado (HAPP 2000 data) indicate that these mobile males visit sex workers approximately once each month. Forty-one percent of these men surveyed reported that they had engaged in a sexual encounter with a FSW during the previous 12 months.

c. A Nation of Increasing Risks

Indonesia's new HIV prevalence data are even more disturbing when viewed in the context of *contributing risk factors*. Key contributing factors are:

- Low condom use
- High STI rates
- A vast unreported sex industry (formal and informal, female and male)
- Limited STI clinic and laboratory services
- A highly mobile population
- Rapidly expanding injecting drug use
- The aftermath of a major economic crisis (including women in search of survival or opportunities, increasing numbers of children and families living and working on the streets)
- Recent government decentralization with a changing, and still undefined, division of health care responsibilities between central, provincial and district governments.

High risk sexual behavior among individuals at risk continues while the use of condoms for disease protection remains low. Despite intensive behavioral change strategies and local interventions by NGOs, condom manufacturers and a social marketing campaign in targeted localities to encourage risk-reduction behavior, condom use remains far too low among men with multiple sex partners. While condom use among FSWs exhibited some improvement in the late 1990's, condom use by sex workers in major urban areas has sharply fallen as in some areas these women workers are forced to work independently or move underground with the closure of some organized brothel complexes.

There are also indications that STI health-seeking behavior among these same populations is on a decline, with increased numbers of at-risk men preferring STI self-treatment to clinic-based services.

Indonesia's trend in STIs remains high. The presence of STIs, other than HIV, increases vulnerability to HIV infection from 10 to 20%. Between 1996 and 2000 the presence of STIs among FSWs increased from 23% to 52% in Jakarta.

Quality STI clinics and laboratory services are available to the minority of Indonesians who can afford private sector services. Most STI clinics and services are currently presently supported by donor programs or by large private companies for their workers.

The population of Indonesia is unusually mobile. As a nation of islands, Indonesia's economy depends on a vast array of seamen and seafarers traveling through the archipelago on both domestic and international ships. With a vast natural resource base, Indonesia maintains large agricultural and extractive resource enterprises from east to west. While many of the agricultural plantations are near developed areas, most of the extractive industries, employing predominantly male labor, are located in remote, rural locations. In addition, the Indonesian military and police, estimated at approximately 500,000 men, maintain battalions nationwide, with frequent movements in and out of regions, from Aceh (Sumatra) in the west to Kalimantan and Sulawesi in the north, and Maluku, West Timor and Papua in the east.

Use of injecting drugs among young adults in urban areas throughout Indonesia has expanded rapidly in the last two years, especially among the sexually active group aged 18-29 years. While knowledge of HIV/AIDS is high among IDUs, this population group continues to engage in very risky behaviors, including the frequent sharing of needles, poor needle cleaning practices, sex with multiple partners and very low condom use. There is great concern among experts from the region that the rapidly changing injecting drug use patterns now seen among Indonesian urban youth could replicate drug use patterns and HIV prevalence rates present in Thailand and in Eastern Europe. Indonesian urban youth have easy access to inexpensive injecting drugs and studies reveal that despite knowledge of HIV/AIDS, condom use among this population group continues to remain very low.

Today Indonesia ranks third (after India and China) on the list of countries with the highest tuberculosis (TB) burden worldwide. TB is the third highest cause of mortality in Indonesia. The GOI estimates that up to 30% of new TB cases in Indonesia are attributable to HIV/AIDS. As the prevalence of TB is on the rise in Indonesia as well as globally, it is an increased cause of concern. People living with HIV are more susceptible to TB, one of the main opportunistic infections that kills people with AIDS.

On January 1, 2001 two decentralization laws went into effect that moved Indonesia from years of tight control to a far more decentralized and autonomous system of local governments, including financial decision making at the local level. Many national government service responsibilities, such as procurement, have been transferred to provincial or district governments. Local governments have been allowed somewhat greater taxation and revenue generation authority. New mechanisms of revenue sharing by the national government (block grants) are being instituted while program grants to ensure local funding for "national priorities" are being considered.

Communicable diseases, including HIV/AIDS, STIs and TB, are now district government responsibilities, while the MOH's Communicable Disease Control (CDC) program maintains support for strategic planning, resource mobilization and the provision of essential logistics (e.g. some drugs, vaccines and equipment). Transfer of authority to the district implies that decisions on planning and resource allocation will be taken at the local level. This constitutes a considerable risk for programs with positive externalities, including AIDS prevention and TB control programs. Decentralization also presents significant opportunities to encourage effective local planning and management of HIV/AIDS activities.

III. HOST COUNTRY STRATEGY AND ACTIONS

a. Indonesia's First National AIDS Strategy

Recognizing the threat that a widespread AIDS epidemic would pose on national development, the Government of Indonesia is committed to step up HIV/AIDS prevention and care and support efforts. Even before the first case of AIDS was reported in the country in 1987, a working group had been established by the Ministry of Health. Since then HIV/AIDS cases have been reported in 32 out of 33 provinces.

In 1994 Indonesia developed its initial National AIDS Strategy and created a National AIDS Commission. Indonesia's national strategy has promoted a national effort to control HIV/AIDS, carried out by government, non-governmental organizations, private sectors and communities through a multi-sectoral collaboration. Indonesia's national strategy aims to mobilize families and communities to protect themselves against HIV infection and seeks to ensure the appropriate treatment, care and support services for individuals and families infected by HIV. The following basic principles guide the national response to HIV/AIDS:

- HIV/AIDS control is implemented by community participation, with the government providing direction and supervision as well as creating a legal and policy environment in which to work;
- HIV/AIDS control measures should reflect religious and cultural values;
- Activities should be aimed at defending family welfare and resilience;
- HIV/AIDS prevention should be aimed at educating the public in order to prevent HIV transmission and to change risk behavior;
- Every individual has the right to obtain information on HIV/AIDS prevention;
- Policies, programs, services and activities should respect the dignity of HIV/AIDS patients and their family;
- Counseling should be provided prior to diagnosis and testing of HIV/AIDS and confidentially should be guaranteed;
- Laws and regulations should be in line with the principles of AIDS control; and
- Public services must not discriminate against HIV/AIDS patients.

Critical to the HIV/AIDS national strategy is the role of the National AIDS Commission (KPA). Established by presidential decree in 1994, the national commission brings together senior decision-makers from a number of social and economic sectors, and includes representatives of affected communities, religious leaders, local NGOs, private sectors and others. Similar committees have been formed and are now active at the provincial and district levels (KPAD). The national commission and local committees work to guide the response in locally appropriate ways in Indonesia's new system of decentralized local government.

Changes in government structure have influenced the national response to HIV/AIDS. At the present time the National AIDS Commission is under the leadership of the Coordinating Minister for People's Welfare, which positions HIV as a multi-sectoral issue rather than a health issue.

In its coordinating role, the National AIDS Commission identifies National Program priorities for the prevention and control of AIDS. The ten priority programs currently include: (1) Information, education and communications; (2) Prevention; (3) Testing and counseling; (4) Treatment and care; (5) Education and training for health workers; (6) Research and development; (7) Monitoring and evaluation (surveillance); (8) International cooperation; (9) Program institutionalization; and (10) Laws and regulations.

Key to the Indonesia's National Program is the role of international donor funding and cooperation. The 1998 economic crisis severely affected the GOI's ability to support health care services,

particularly disease prevention and surveillance activities in 359¹ districts. This year the national HIV/AIDS budget increased to US \$6,100,000. Over the next five years (2003 –2007) the national budget for HIV/AIDS is expected to rise to approximately US\$ 22.2 million per year. The financial and technical resources required to combat HIV/AIDS across a massive archipelago, has increased Indonesia's reliance on donor assistance, as is the case with other public health and development challenges currently facing Indonesia. In the field of HIV/AIDS, the GOI welcomes the transfer of technology and intervention assistance, particularly now as HIV prevalence rates soar across the archipelago and local governments test decentralized governance.

b. Planning the Second National AIDS Strategy

Following the signing of the Indonesian Government's Declaration of Commitment at the UN General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001 the Ministry of Health established an Ad Hoc Committee to initiate a review and update of the national strategy. In early 2002 a new Ministry of Health AIDS Strategy document was produced, serving as (1) a precondition to the GOI's proposal submission to the Global Fund (GFATM); and (2) an initial framework to the development of the multi-sectoral update the National AIDS Strategy. In April 2002 the Secretariat of the National AIDS Commission established a representative Steering Committee to oversee the development of the National AIDS Strategy, beginning in July 2002. Unlike the previous national strategy, this new strategic planning process includes the participation of relevant ministries, affected communities, civil society institutions, academic and medical institutions, the private sector and all levels of government (national, provincial and district) in extensive consultations, dialogue and analysis. This process is being jointly funded by the major donor partners active in the sector (UNAIDS, USAID, AusAID) and is supported with specialized technical assistance from the USAID and other donor programs. The nine programmatic areas of the new strategy are to include:

- Reduction of vulnerability of specific populations; (including IDPs and migrants)
- Promotion of safer sexual behavior;
- Promotion and distribution of condoms;
- Treatment and care of sexually transmitted infections;
- Safeguard of the blood supply;
- Promotion of safer injecting drug behavior;
- Treatment and care of people living with HIV/AIDS;
- Social and economic support for people living with HIV/AIDS;
- Laws and regulations.

It is expected that this new strategy development process will conclude in December 2002 at a national consensus meeting, with a completion date of January 2003. Challenges the GOI will face with the implementation of the new National Strategy are rising budgetary requirements during a period of increasing fiscal constraints on social welfare spending, heightened religious conservatism, and a growing population of citizens living with AIDS. Addressing these challenges will require increased attention to coordination from the National AIDS Commission, national and local advocacy for HIV/AIDS, and strengthened management of the very limited national and donor resources available for HIV/AIDS prevention and care.

¹ As of October 24, 2002 Indonesia's Association of Local Governments report a total of 88 urban (*kotamadya*) and 271 rural (*kabupaten*) districts for current total of 359 districts.

IV. CURRENT RESPONSE

a. Description of USAID's 2000-2002 HIV/AIDS Activity

USAID/Indonesia's HIV/AIDS assistance to Indonesia from 1993-1999 totaled approximately US\$ 26 million in bilateral, core and regional funding. From FY94 - FY99 USAID supported the *HIV/AIDS Prevention Project (HAPP)*, a collaborative activity of USAID and the Ministry of Health with a focus on: (1) facilitating the development and initial implementation of policies supporting HIV/AIDS prevention and control; (2) supporting effective program interventions to reduce HIV and STI transmission through behavior change, including condom use; and (3) technical assistance and the capacity-building of NGOs to manage outreach activities targeting individuals at highest risk. (See Annex 3, the Assistance Completion Report (ACR) for the *HIV/AIDS Prevention Project*.)

In 1998, USAID/Indonesia prepared a "Crisis and Recovery" country program strategy to focus efforts on mitigating the impact of Indonesia's economic and political crisis. In response to a new set of challenges directly affecting the health of Indonesia's most vulnerable citizens, its women and children, USAID/Indonesia entered into a Strategic Objective Agreement Grant (SOAG) with the Government of Indonesia in August 1999 with the purpose and strategic objective of "***Protecting the Health of the Most Vulnerable Women and Children***".

In 2000 as the Indonesian economy appeared to stabilize and show signs of improvement, USAID/Indonesia was requested by the ANE bureau to revise its country strategy once again, this time focusing on the principles of support for reform to broaden the economic transition and strengthen the capacity of key institutions to meet the priority needs of the Indonesian people. USAID/Indonesia's new Country Strategy "***Transition to a Prospering and Democratic Indonesia,***" approved in September 2000, is a four-year strategy for the period September 2000 – 2004.

As part of the current country strategy, USAID/Indonesia's revised strategic objective (SO 8) for its health program continues to protect the health of the most vulnerable women and children. As Indonesia recovers from the economic crisis and as democratization takes root, USAID's health strategy has evolved into a three-pronged approach supporting the supply and demand aspects of health within the context of decentralization. Firstly, the strategy works to improve the enabling environment in accordance with health reforms underway. Secondly, the strategy works to strengthen the capacity and commitment of the GOI and the private sector, particularly at the district level, to meet the needs of the people. Thirdly, the strategy works to help individuals and communities to participate more fully in building a healthy Indonesia.

To achieve the overall Health Strategic Objective, USAID/Indonesia manages an activity portfolio to ensure the following three Intermediate Results (IR):

- **IR1: *Policy environment for reproductive and child health, HIV/AIDS and infectious diseases improved;***
- **IR2: *Health service systems are strengthened to improve access, quality and sustainability; and***
- **IR3: *Women, families and communities are empowered to take responsibility for improving health.***

HIV/AIDS and other infectious diseases are one of five program components (family planning; maternal and child health and nutrition; HIV/AIDS and other infectious diseases; complex emergency responses; and decentralization) in which activities are supported and implemented. Within the *HIV/AIDS Component*, USAID/Indonesia has prioritized **five Sub-Intermediate Results (Sub-IRs)**:

**Table I.
SOAG Intermediate Results and HIV/AIDS Sub-Intermediate Results**

Intermediate Results	Sub-Intermediate Results
<i>IR1: Policy environment for reproductive and child health, HIV/AIDS and infectious diseases improved</i>	<i>Sub IR 1.1: Increased leveraging of programmatic interventions and financial resources.</i>
<i>IR2: Health service systems are strengthened to improve access, quality and sustainability</i>	<i>Sub IR 2.1: Strengthened quality, accessibility and utilization of prevention, care and treatment services for individuals most-at-risk for STI/HIV/AIDS.</i> <i>Sub IR 2.2: Enhanced capacity and quality of GOI HIV/STI surveillance systems and their use in decision-making.</i> <i>Sub IR 2.3: Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI responses.</i>
<i>IR3: Women, families and communities are empowered to take responsibility for improving health</i>	<i>Sub IR 3.1: Increased risk reduction behavior and practices among individuals most-at-risk for HIV and sexually transmitted infections.</i>

In August 2000 Family Health International (FHI) was awarded a three-year, US \$13.9 million cooperative agreement (August 1, 2000 – July 31, 2003) to manage and implement USAID/Indonesia's *STI/HIV/AIDS Prevention Support Program*. Known locally as *Aksi Stop AIDS* or *ASA*², the program works in partnership with the Ministry of Health's Directorate General for Communicable Disease Control and Environmental Health (MOH/CDC & EH) and local government offices and civil society organizations.

The ASA technical strategy supports prevention and surveillance interventions for core-transmitter and bridge-population groups in ten priority geographical sites in order to reduce risk behaviors. The goal is to keep HIV prevalence in the population low, thereby preventing and delaying the spread of HIV throughout the Indonesian archipelago. ASA's intervention strategy to reach core transmitter and bridge population groups is a part of the GOI's 1994 national prevention strategy for HIV and other sexually transmitted infections. *The ASA strategy is based on substantial, worldwide epidemiological evidence regarding the transmission of HIV epidemics. HIV prevalence rises initially in core transmitter groups (including FSWs, MSM and IDUs), then gains a critical mass, allowing the epidemic to be sustained, and then spread on to the general population. Male clients of sex workers serve as the primary epidemiological "bridge" to the general population, transmitting HIV to their wives, girlfriends or other sexual partners. Targeting the core-transmitter and "bridge" population groups with intense prevention resources and interventions works to reduce the risk behaviors of these population groups, thereby maintaining low HIV prevalence, and preventing and/or delaying its spread to the entire population.*

To maximize the limited resources for HIV/STI prevention in Indonesia, together, the GOI, USAID and FHI identified ten priority geographical areas for program support where either high densities of

² In Bahasa Indonesia ASA means "hope".

the specified population groups are present or epidemiological and behavioral evidence suggests an escalating epidemic. (see Annex I)

In a phased implementation approach, priority support is designated for communities most-at-risk in (1) Papua, (2) DKI Jakarta, (3) East Java (Surabaya/Malang), (4) North Sulawesi (Manado/Bitung) and (5) Riau (Pekanbaru and the Riau islands) in Years One and Two. Program expansion to (6) West Java (Bandung), (7) North Sumatra (Medan), (8) Central Java (Semarang), (9) South Sumatra (Palembang), and (10) Maluku (Ambon) follows in Years Two and Three of implementation.

b. Other Donor Activities

During the period 1993-99 the donor community, including USAID, invested up to US\$ 79.0 million in assistance activities to support the GOI's national HIV/AIDS prevention program. Since the 1997-98 economic and political crisis, donor participation and funds for health programs in general, and HIV/AIDS in particular, have shown a dramatic decline in Indonesia. During the period 1997-99 only 5% of donor funding (US\$ 97.9 million) to Indonesia was provided to support the health sector³. In addition to the USA, major donors providing HIV/AIDS assistance to Indonesia prior to the fall of Soeharto's New Order Government in 1998, included: the UN Agencies of the World Health Organization (WHO) and the Joint UN Programme on HIV/AIDS (UNAIDS); the World Bank; the Australian Agency for International Development (AusAID); and the Kreditanstalt für Wiederaufbau (KfW). Along with USAID contributions, average annual donor commitments to HIV/AIDS in the late 1990s averaged US\$ 13.0 million per annum.

Today bilateral and multilateral support for HIV/AIDS in Indonesia has reduced to only three bilateral donors -- USAID, AusAID, and KfW, and the bilateral UN Agencies (WHO, UNFPA, UNICEF, ILO and UNAIDS). In 1999 the World Bank prematurely closed its large HIV/AIDS project due to management and implementation difficulties. Of a total IBRD credit of US\$ 24.8 million, only 16% of the funds were actually expended.

As HIV sero-prevalence rates rapidly rise among sub-populations across the nation, the availability of external resources for HIV/AIDS is at its lowest point in five years. During the last fiscal year (FY01), USAID's contributions totaled US\$ 5.0 million, with KfW contributions of US\$ 3.0 million, minimal funding from AusAID (awaiting the start-up of new procurement), and a UN agency budget of approximately US\$ 2.0 million. With 2001-2002 donor funding at less than US\$ 11.0 million, the US Government's contribution remains a major part of HIV/AIDS donor assistance in Indonesia.

The issue of coordination and collaboration of international donors working in HIV/AIDS in Indonesia has remained a constant constraint in the sector. Over the past decade there has been uneven coordination of HIV/AIDS donor programming, planning and budgeting among donors and the GOI. Since the late-1990s the USAID and AusAID programs have worked closely together to coordinate program design and activity management to minimize duplication and maximize use of resources. This is particularly important as both the USAID and AusAID HIV/AIDS initiatives are comprehensive strategies supporting similar types of activities and assistance packages. Collaboration between the two programs has been most pronounced in the area of behavioral surveillance survey management, but more recently has expanded with the funding of joint initiatives and expanded multi-sectoral assistance to the GOI and local AIDS commissions. Today both the American and Australian governments recognize their strong relationship and coordination as critical elements of their respective HIV/AIDS strategies in Indonesia. Since the start-up of the ASA program in 2000, USAID and the KfW implementing agency, DKT International, have worked to create a new collaborative climate in the areas of prevention and condom promotion. Today DKT is a key ASA collaborating partner, with joint planning and coordination at the activity level.

³ October 9, 2001 OECD/DAC International Development Statistics for the Health Sector.

The active participation of fewer numbers of donors in the HIV/AIDS sector in Indonesia has begun to have a positive impact on the issue of donor coordination in Indonesia. The availability of limited resources has forced the GOI and its donor partners to reach out and work together. In the development of the Mission's 2000 HIV/AIDS strategy, lengthy negotiations were conducted by Mission staff with the Ministry of Health and international donors to identify and prioritize activity intervention areas. In January 2002 UNAIDS launched a new initiative to revitalize a long dysfunctional donor coordination mechanism with the support and encouragement of the USA, Australian and German bilateral programs. Currently the UNAIDS HIV/AIDS Working Group meetings on a monthly basis with the participation of some government officials, the major donors (including USAID), the private sector and active domestic and international non-governmental organizations. Donor participation and technical assistance in the GOI's on-going efforts to draft a new National Strategic Plan for HIV/AIDS is an example of the new form of donor collaboration seen in Indonesia today.

The UN Agencies

With a 2002 annual HIV/AIDS budget estimate of up to US\$ 2.0 million the UN agencies form the UN Theme Group, including WHO, UNICEF, UNDP, UNFPA, ILO, UNDCP, World Bank, UNESCO, and UNAIDS. Aside from UNAIDS and UNFPA, the majority of UN initiatives in HIV/AIDS have largely been small pilot projects or ad hoc activities. The ILO is currently in the process of developing an HIV/AIDS strategy which will focus on migrant workers and mobile population groups, and UNICEF is expanding into HIV/AIDS with the hiring of new HIV/AIDS technical experts in mid-2002.

Current funding for HIV/AIDS includes WHO funding of one expatriate and one local medical officer for STI/HIV/AIDS as well as support for the 100% condom use pilot project in Papua and a methadone substitution pilot in Jakarta and Bali. UNICEF continues to support a life skills education project with the Ministry of Education, which includes sexual behavior and prevention elements working in six provinces. UNICEF also supports one full-time HIV/AIDS advisor. The UNDP works to mainstream HIV/AIDS as part of its overall program portfolio and is currently funding the on-going National HIV/AIDS Strategic Planning process involving both government and non-government contributors. The UNFPA supports a new four-year (2001-2005) prevention effort through NGOs as part of its reproductive health program support to the National Family Planning Coordination Board (BKKBN), the "Prevention of STI and HIV/AIDS Transmission among High Risk Groups" in four provinces: South Sulawesi, West Kalimantan, West Java and Nusa Tenggara Timor. ILO's recent participation in HIV/AIDS has supported related research on social and economic security, plus the completion of a research study on migration, mobility and HIV/AIDS. Currently UNDCP is in the process of planning a new regional program, which includes activities for Indonesia. USAID's IDU component plans coordinated programming and collaboration with future UNDCP-sponsored activities. The World Bank is planning a study on decentralization and communicable disease control, which is purported to include HIV/AIDS and TB as a part of its Provincial Health Project. UNESCO has supported various efforts to strengthen HIV/AIDS in education curriculum nationally, as well as an informal education project in Bandung.

The role of the UNAIDS country program in Indonesia changed significantly with the arrival of a new Country Programme Advisor in April 2001, filling a seat vacant for nearly two years. It is the aim of UNAIDS in Indonesia "to provide leadership in the response to HIV/AIDS, including the promotion of sound principles and effective responses". Coordinating the UN response (the UN Theme Group) to HIV/AIDS in Indonesia, UNAIDS has focused efforts on support for pilot efforts and the promotion of dialogue with the National AIDS program, including the National AIDS Commission (KPA), NGOs, and ASEAN. Major thrusts for UNAIDS have included support and technical assistance for Indonesia's participation at the 2001 UNGASS, World AIDS Day, and an on-going leadership role in facilitating technical assistance needs in the development of Indonesia's new National Strategy for HIV/AIDS.

AusAID

In the current year AusAID will transition from Phase 1 of its *HIV/AIDS Prevention and Care Project* (1995-2001) into a new, five-year (2002-7) Phase 2 project. Due to delays in the new procurement, AusAID has continued to provide limited project funds to key NGO partners during a “care-taker period” since the closeout of Phase 1 in mid-2001. AusAID anticipates Phase 2 mobilization to begin in mid-2002 with a life of project budget of AS\$ 34 million. (US\$ 18.5 million). An expansion of Phase 1 activities, AusAID’s new program strategy complements USAID’s approach to STI/HIV/AIDS prevention and care. The underlying principle of the AusAID approach is to reduce vulnerability through targeted approaches. Applying a “rolling design” strategy to allow for program flexibility, the purpose of the program is to facilitate an expanded multi-sectoral response to HIV/AIDS in designated provinces and districts. Key elements of the program include: (1) capacity building for the National AIDS Commission, provincial and district level AIDS commissions and NGOs, (2) HIV prevention interventions targeted to sex workers and clients, MSM, youth, and IDUs; and (3) treatment, care and support for persons living with AIDS as well as vulnerable groups. The geographical coverage of Phase 2 will continue program support in Bali, South Sulawesi and NTT with planned expansion to three new provinces to include: DKI Jakarta, Papua, and West Java/Banten. Unlike other HIV/AIDS program designs, AusAID requires its selected management agency to maintain open communications and coordination to avoid duplication and make best use of program resources at the national level and in those provinces where other donor (i.e., USAID) agencies work.

KfW

The Development Reconstruction Bank of Germany (Kreditanstalt für Wiederaufbau) has supported the social marketing of condoms through DKT International since 1996. Working under the umbrella of the Ministry of Health (MOH) and the National Family Planning Coordination Board (BKKBN) to social market condoms and other contraceptives, DKT’s current program (Phase II) continues through 2003 with annual funding of US\$ 3.0 m. in KfW soft loan funds as well as contributions of US\$ 0.2 m. from the GOI. In support of HIV and STI prevention, DKT manages the procurement, packaging, distribution, marketing and promotion of the *SUTRA* brand condom. Initially marketed at reduced (subsidized) cost, since March 2002, *SUTRA* condoms are sold at the local market price. DKT’s current social marketing program works in 12 urban areas across the country focused on at-risk, heterosexual consumers, including sex workers and clients. DKT’s social marketing strategies include a major mass media strategy using television and print venues; NGO partnerships supporting small-scale activities, IEC materials, and condom revolving funds. Intensive marketing strategies pushing non-traditional outlets has helped to expand Indonesia’s overall retail condom market from 30 million units to 60 million units per annum in 2001. A new strategic approach utilized by DKT to expand the condom market is expanded collaboration with USAID’s ASA program in terms of sharing research and the shared programming of complementary behavior change activities and mass media to reach target consumers and audiences (i.e. highway and port-based activities, military and police audiences).

V. USAID’s EXPANDED RESPONSE

a. Strategic Approach

The Indonesia HIV/AIDS strategy focuses on prevention and surveillance interventions for core-transmitter and bridge populations in ten priority geographic areas (see Map in Annex 1). Nationwide, these populations include female sex workers, males who have sex with males (including male sex workers); injecting drug users (including youth and young adults) and the bridge population of clients of sex workers. The goal of the strategy is to keep HIV prevalence low in these

populations most-at-risk, thereby preventing and delaying the spread of HIV throughout the vast Indonesian archipelago. This strategy fully supports the GOI's national AIDS strategy, GOI and USAID geographical priorities and is designed to complement other donor planning.

This expanded strategy retains the two-phase, ten target area program approach initiated in 2000. The first phase focuses on areas where local epidemics are clearly evident and expanding and where USAID activities currently have a comparative advantage. Phase one areas include: (1) Papua, (2) DKI Jakarta, (3) East Java (Surabaya/Malang), (4) North Sulawesi (Manado/Bitung) and (5) Riau (Pekanbaru and the Riau Islands). This program will be expanded with the objective of 80% coverage of groups most-at-risk by 2005.

Five additional areas are identified for second-phase programming to begin in 2002-2004. Phase two areas are those new to the USAID program, having little experience and/or capacity in HIV/AIDS programming, or in on-going conflict regions (the Maluku). The phase two areas include: (6) West Java (Bandung), (7) North Sumatra (Medan), (8) Central Java (Semarang), (9) South Sumatra (Palembang) and (10) the Maluku Islands. In all ten sites, the Mission will have an excellent opportunity to meet USAID's expanded program goals: to maintain prevalence below 1% among these 15-49 year olds in Indonesia, and to provide a comprehensive package of prevention activities for 80% of the targeted population over the next 3-5 years in collaboration with other donor programming.

A new element of this expanded strategy is a Care and Support component, linked to voluntary counseling and testing (VCT), which will be supported in most, if not all sites.

The province of Papua stands out as an area that deserves a somewhat different program strategy since it is the one region of Indonesia at the greatest risk of a more generalized HIV/AIDS epidemic. Papua's reported HIV/AIDS cases constitute approximately 33% of reported cases in Indonesia although Papua contains only 1% of Indonesia's total population. Some of this contrast may be a result of the relatively high levels of surveillance and testing in some Papuan cities. However, Papua's cultural and sexual practices among a largely tribal population (e.g. absence of circumcision), combined with rapid modernization in areas affected by extractive industries and fishing industries, low levels of education and awareness, high rates of internal and external migration, and very limited health services all combine to make Papua unusually vulnerable to the spread of a more generalized HIV/AIDS epidemic.

Key priorities elements for program expansion in Papua will include:

- Expanded awareness and IEC/media campaigns, moving from the current intervention sites highland, interior regions and secondary cities partnering with increased numbers of NGOs, tribal and church groups, with increased emphasis on youth programming.
- Expanded STI and HIV/AIDS laboratory testing services in up to eight sites after careful analysis of capacity constraints.
- Significantly expanded epidemiological and behavioral surveillance development assistance.
- Expanded partnerships with private sector entities, particularly the large extractive industries (mining, timber and oil including the new BP GDA collaboration in the Bird's Head region).
- Initiation of a major Papua-specific prevention marketing campaign, drawing from similar approaches used in Papua New Guinea (PNG).
- Initiation of care and support activities and encouraging persons living with HIV/AIDS (PLWHA) to organize and to present a "Papuan face" to break down the "not us" stereotype.
- Collaboration with UNICEF/WHO on pilot MCTC programs.
- Close collaboration with AusAID to ensure synergistic use of donor resources in Papua.
- The leveraging of significant financial contributions for HIV/AIDS programs from the increased budgetary resources of Papuan local governments, as well as from "local development funds" provided by some large extractive industries.

b. Expanded Response Priorities

Activities and technical support of highest priority in the expanded strategy with additional funding resources are:

- 1) The development of effective surveillance systems in all ten sites.
- 2) The finalization of the HIV/AIDS test kit analysis, the establishment of national test procedures, and support for VCT testing in each intervention area.
- 3) The initiation of IDU interventions in priority urban sites to address the rapid expansion of injecting drug use among urban youth and young adults.
- 4) The expansion of NGO capacity building efforts including the strengthening of technical capacity; encouragement of the *NGO forum model* at all program sites; expansion of *nodal or "hub" models* linking intervention efforts between sites where feasible; and the start-up of collaborations with international volunteer organizations placing experienced volunteers with key NGOs.
- 5) The provision of increased technical support and assistance to the provincial and district level AIDS Commissions (KPAD) to: assist in the clarification of provincial and district responsibilities; ensure wider non-government participation; the replication of one or more truly functional KPAD models; and the encouragement of increased budgetary resources by provinces and districts in KPAD-sanctioned programming.
- 6) Continued support for phased Mass Media Campaigns and initiatives including the design and implementation of sub-campaigns appropriate for the Papua and Riau areas.
- 7) Increased efforts to encourage advocacy and participation in HIV/AIDS issues, activities and dialogue among senior-level government officials, nationally known personalities and respected religious leaders.

c. Indonesia's HIV/AIDS Results Framework

Indonesia's Results Framework, including the five sub-intermediate results follow in sequence of HIV/AIDS programming priorities for Indonesia, as presented in the Mission's 2000 HIV/AIDS Strategy, and confirmed by the Indonesia HIV/AIDS Strategy Review Team visit in early 2002. The key intermediate results are numbered to correlate directly with the Mission's SOAG Three Intermediate Results presented in Table I. on page 15 above.

(1) Sub-Intermediate Result 3.1

Increased risk reduction behavior and practices among individuals most-at-risk for HIV and sexually transmitted infections

The complex political, economic and social crisis in Indonesia continues to have a major impact, especially in hard-hit urban areas, on household income and health-seeking behaviors. Expected impacts on health include increased levels of risk behaviors involving commercial sex and injecting drug use. The crisis may also exacerbate the spread of sexually transmitted infections (STIs), including HIV/AIDS.

USAID's technical approach to HIV prevention is based on global experience and substantial epidemiological evidence regarding the trajectory of HIV epidemics. Current epidemiological

evidence indicates that this strategy is appropriate for Indonesia. Therefore, the USAID HIV prevention approach focuses on the four most vulnerable population groups:

- Female sex workers (FSW)
- Clients of sex workers (the main epidemiological bridge group to the general population)
- Injecting drug users (IDU)
- Males who have sex with males (MSM), including male sex workers (MSW)

This approach will ensure that 1) a critical mass of mutually-reinforcing interventions are developed for core and bridge groups in the priority local areas and 2) monitoring and surveillance systems are in place to confirm that the interventions are leading to significant behavioral change. Program resources will be concentrated in ten priority provinces where either high density of the specified core groups are present or behavioral and epidemiological evidence suggest an escalating epidemic, as agreed upon by the GOI and USAID. The strategy will allow for the testing of new and innovative approaches to communication for behavior change in order to affect increased risk reduction behavior, condom use practices, and complementary health seeking behaviors among individuals at most risk of infection. There will be continued use of mass media and printed information, education and communication (IEC) materials and peer education approaches with FSW and MSW, their clients, transvestites, other MSM, IDU, and other identified population groups most-at-risk (e.g., specific Papuan tribes). While the development and piloting of new and different behavior change approaches and models appropriate to specific target groups will be key to motivate improved risk reduction practices, the focus will be on implementing scaled-up activities, based on previous global as well as Indonesia-specific lessons learned.

1. Female Sex Workers

Problem discussion

FSW in Indonesia are stigmatized because of their occupation. As a result, FSW tend to stay away from government health clinics and services, and often will also stay away from NGO clinics and services that are not affirmatively FSW-friendly. In most Indonesian cities, establishment-based FSW are concentrated in *lokalisasi* (*de facto* concentrations of “locally accepted” commercial sex establishments of brothels, massage parlors, etc.) and therefore are theoretically identifiable and easier to reach. Recently there have been some moves by religious, and sometimes political groups in some cities, including Jakarta and Palembang, to close down the *lokalisasi*. While these efforts have had varying degrees of success, they will continue to be a factor in the HIV prevention strategy of implementing NGOs and government. Experience with already-closed *lokalisasi*, and from other parts of the world, suggests that the sex industry will not cease to exist, but will disperse “underground”. Already, in Jakarta, the closing of the *Kramat Tunggak lokalisasi* has resulted in the development of pockets of commercial sex based on the street, in fixed sites in “entertainment” areas and in discrete outlying areas. In any case, government agencies serving the social and public health needs of the *lokalisasi* will not be able to effectively reach these populations. Similarly, the role and activities of NGOs serving populations at high risk will have to adjust to remain effective. Already existing street-based FSW require a different approach than that used to reach those in *lokalisasi*. Finally, FSW in Indonesia are a very mobile population, with large proportions of FSW traveling from one part of the country to another on a frequent basis.

Expanded program response

USAID/Indonesia plans to support and expand interventions directed at FSW, including:

- Replicating and expanding successful NGO education and outreach efforts among FSW, with the goal of greatly increasing coverage of this key at-risk population;
- Instituting models of FSW peer led interventions, which focus efforts on addressing the needs of FSW, stressing greater and more meaningful involvement of program beneficiaries. Models that empower sex worker networks should be supported, helping community-based

groups, including local sex worker networks with the potential to become sex worker associations, to become service organizations;

- The testing of new 100% condom use interventions in specific sites;
- Localized strategies to reach street-based, independent and highway-based FSW; Complementary interventions for FSW should seek to influence local government, other authorities, managers, pimps, and others whose livelihoods are linked with sex work; and
- Building the capacity of FSW to actively participate in the planning and management of their own drop-in centers and outreach programs.

2. Strategies Targeting MSM

Problem discussion

In Indonesia same sex sexual relations is a highly stigmatized behavior; therefore, like FSW, MSM, including MSW, generally do not access government clinics and services for STI treatment, and only access NGO clinics and services when such services specifically target MSM, or are otherwise viewed as MSM-friendly. MSM and MSW are often a bridge to the general population as many MSM and MSW who do not identify as gay also have sex with female partners. Additionally, reaching *waria*, who very often sell sex, either full-time or in addition to other employment, requires different strategies than that used for reaching other MSM. USAID/Indonesia presently supports limited, but growing, MSM outreach interventions, including creative and seemingly successful community-oriented *waria* activities in Jayapura, Papua.

Expanded program response

USAID/Indonesia will strengthen and expand its MSM work by:

- Increasing support for the collection and analysis of MSM behavioral and seroprevalence data, to include data on non-gay/non-SW MSM, MSW, *waria*, and self-identified gay populations;
- Instituting models of MSM peer led interventions, which focus on addressing the needs of program beneficiaries. Models that empower MSM networks will be supported, helping community based groups to become service organizations, with the goal of having at least one USAID-supported MSM organization in each of the USAID-focus provinces;
- Working through existing networks and organizations of *waria* and other MSM sub-groups to enhance the coverage and quality of behavior change interventions that reach these groups;
- Linking with the condom social marketing activities supported by DKT for more effective condom promotion to MSM, both identifiable MSM like MSW, *waria*, and gays, and the larger population of MSM hidden in the general male population; and
- Where appropriate, replicating successful models of visible community-oriented MSM prevention activities, as a means of getting the message out as well as a means of reducing stigma.

3. IDU Focused Strategies

Problem discussion

Injecting drug use is a highly stigmatized behavior that puts individuals at high risk for HIV. Furthermore, injecting drug use is an illegal activity that is very often prosecuted by authorities. Therefore, both stigma associated with the activity and fear of exposure and arrest make it difficult to reach this group with prevention messages and services. In an effort to avert or delay the development of an acute HIV epidemic among IDU (the majority of whom are between the ages of 15 and 30) in Indonesia, USAID is supporting selected parts a comprehensive approach to prevention among IDU. In order to ensure impact, the implementation of this approach must be coordinated with other stakeholders/donor agencies. In the past, such coordinated programs have

included: gaining the support of policymakers and stakeholders; penetrating the social networks of IDU in locations where they congregate; establishing effective outreach teams and drop-in centers to reach IDU; building a peer-driven program whereby *IDU network leaders* are involved in the actual implementation of HIV prevention activities and condom promotion; and promoting use of drug treatment and substitution programs, HIV counseling and testing, and primary health services. Just as such USAID-supported IDU interventions are gaining momentum, new data collection shows an alarming escalation of tested IDU to be HIV positive. Additionally, a growing pool of middle and higher class youth and young men are engaging in injecting drug use as the price of locally available narcotics have fallen over the past year.

Expanded program response

USAID/Indonesia will rapidly strengthen its IDU related activities by:

- In the short-term, prioritizing the scale-up of IDU interventions over the scale-up of other target population interventions, as recent prevalence data for IDU demonstrates the urgency of the issue;
- Expanding peer-led IDU outreach activities, both in the areas presently covered, as well as in new areas in coordination with the AusAID program, such that there will be IDU prevention activities in each GOI priority site;
- Linking IDU prevention activities with DKT and other condom promotion activities, as most IDU in Indonesia are young and sexually active; and
- Engaging national and provincial drug control policy makers and program managers on HIV/AIDS issues and strategies.

4. People Living With HIV/AIDS Involvement in Prevention

Problem discussion

For most Indonesians, HIV/AIDS remains a very distant and unreal threat. As an awareness-creating element of behavior change intervention activities, the participation by skilled representatives of the People Living with HIV/AIDS (PLWHA) community can personalize the AIDS epidemic by showing the range of people affected by the epidemic, thereby making prevention messages more relevant and meaningful. In some areas, such as Papua, involvement of PLWHA is especially important to demonstrate that the HIV is no longer a “foreigner” infection.

In addition, individual PLWHA in Indonesia are often afraid of exposure, experience a sense of isolation and are subject to outright discrimination. This makes them extremely reticent to participate in any activities, which would identify them as HIV infected. This reticence, together with the lack of referral mechanisms available in most VCT settings, as well as an emphasis on preventing transmission in vulnerable, uninfected populations effectively precludes prevention activities with PLWHA.

Indonesia’s geographic size and diversity also helps to contribute to the difficulty in mobilizing and supporting PLWHA. Yayasan Spiritia, an NGO created by people infected with and affected by HIV/AIDS that supports the development of PLWHA groups in 13 provinces, identifies motivating PLWHA who can advocate effectively as its greatest challenge.

Expanded program response

USAID/Indonesia recognizes the necessity of involving PLWHA in the decision-making processes at all levels of prevention program development, implementation and monitoring. USAID will focus on:

- Supporting the development of nascent PLWHA organizations, in order to empower PLWHA to be able to mobilize and provide support to their constituencies;

- Increasing technical support for organizational and advocacy efforts, and legal protections to PLWHA organizations so that they will be able to play a role in addressing the epidemic in Indonesia;
- Providing PLWHA with opportunities as educators and spokespersons for prevention messages, not only to empower PLWHA but also to serve to de-stigmatize the disease by reducing the social distance between those infected and those who are not; and
- Insuring that prevention messages are targeted to PLWHA.

5. Healthy Ports and Highways

Problem discussion

Given Indonesia's geographical identity as an island nation it is not at all surprising that the USAID geographic focus provinces are all maritime regions. Each priority area contains at least one major port city. Port cities and border towns in Southeast Asia and Indonesia are among the highest-risk centers for HIV transmission in the region, and USAID/Indonesia currently supports a *Healthy Highways and Ports* integrated intervention strategy linking behavioral change interventions with complementary sexually-transmitted disease (STI) services and condom promotion activities among groups at high risk moving through the archipelago's key port cities, highways and urban centers. The strategy is designed to reach mobile and most-at-risk men (the clients of SW: transport workers, seamen, seafarers, travelers and tourists) and female and male sex workers located along key highway routes and connecting with key cross-border port cities.

Expanded program response

USAID/Indonesia will strengthen and expand coverage of the ports and highways interventions by:

- Engaging in more intensive NGO outreach in the target port and highway areas;
- Supporting innovative promotional materials directed at increasing condom use among the targeted clients of SW;
- Developing closer linkages with the DKT condom social marketing activities in all target port and highway areas, with the goal of making condoms more available in non-traditional outlets in the target areas "hot spots";
- More programmatic recognition of the use of MSW, including *waria*, by the target male client of SW population;

6. Condom Promotion

Problem discussion

Consistent use of condoms is the one critical behavior by which males at high risk, including both the clients of sex workers and MSM, can protect themselves from HIV. The good news is that in Indonesia, condoms are readily available at affordable prices. The bad news is that condoms carry a negative stigma and they are very underutilized by at-risk groups.

Beginning in the 1970s, condoms were de-emphasized by health care providers as part of the family planning program that promoted female methods such as pills and injectable contraceptives. As an unexpected result, condoms have become highly stigmatized as a product primarily used for non-family planning activities (commercial sex, pre-marital sex, adultery and free sex). Condoms have been a part of the GOI's core public health response to the epidemic. In support of the National AIDS Strategy, the IEC approach is abbreviated as "ABC" – *Abstinence, Be Faithful and Condom Use* (if A and B are not followed). For a variety of cultural, social, religious and legal factors the government's public health approach has emphasized "A" and "B", while non-governmental organizations, with donor support, have taken the additional step to further promote "C"-- effective condom use. As HIV prevalence rapidly changes in Indonesia, even the government's position on

condoms is under-going a major strategy change. One of the key areas of the Second National AIDS Strategy is the promotion and distribution of condoms. And, in September 2002, the National Family Planning Board (BKKBN) began a consultative process to plan the national launch of a new *dual protection* strategy to re-energize condom use for family planning and disease protection nationwide.

Presently, condom use remains very low. Although the market has doubled to 60 million units since 1994, the estimated market for a country for the fourth largest country in the world (210 million people) is 200 million units/year. Behavioral surveillance data showed that the percentage of men using condoms with SWs in three cities where USAID's HAPP program worked has increased only from 14% in 1996 to 28% in 2000.

The marketing of condoms in the commercial (private) sector in Indonesia, as represented through the Indonesian Consortium of Condom Manufacturers (ICCM), has been impacted negatively by both the national economic crisis (97-98) and the introduction and subsequent domination of the KfW/DKT subsidized, socially marketed condom, *SUTRA*. KfW introduced the DKT condom social marketing program in 1996 in the face of much opposition from the ICCM, to promote subsidized condoms, media campaigns and IEC materials. DKT works collaboratively with the MOH and NGOs, providing a \$200,000 NGO support fund to promote condoms in 12-18 cities. In reality DKT's *SUTRA* brand condoms are being sold throughout the archipelago at a recommended retail price of Rp.1,500 (US\$ 0.16) for a 3-condom packet. The DKT promotion price to NGOs is only Rp.180 (US\$ 0.02). The DKT program is expected to continue through 2003 with DKT preparing plans for an extension should the GOI request further KfW funding. The ICCM is opposed to an extension of KfW support for DKT as it continues to undercut and stagnate the viability of the Indonesian commercial sector and is not sustainable. The MOH and other parts of the GOI are considering the long-term implications of continuing the DKT program for the indigenous commercial sector.

Expanded program response

USAID HIV/AIDS efforts have focused on condom promotion among groups at high risk and the strengthening of the private sector's ability to market condoms for disease prevention. The at-risk groups are often not self-identified groups and their members are hidden among the general population.

Key elements of the USAID strategy include:

- Advocacy with Indonesian leadership at the national, provincial and district levels to encourage condom use and to break the no-condom culture;
- Collaboration with other national and donor organizations including BKKBN, the Indonesian Consortium of Condom Manufacturers and DKT to further promote condom use;
- An expanded focus on clients of FSWs including transportation workers, port workers, seafarers, police and military as well as MSW who also have MSM risk behaviors. The program will work collaboratively with the Indonesian Consortium of Condom Manufacturers and DKT to ensure that condoms are promoted and readily available at activity sites;
- Encourage local government officials to institute 100% condom use regulations (and enforcement) at the *lokalisasi* in target areas;
- Undertake special efforts to establish condom marketing activities for non-brothel-based Papuan FSWs and for their (often Papuan) clients in the target cities in Papua;
- Encourage condom availability in government health facilities in activity areas in support of the GOI's new *dual protection* condom strategy. At present many facilities only stock Indonesian-made condoms packaged for "family planning" use. In the future supplies of condoms for dual use should be made available and accessible at all government health facilities;

- Encourage condom availability in private sector workplaces as part of the private sector strategy; and
- Maintaining stocks of free distribution condoms supplied through USAID's *HIV/AIDS Condom Fund* at intervention sites to ensure the availability of adequate condom supplies for promotional activities, training and for communities where private sector condoms are neither available nor affordable to local populations.

7. Prevention Marketing and Mass Communication

Problem discussion

To facilitate effective risk reduction and behavior change among the population groups most at risk it is necessary to move one step beyond core interpersonal behavior change interventions and complementary strategies to utilize mass communications as part of an expanded *prevention marketing* approach. The marketing of prevention messages through a variety of media materials and the promotion of the primary HIV/STI prevention product, the condom, has been piloted and utilized in Indonesia over the past five years by several donors (including USAID's previously funded HAPP project) as well as private sector condom manufacturers and the DKT condom social marketing program. By and large the approaches used have been piecemeal, focused on increasing condom awareness and marketing the personal advantages of condom use. Today the challenge with condoms is how to change personal preferences, dispel myths and create a motivation to use condoms as personal protection. Similarly, the challenge remains in Indonesia on how best to utilize lessons learned from condom prevention marketing to apply to other prevention marketing packages such as pre-packaged STI treatment.

Expanded program response

USAID/Indonesia will support a creative, cross-cutting, prevention marketing approach to promote and position products and services to facilitate risk reduction behaviors among the program's vulnerable population groups. This will include:

- The development of a mass communications strategy and implementation plan to deliver a *prevention marketing* mass communications campaign to reach ASA's targeted intervention groups, including sex workers and clients of sex workers, such as transportation workers, port workers, seafarers, military, and police. The aim of the communications interventions will be to create a personal sense of risk of infection (for each target group), encourage health seeking behavior, promote STI treatment sites, promote abstinence/delay and correct and consistent condom use, promote harm reduction behaviors, and foster the condom negotiation skills of female and male sex workers;
- Support the development of general public targeted-media to reach women, men and youth with the *ABC* messages promoting abstinence, delay, fidelity, and correct/consistent condom use (dual protection) in coordination with USAID reproductive health partners, MOH/CDC&EH and BKKBN;
- The selection and contracting of an Indonesian advertising firm capable of developing, leading and managing a professional media campaign;
- Qualitative research to guide the development of the prevention marketing strategy, to include: (1) formative research to determine key characteristics and psychographics of the target audiences; (2) followed by the development of positioning concepts; and (3) ending with positioning research to identify the communication routes with the maximum potential for a prevention marketing campaign;
- The development and management of a prevention marketing media plan utilizing a variety of effective communications materials and media approaches (television public service advertisements, enter-educate programming, radio messages and programs, newspaper and other print media outlets) to maximize impact. The media plan will be well coordinated with the program's field based activities and maintain flexibility to address specific area or

population group needs. Two geographical areas needing special regional prevention marketing approaches or complementary strategies outside the mass communications target include the province of Papua and the Riau Islands. In addition, appropriate communications messages and approaches to reach IDU will be developed as the epidemic progresses;

- Regular monitoring and evaluation of all mass media approaches will be conducted over the life of implementation to closely monitor behavior change and program impact; and
- The development and piloting of other *prevention marketing* schemes such as single dose STI treatment for men and women or other pre-packaged options based on the lessons learned from the condom prevention marketing experiences.

8. Uniformed Services

Problem discussion

Given the political situation in Indonesia, the military, police, and other uniformed services are a population at risk for HIV and other STIs, and can serve as a core transmission group for these infections to the general population. The military maintains battalions nationwide, with very large contingents of soldiers moving in and out of key hot spots, from Papua to the Maluku Islands to West Timor to Kalimantan and Aceh. Military commands include both land-based units that protect key national interests, as well as naval operations, which control ports and harbors. It is estimated that Indonesia currently supports a force of 70,000 central commands and more than 150,000 deployments nationwide as part of the government's current national security strategy.

Similar to other predominantly male, transient occupational groups, Indonesian military bases and short-term camps attract a dedicated service sector, which includes a variety of sexual entertainment enterprises and FSWs. It is important to note that HIV prevalence rates among Indonesia's military is privileged data and historically has not been shared with the Ministry of Health. Consequently, neither GOI nor any of the donors have been able to utilize military prevalence rates in data analysis or projections.

Similarly, the police forces constitute a large presence in Indonesian society and constantly interact with risk groups such as FSWs and IDUs on both a formal and informal basis. Behavioral surveillance in Indonesia, as opposed to other countries in South East Asia, has not looked at police as a possible group at high risk and very little data is available on risk behaviors in this population. However, from what has been seen in many other countries, HIV risk behaviors and prevalence rates among the uniformed services often times are significantly higher than among the general population.

To understand this situation, one must consider the circumstances of those who serve in uniform in Indonesia. Many are young men who are often posted or required to travel for extended periods away from home, or must await proper housing before sending for their families. Confronting risk daily inspires other risky behaviors, and the sense of invincibility the services promote sometimes carries over into personal behavior. These groups also tend to have more frequent contact with sex workers. Finally, the on-going transition from a centralized, authoritarian society to a civil society has raised issues about the status, role and responsibility of uniformed services in Indonesia.

Since early 2002 several key opportunities have transpired which have allowed the USAID program to provide direct technical assistance to the Indonesian uniformed services, including both the Department of Defense and National Police. In January 2002 ASA supported an HIV/AIDS prevention workshop that was jointly organized by the national military and police hierarchies. The workshop resulted in internal advocacy and strategic planning supplemented with additional technical assistance opportunities. By mid 2002 the military and police commands opened the doors to create their own AIDS Commission (KPA) as well as the drafting of new HIV/STI prevention policies.

Expanded program response

As a result of their command and control hierarchical structures, uniformed services permit sustainable integration of HIV/AIDS/STI prevention into the military health care systems already in place. Since early 2002 the door has opened wide for USAID and other donor participation in a formerly closed setting. Current and future USAID support to Indonesia's uniformed services includes:

- Technical assistance support for the collection and analysis of uniformed services behavioral and sero prevalence data, including qualitative assessments to learn how officers and the ranks perceive risk and risky behavior, where they seek treatment for STIs, when they use condoms, what they do for recreation, whom they listen to for information about HIV/AIDS/STI, and what they value;
- Strategic planning based on an assessment of the potential for integrating STI/HIV/AIDS services and activities into existing systems and structures;
- Behavior change communication (BCC), based on the assessment, including peer led interventions; and
- Condom distribution and policies, including the promotion of 100 percent condom use policies in surrounding communities and garrison towns.

9. Emerging Groups Most-at-Risk

Problem discussion

A newly emerging most-at-risk group in Indonesia are prison populations. Since 1993 prisoners have been used as a sentinel population for HIV sero surveillance. This population was not selected as a sentinel population because of documented evidence, but as a result of testing accessibility. In 2001 HIV infection rates among tested prison populations in Jakarta, West Java, East Java and Bali were recorded at 10.3 - 22.0%, 25%, 4.3 - 9.0% and 9.7% respectively. Until recently there has been little interest nor encouragement by GOI officials to include prisoners in HIV/AIDS prevention initiatives funded by donors or other agencies. This is quickly changing as a result of the rapidly expanding rates found in Jakarta's Salemba prison (and elsewhere, including Bali). Through 1999 rates at this central Jakarta prison remained below 1%. In 2000 HIV prevalence was 17.5%, increasing to 22% in 2001. It is believed that in general, Indonesian prisoners engage in unprotected sex and injecting drug behaviors, and that many urban prisoners have been incarcerated as a result of drug-related offenses. Recently the door has opened wide by Jakarta prison authorities in several prisons seeking immediate technical and programmatic assistance to reach prisoners. This mirrors the new national five-year development plan for prisons that includes the start-up of HIV/AIDS prevention strategies for prisoners.

Expanded program response

In support of this new opportunity to reach prisoners in greater Jakarta prisons with prevention activities, USAID plans to support:

- NGO-managed pilot prevention initiatives in two central Jakarta prisons, followed by scale-up in other areas of Jakarta and other intervention sites once systems are tested.

(2) Sub-Intermediate Result 2.1

Strengthened quality, accessibility, and utilization of prevention, care and treatment services for individuals most-at-risk for STI/HIV/AIDS

The strengthening of public and private sector HIV/STI services for persons at risk constitutes a critical public health need in Indonesia. In the absence of efforts aimed at strengthening the

accessibility, effectiveness, affordability, and overall demand for quality services, the fight against HIV will not be successful. There are many obstacles which make it both difficult and costly to improve STI and HIV services.

1. STI Clinical and Laboratory Services

Problem discussion

In many places, STI services for female sex workers are provided through “mass treatment,” syndromic examinations or via self-treatment. These practices lead to an increase in costs, inadequate treatment, and the possibility of drug resistant variants. Mobile men with money, who are the clients of FSW, represent a vast target group who either self treat or go to private practitioners. Due to GOI law, which does not allow workplace health insurance coverage for sexually transmitted infections, there are barriers to men receiving STI services in the workplace. Few STI service providers are friendly to *waria* and gay-identified men. Both men and FSW demonstrate low condom use.

STI/HIV counseling services are either not available in many urban settings in Indonesia or, in many cases, those who have been trained in counseling techniques have not incorporated them into their patient care. Often there is a lack of a functioning referral system, while in other sites there is a lack of continuous, adequate supply of syringes, drugs, reagents and condoms. Data on STI prevalence in Indonesia are incomplete. The only reliable data on the occurrence of STIs are from surveillance of FSWs for syphilis and occasional studies of gonorrhea, syphilis and chlamydial infection among women.

In Indonesia today there still is little regard for STI services and treatment, particularly in public sector health facilities because most STIs are still not considered serious health problems. Many of the high transmitters are hard to find. While generally FSW in *lokalisasi* and *waria* are relatively easy to detect, other groups are much more difficult to access (e.g., MSM and IDU). Providing services to these vulnerable communities is also seen as act to legitimize or legalize their behavior. Issues such as prostitution, homosexuality and drug use remain so sensitive in Indonesian society that even KPA/KPAD members who are tasked to advocate for favorable HIV/STI policies have difficulty discussing the issues. In addition, syndromic treatment of STIs, while offering simplicity in service settings where laboratory diagnosis is not feasible, often lacks sensitivity and specificity, and requires the provision of a number of drugs, which can be relatively expensive for patients at risk.

Expanded program response

USAID/Indonesia plans to support and strengthen at least one core facility in each intervention area to provide quality STI clinical and laboratory services. Support will be provided to both public and private/non-profit health facilities that can maintain quality, are sustainable, or have the potential to become sustainable. The USAID support will emphasize:

- Routine voluntary STI screening and syndromic treatment of FSWs using simple laboratory confirmation;
- Comprehensive STI services including counseling and condom promotion;
- Mobile STI services and outreach activities to reach more men at risk;
- Linking STI/HIV services with surveillance efforts;
- Linking outreach activities and referral systems to STI services; and
- Delivering interventions aimed at keeping the focus on counseling as an integral part of STI services, such as STI/HIV/Reproductive Health Counselor monthly meetings.

An example of a major program underway in several intervention areas which can be scaled up across the archipelago is the **Healthy Highways and Ports** activity described under Sub-I.R. 3.1 above. This integrated intervention strategy links behavioral change interventions with

complementary sexually-transmitted disease (STI) services and condom promotion activities among groups most-at-risk moving between island port cities, highways and urban centers.

Since *waria* and MSM constitute a vulnerable but underserved population, working through existing networks and organizations currently serving *waria* and other MSM subgroups, selected clinics will be supported in regular serologic testing and treatment of STIs, particularly syphilis, the prevalence of which is particularly high among *waria*.

2. Care and Support

Problem discussion

Care and support services for PLWHA are limited across Indonesia. As the number of HIV infections increases throughout the country, the need for care and support services will increase.

Papua, with nearly 33% of the identified HIV infections, has the most limited capacity to respond due to logistics and communication problems and lack of qualified personnel. Home care services and temporary shelters for PLWA are limited to a few NGOs, modestly in Java, Bali, and in one city in Papua. Only a handful of Indonesian physicians are trained and experienced in the identification of AIDS, treating AIDS opportunistic infections, including the management of anti-retroviral therapy (ART). Dissemination of a standard GOI recommended protocol for ART has not taken place.

Voluntary Counseling and Testing (VCT) is an important entry point for both prevention and care services, as well as an effective mechanism for decreasing the effects of stigmatization. All provincial health laboratories are capable of performing HIV testing but counseling services tend not to be available. VCT services are generally only available in a few urban areas and there are issues related to both laboratory and human resource capacity.

Due to the lack of surveillance data, the extent of Mother to Child Transmission (MTCT) is currently unknown. Implementing MTCT interventions in resource poor areas is complex and often dependent on a functioning Maternal and Child Health system. It is unlikely that many of the women at highest risk for HIV are accessing antenatal clinics on a regular basis.

Expanded program response

Currently, the number of people living with HIV and their families and caregivers is small, but will increase as the epidemic matures and VCT services become more available. PLWHA need medical services and nursing care that will reduce morbidity and mortality as well as optimize their quality of life. Such services include appropriate diagnosis; treatment and prevention of tuberculosis and other opportunistic infections and HIV related illnesses, provision of ART, and palliative care. Psychological care and support is also critical for helping PLWHA, their families and caregivers cope with the stresses related to the disease. The current strategy should focus on strengthening systems and building capacity in the public and private sectors to deal with the growing need.

USAID/Indonesia will undertake steps aimed at improving the quality care and support services for PLWHA, their families and caregivers. Assessments of health worker needs in the areas of education, training and resources will be conducted in order to develop capacity building activities for care and support programs. Workshops, seminars, and/or other training activities might then be developed based on the results of need assessments.

Care and support activities will address improvement in communication to nurses and doctors regarding new strategies, improve quality, develop feasible laboratory linkages and ensure ethical patient data and management practices. A counseling based strategy for providing holistic interventions to PLWHA may be introduced through case management workshops, home care training, and networking PLWHA with STI/HIV service providers.

Support for community-based organizations of PLWHA to increase their participation in all areas of HIV/AIDS prevention and care and support through the development of support networks in the target areas is also an important intervention that will be addressed.

An on-going evaluation of HIV test kits used for determining HIV infection in the Indonesian context and support for better laboratory analysis will contribute to the process of improved quality of surveillance data. The decision on the use of HIV test kits will be made as soon as possible and the test kits made widely available.

USAID/Indonesia will support efforts that:

- Build on GOI guidelines and protocol;
- Develop VCT skill training that produces a competent cadre of counselors;
- Assist sites in target areas in the development of a system that promotes appropriate use of confidential VCT; and
- Strengthen linkages between VCT services and other prevention, care and support services.

USAID/Indonesia will work closely with the GOI, UNICEF and the WHO to develop pilot Mother-to-Child Transmission (MTCT) programs in Papua and Riau which can be scaled-up nationally should the need arise. Such activities may focus on:

- Improved availability, quality and use of MCH services for women most vulnerable for HIV;
- HIV VCT;
- Antiretroviral therapy;
- Infant feeding options;
- Delivery options to reduce viral transmission; and
- Care and support for infected mothers.

3. Health Care Workers

Problem discussion

Many health care workers either ignore or are not aware of their own behaviors in a professional setting. For instance, many health care workers are trained in Universal Precautions (UP), but few practice UP in the workplace. Other health care workers exhibit behaviors, which promote stigmatization of marginalized persons, including FSW and PLWHA.

Health care workers are generally underpaid and health care centers are understaffed. Many resource poor areas, like Papua, lack trained health care workers. Decentralization has brought additional concerns. With more provincial autonomy, many health care workers, formerly paid through the central government are now paid locally. In some areas of Indonesia, many non-local health care practitioners are leaving their posts in fear that local decisions may affect their careers.

Expanded program response

Increasing the capacity of health care workers to respond adequately in a variety of clinical situations is imperative if quality services for HIV and STI are to be made accessible.

USAID/Indonesia will support a variety of capacity building activities for health care workers through workshops, skills building activities, mentoring and partnering. These activities will include:

- Promotion of GOI standard protocols for STI service delivery;
- Clinical skill training in STI/HIV and laboratory services;
- Managerial training and/or manuals to guide health services managers in more efficient services;
- Customer service training;
- Universal Precautions training and promoting infection prevention systems which can support these practices; and

- Promoting strategies for cost recovery and sustainability in health care.

4. Laboratory Services

Problem discussion

An important component of any HIV/STI service program is the quality of laboratory services. Laboratory services both for STI and HIV are limited and vary greatly in quality. Most provincial and district-level laboratories lack functioning equipment, essential reagents, and quality assurance activities. The current interface between the GOI central laboratory and the provincial and district level facilities must be improved.

Additionally, preliminary research has shown that the sensitivity and specificity of HIV rapid tests currently used in Indonesia yield a high percentage of false positive results. HIV confirmatory testing (western blot) is only available in Jakarta, which means that provincial sites have considerable time delays in receiving results. Alternative strategies for confirmation for diagnostic purposes have not been developed.

Expanded program response

USAID/Indonesia will participate in the assessment of provincial labs in Jakarta, Surabaya, Papua and other provinces in collaboration with the GOI central and provincial laboratories, MOH/CDC&EH, and the National Institute for Health Research and Development (LITBANGKES) for the establishment of national reference capacities for the diagnosis of both HIV and STI.

In order to strengthen regional and national STI reference laboratories, USAID/Indonesia could assist STI service providers with needs assessments, personnel training and mentoring and procurement of laboratory equipment.

A jointly sponsored USAID/Indonesia/WHO evaluation of HIV test kits currently used for determining HIV infection has been completed and serum bank developed. Alternative strategies to western blot testing are being developed.

USAID/Indonesia will also work to improve strategies for routine clinic assays for PLWHA such as CD4 testing necessary to monitor HIV treatment, including ART. This would assure quality and reproducibility for this technologically challenging testing and greatly improve care and support for PLWHA.

5. Tuberculosis

Problem discussion

Indonesia has the world's third highest disease burden from tuberculosis (TB) after India and China. Within Indonesia, TB is the third highest cause of mortality and seventh highest cause of morbidity. WHO estimates there were 591,000 new cases in 1998 alone. This was an increase of one third over the previous year, with more than 140,000 TB-related deaths. Seventy-five percent of TB cases occur within the most productive age group, 15-49 years old.

When HIV and TB come together in the same population, the effect is explosive. Around the world TB is the leading cause of death among people with HIV/AIDS. TB is the common opportunistic infection associated with AIDS and is easily spread to other members of the general population. TB shortens the life expectancy of HIV positive people, because it takes hold at an earlier stage of immune deficiency than most other opportunistic infections.

The TB drug procurement and monitoring system in Indonesia does not function well, and this has led to the unavailability of drugs in many districts. This problem is partly due to inadequate planning,

assessment of drug requirements and logistics management. Because the National Tuberculosis Program has no buffer stocks, the shortages cannot be solved.

In the absence of a reliable drug supply, training activity for TB treatment and control will continue to be ineffective and may even be detrimental as identified TB cases will receive no treatment, partial treatment or fail to complete the full course of treatment. This will inevitably lead to the development of drug resistant TB (including multi-drug resistance), making future treatment and prevention increasingly difficult.

Surveillance is seriously hampered by delay and incompleteness of reporting from the districts. The majority of district supervisors face problems. Many are not capable to fill out the quarterly reports and some districts fail to send any reports at all. Another problem is the budget constraint for supervision. Lack of transportation at the district and provincial level is aggravating this problem. Compilation of data at the national level is still weak which results in data not being available for evaluation and planning.

The majority of problems are related to insufficiency of management capacity at various levels, and the program not being able to keep up with the speed of expansion. Transfer of authority in the process of decentralization necessitates careful planning of capacity building: technical and management capacity at central, provincial and especially district level needs to be urgently strengthened, particularly with regard to manpower, supervision, logistics, health information systems and planning.

Instructions on national TB control guidelines are generally not yet covered in the basic curriculum of pre-service education for doctors and para-medical workers. Consequently, newly assigned doctors and nurses lack of the necessary knowledge and skills to implement the Directly Observed Treatment, Short-Course (DOTS) guidelines.

Expanded program response

USAID/Indonesia is currently supporting the strengthening and establishment of national reference laboratories via the TB Coalition's *Stop TB Initiative*, managed by the Royal Dutch Tuberculosis Association (KNCV) with funding from the Infectious Disease account.

USAID/Indonesia will seek ways to:

- Further link its TB and HIV/AIDS activities;
- In close cooperation with the *Stop TB Initiative*, a sentinel survey will be carried-out in high prevalence areas. In these sentinel centers, TB patients will receive counseling and screening for HIV. The survey will provide information on the trend of co-infection and enable better planning in the future; and
- PLWHA will be screened for signs of active tuberculosis. Under the USAID/KNCV program support, those patients who are found to suffer from TB will receive a full course of anti-tuberculosis treatment. Patients without signs will receive prophylactic treatment with Isonicotinyl Hydrazine Isoniazid. By these efforts, the TB-AIDS linkages will improve case detection, reduce the spread of TB, and enhance the effectiveness of HIV/AIDS activities.

(3) Sub-Intermediate Result 2.2

Enhanced capacity and quality of GOI HIV/STI surveillance systems and their use in decision-making

1. Surveillance Systems

Problem discussion

Since the beginning of the AIDS epidemic, the Ministry of Health (MOH) has managed the national HIV surveillance system. Using limited core GOI budget support, the MOH has relied on additional financial resources from the World Bank and technical support from WHO for the development of National Surveillance Guidelines. The MOH surveillance system includes passive case reporting and active sero-surveillance. The case reporting data is unreliable: HIV positive samples identified during active sentinel surveillance are entered as line items in the passive case reporting data base, even though they are reported anonymously and may well represent duplicate cases.

An over-zealous application of WHO guidelines and a poor understanding of the difference between a sentinel site and a sentinel population means that much of the surveillance activity that takes place gets classified as “ad hoc”, even when the same methodology is used in the same population over time. Only 15 provinces have what are formally classified as sentinel surveillance sites, even though active surveillance data are available for almost all provinces and for a number of populations.

An ongoing in-depth review of the quality of surveillance supported by USAID and undertaken in conjunction with the MOH has identified strengths and weaknesses in the system. In general, it seems surveillance is technically sound, with specimen collection, handling and testing procedures in line with internationally recognized protocols. The major weaknesses are in data reporting, interpretation and use. An additional weakness is that ethical protocols specifying unlinked anonymous testing are not always adhered to.

The majority of surveillance activity is in female sex workers, usually representing population-based samples recruited in *lokalisasi* (official red-light districts). The MOH surveillance authorities may face new problems in obtaining samples and measuring comparable trends over time as a result of the closing of some *lokalisasi* with the consequent dispersal of FSW.

Time series data are also available for *waria* (transvestites) and IDUs in Jakarta (the latter from the only public treatment center, the Drug Rehabilitation Hospital (RSKO), for prison populations in several provinces, and for military recruits. The MOH has conducted truly “ad hoc” surveys (once-only surveys in specific populations) for a number of other populations, including truck drivers, seafarers, and other groups representing men highly likely to engage in sexual risk. The health department of the armed forces (TNI) have conducted sero-surveillance among mobile units returning from active duty but the data (which show extraordinarily low prevalence) have not been widely published. There is no evidence to suggest that the technical quality of the surveillance is low. Inasmuch as data are available, they can be considered reliable.

As can be seen, there is a great deal of HIV testing taking place, most of it in groups likely to be at risk for HIV. Because the range of population groups selected for surveillance varies across provinces and has changed over the years, it is difficult to use these results to establish national trends or patterns. There is little coherence in the system, little effort to ensure adequate coverage geographically or of risk groups, and little effort to ensure trends are adequately measured over time. This is in part because of a lack of clarity in roles. On paper, HIV surveillance is a central responsibility. In practice, it is implemented at a local level using local resources, with only the reagents provided by the center. There is little or no central oversight of the choice of sentinel populations, and the center is not proactive in ensuring that data are correctly reported, or indeed reported at all.

Poor reporting and interpretation contribute to the fact that data are frequently under-utilized. Important trends in prevalence have been misclassified or just missed completely even at the central level, and very few district or provincial level offices have the skills to analyze data critically. As is true in many countries, there is no mechanism for ensuring that appropriate action is taken on the basis of surveillance data, even when worrying trends in HIV prevalence or behavior are identified.

The HIV data from screened blood donations provides an indicator of HIV prevalence in the general population. The screening of blood donors for HIV infection (at almost all of the Indonesian Red Cross Blood Transfusion units) has been done routinely although sometimes duplicative reporting occurs (one HIV positive blood donor can be reported more than one time). At present, these are the only data available for the "general population". It is appropriate in Indonesia's epidemic state that the large majority of surveillance activity remains concentrated in populations most at risk for HIV. However, the ongoing review of the surveillance system is expected to make a strong recommendation that antenatal care (ANC) sites be added to the system in the highest prevalence provinces of Jakarta, Riau and Papua.

Active STI surveillance which is critical in basic and intensive focus HIV epidemic settings, does not routinely occur in Indonesia (except for syphilis). Limited data on STI prevalence in at-risk groups is available.

Since 1995, behavior surveillance surveys (BSS) have been conducted among FSW and client groups in Jakarta, Surabaya and Manado under USAID/HAPP support, and in Makasar (South Sulawesi) and Denpasar (Bali) under AusAID support. However, the results have not been widely shared with program planners, decision-makers or other affected communities. BSS among IDU and *waria* were conducted in 2000 in Jakarta under USAID/ASA support.

Under Indonesia's newly decentralized health system, the MOH's Communicable Disease Control and Environmental Health Branch (CDC&EH), retains responsibility for national disease surveillance. CDC&EH has a limited budget for sero-surveillance surveys at the central level, and currently commits no funds to the BSS, which are a critical part of Second Generation Surveillance (SGS), especially in emerging epidemics such as Indonesia's. Decentralization of decision-making means that the capacity to collect, analyze and use data at province and district levels will assume a new importance in Indonesia. Locally collected data should remain in the hands of and be used by local officials and NGOs in planning and monitoring the epidemic with technical assistance from partners who have the skills, capacity and system integration to implement the SGS activities (such as the Population Council/University of Indonesia and the Central Bureau of Statistics/BPS), under the guidance of the CDC&EH.

It is important that the GOI's surveillance data not only be comprehensive and reliable, but also that the surveillance process be 'transparent' so that the data are perceived as credible. Resolving these issues and making the necessary changes to the surveillance system in order to ensure that acceptable standards are maintained in the future are key areas of USAID support under Sub-IR2.2. USAID is committed to strengthening the capacity of GOI program management and decision making at the national, provincial and district levels to use relevant and improved high quality surveillance systems and epidemiological data in planning HIV prevention and care programs in order to leverage and manage available resources in support of HIV/AIDS prevention and care.

Through the use of Second Generation Surveillance (an integrated HIV surveillance, behavior, and STI surveillance system), the improved system will allow for better monitoring of the epidemic at all levels, and more rapid responses if indicated.

The objective of the strengthened system is to concentrate resources where they will yield information that is most useful in reducing the spread of HIV and in designing strategies to provide

care for those affected by HIV/AIDS/STI. That requires tailoring the surveillance systems to the pattern of the epidemic in each area, as well as maintaining the primary focus of data collection in most vulnerable populations. The on-going surveillance review is likely to make a strong recommendation that the central level define and fund a minimum surveillance system which ensures adequate geographic and risk group coverage, includes ANC in strategic locations (Papua), and ensures trends over time. Central control over a minimum system should also help overcome some of the data reporting problems that are a major obstacle to effective data use.

Monitoring HIV prevalence in STI clinics and among TB patients will be useful in indicating emerging HIV epidemics. In Indonesia there are a limited number of STI clinics with substantial patient numbers, so this option may be restricted to a few sites. In addition to its sentinel role, surveillance among TB patients is of relevance for planning clinical management protocols.

Expanded program response

USAID/Indonesia's response will include:

- Development and strengthening of the SGS at the national level to ensure that implementation is clear on the type of target groups, sampling procedures and lines of reporting from district to province to national level, while still allowing some flexibility at a provincial level;
- Completion of the test kit evaluation, the establishment of test procedures, and the assurance of the wide availability of tests;
- Assisted by the Population Council/University of Indonesia, the USAID-supported program will develop capacity within the Central Bureau of Statistics (BPS) to carry out BSS in conjunction with CDC&EH and local surveillance management boards (composed of MOH, KPAD and NGO staff);
- The provision of training to national and provincial level surveillance staff in data analysis and interpretation, and adapt software to assist in trend analysis;
- Management of a series of workshops to develop national policy and guidelines as well as strategies to involve health officials at other levels in a meaningful way. The collection of data will focus on information that can monitor on-going interventions and areas where behavior change may be needed;
- The acceleration of testing the national SGS guidelines in three priority provinces (North Sumatra, DKI Jakarta and Riau) and their replication and implementation in other seven provinces at adequate levels by 2003.
- In order to develop the capacity to perform STI surveillance as a routine part of SGS HIV surveillance in Indonesia, USAID will support the integration of STI surveillance in the limited number of USAID supported sites (Papua and Riau) that are planning active implementation of 100 % condom use programs;
- Implementation of STI ad hoc surveys, such as prevalence surveys every two or three years in STI patients attending sufficiently large specialized clinics. Monitor antibiotic susceptibility, using syndromic approach, to help decide treatment regimens;
- In close cooperation with Indonesia's *Stop TB Initiatives/KNCV* program, carry out sentinel surveillance in high prevalence areas;
- Support for more effective analysis, dissemination and use of data for intervention planning and lobbying will be provided to district-level stakeholders;
- The comparison of information on HIV prevalence and the behaviors that spread HIV to build an understanding of changes in the epidemic overtime. This will make use of information from other sources, including STI surveillance; and
- Support for a national estimation process that encourages critical analysis of all types of HIV-related data including population size estimates. Assist the development and publication of an annual national report on HIV (an advocacy rather than a technical document), based on the data reviewed during the estimation process, and the results of the process.

2. Policy

Problem discussion

The development of supportive policies to facilitate effective HIV and STI prevention and care activities and institutions as a result of strengthened surveillance is key to a successful national STI/HIV/AIDS program. The policy environment is a critical arena to support new and innovative STI and HIV prevention and care responses needed today in Indonesia. This is especially important in countries such as Indonesia where concentrated epidemics exist among sex worker groups, drug users and other population groups who remain disenfranchised from mainstream society. Current draconian laws and tactics used to control and punish members of these groups for their behaviors, often violating their human rights, makes effective prevention, outreach and treatment to them difficult, if not impossible.

Policymakers who understand HIV prevention and care can serve as critical advocates and supporters both at the national and community levels. They cannot only break down barriers which other policymakers, ministries or communities may have created to hinder program implementation, but they are key players in lobbying for increased funding resources. Friendly policy stakeholders from a broad spectrum of government will make it easier for officials and departments responsible for HIV/AIDS to implement interventions that are implicated by better surveillance.

The time is ripe in Indonesia to encourage participation and ownership of the HIV/AIDS challenge. Democracy and decentralization remain very young in Indonesia. By and large legislators at the national and local assembly level remain uneducated about the potential impact of HIV/AIDS across the archipelago and in local districts. As a new, multi-sectoral national AIDS strategy is negotiated and approved in early 2003 it is even more strategic to push policy efforts on behalf of HIV/AIDS to ensure sufficient budgetary support for Indonesia's national program.

In preparation for increased investment in the policy arena, since mid-2002, the USAID/Indonesia program is conducting an assessment and planning process with a senior parliamentary consultant to develop an implementation strategy for the national and local legislatures. To complement the legislative side, a new cross-cutting advocacy strategy is also under development to influence all key stakeholders, including social, cultural and religious leaders. Policy assistance in Indonesia will only be effective with multiple donor participation. Currently USAID and UNAIDS are the only major donors active in policy support, however with the start-up of the AusAID program and their firm commitment to strengthening the National AIDS Commission and related policy improvements, it is clear that USAID's contributions will be part of a coordinated, multi-donor effort.

Expanded program response

USAID/Indonesia will support a variety of efforts to improve the policy environment including:

- Technical support to the Parliament's (DPR) health and social welfare legislative support division, *Commission Seven*, to educate and lobby national legislators on HIV/AIDS issues as well as assistance in drafting new legislation to response to priority concerns;
- Complementary assistance to reach local legislators (DPRD) through similar initiatives at the district level;
- Advocacy initiatives to encourage the establishment and legalization of 100% Condom Use Programs (CUP) in key communities and urban centers (i.e. Papua, Riau, and other sites with established *lokalisasi*);
- Advocacy initiatives to improve public health access and related human rights support to sex workers and sex worker communities;
- Advocacy to increase male responsibility, including behavior change, reproductive health, condom use, and prevention marketing issues with religious leaders, private sector and community interests;
- Initiatives to gain local support for low-cost, basic service delivery of STI, VCT and harm reduction clinical services;

- New efforts to prepare policymakers with issues surrounding stigmatization and the discrimination of PLWHAs, drug users and MSM;
- Orientation and efforts to change work-place policies and health insurance coverage of STI/HIV/AIDS provisions; and
- Support for economic cost-benefit analyses of key HIV/AIDS issues affecting Indonesia.

(4) Sub-Intermediate Result 2.3

Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI responses

Due to the Soeharto-era civil society restrictions, the NGO sector in Indonesia today remains young and inexperienced, and suffers from a profound lack of capacity. That said, in the field of HIV/AIDS, the groundwork has begun to be laid through USAID (and AusAID) supported HIV capacity-building initiatives and technical assistance over the past decade. Since 1993, USAID has supported capacity building of HIV NGOs through a variety of activities including: *EPOCH* (Enabling Private Organizations to Combat/Prevent HIV/AIDS) from 1993-95; *AIP* (AIDS Initiative Project in Papua province) from 1995-2000; the *NGO Capacity Building Initiatives* Project from 1997-2000; and *HAPP* (HIV/AIDS Prevention Project) from 1995-2000. While USAID and other donor capacity-building assistance has had impact on Indonesia's HIV/AIDS non-profit sector, given the nature of Indonesian NGOs, limited domestic resources and the limited geographical reach of donor support to date, there remains much to be done with non-governmental and community-based organizations nationwide.

As the majority of NGOs working in HIV/AIDS in Indonesia are fledgling organizations, NGO capacity building is human resource intensive, and thus requires a great deal of assistance in the area of capacity-building, technical development and organization development. In other USAID countries, this development issue has been addressed by placing technically strong Peace Corps Volunteers in specific HIV NGOs, to serve as a locus of technical assistance and capacity building, both for that specific NGO and others in the neighboring area. While the U.S. Peace Corps does not have an Indonesia presence, the United Nations Volunteers (UNV) and the British Volunteer Service Organization (VSO) are present in Indonesia.

Since 1993, the HIV/AIDS pandemic has received growing attention from the GOI. In 1994 the GOI established an inter-sectoral National AIDS Commission and developed a National AIDS Strategy to combat AIDS. In 1994 national and provincial/district AIDS Commissions (KPAD) were established. While the provincial structures have been in place for some time, they remain relatively ineffective as the capacity of KPADs to plan or act strategically has yet to be developed.

On the government capacity side, while there is technical strength at the national level in the MOH and, perhaps, at the level of some provinces and districts, most provinces and districts suffer from a dearth of HIV experience, knowledge and sufficient staffing resources. The GOI's new national decentralization laws on regional autonomy and central-regional fiscal balance (Law 22/1999 and Law 25/1999) has mandated the delegation of authorities, institutional, financial, management, and technical capabilities to provincial, regency and municipal regions. Decentralization will provide for the local administration and management of many areas, including health. Therefore, as of 2002, STI/HIV/AIDS prevention programming and related health delivery services are no longer coordinated by the central ministry, but are managed by the *Kabupaten* (rural district) and *Kotamadya* (city district) governments. So, while the problem of lack of capacity at the local governmental level had been acute under the previous centralized system, under decentralization it becomes dire as authority and responsibility for HIV/AIDS programs devolve to the district and provincial levels.

1. Non-Government Organizations

Problem discussion

In response to USAID and other donor initiatives in HIV/AIDS, a relatively large number of NGOs have directed much of their focus to HIV/AIDS. It is estimated that there are at least 200 NGOs working to prevent HIV and STIs as part of specific HIV control interventions, community-based social support efforts, and family planning/ reproductive health services. The challenge now is to build the capacity of the NGOs that have a vision and that can have impact over both the short and long term. The good news is that NGOs have proved to be effective agents of change in Indonesia, particularly in working with vulnerable population groups found in difficult to reach environments. As is often the case globally, a local NGO has a clear comparative advantage in managing behavior change interventions in local communities.

Expanded program response

USAID/Indonesia will expand its capacity building support to NGOs and broaden the vision of NGO capacity building to encompass new and expanded models for mobilizing communities and focusing resources, with the goal of enhancing the quality of community responses to HIV/AIDS by:

- Replication of the *NGO forum model*, in each USAID intervention area, where the HIV NGOs in a given locale meet regularly and select one or two leaders to represent the NGO perspective on the local KPAD and in the community to strengthen local NGO participation and contribute to decentralized decision-making;
- Support for USAID activity-wide alliances of NGOs working in the same thematic area (i.e., SW, MSM, IDU, care). These alliances allow for the exchange of technical assistance and lessons learned among similar organizations, and enables the NGOs to speak with a louder voice when dealing with other stakeholders (government, religious leaders, etc.);
- Support for an umbrella USAID activity-wide alliance of all HIV/AIDS NGOs;
- Establishment of new collaborations with international volunteer organizations to place volunteers with key NGOs for a minimum of two years to provide administrative and technical support;
- Ensuring linkages with AusAID's NGO capacity building initiatives;
- Focusing NGO institutional development and outreach activity support on local organizations targeting individuals at highest risk, particularly those NGOs with staff or active involvement of target populations;
- Building the capacity of NGOs to mobilize IEC outreach education activities, counsel clients about behavior change, launch education and link with media campaigns, and recruit and train peer leaders to implement outreach and counseling activities;
- Resourcing strategies to develop and strengthen the capacity of local implementing organizations to plan, budget, manage, and evaluate programmatic responses and interventions to prevent the transmission of HIV/AIDS and STIs in local communities; and
- Assisting NGOs to improve their potential for sustainability by developing alternative financing strategies such as linkages with commercial companies, public relations fund-raising, and leveraging of public resources.

2. Government Institutions

Problem discussion

Local participation and management, often with government support, will be critical for most program activities. As discussed above, the GOI decision to decentralize government services as of January 2001 affects activity management in ways that are yet to be fully seen. An early USAID priority action has been the establishment of working relationships with appropriate government offices (provincial, district or municipal) in the USAID intervention areas. Tailored capacity-building technical assistance will be provided to these government bodies to strengthen their roles in HIV/STI

prevention and care, paying particular attention to the critical management and planning functions of districts and municipalities in a decentralized system that supports an implementing role for NGOs.

USAID/Indonesia will continue to support the intervention areas jointly identified by the Mission and the GOI, with necessary capacity-building support to local government offices involved in HIV/AIDS as well as support to local KPADs. Assistance to the National AIDS Commission (KPA) is a major activity planned for the new AusAID program. As a result, future assistance to the KPADs will be developed and coordinated with AusAID's overall assistance package. A critical issue to be tackled in the near future for the KPA structure is the delegation of responsibility and linkages between provincial level and district level authorities.

Finally, with decentralization there is a reported exodus of trained and experienced health officials from the provinces, as locals take priority for provincial and district level government health assignments. In the near term, this will further weaken already weak local government systems.

Expanded program response

USAID/Indonesia will expand its capacity building support to the GOI's HIV/AIDS efforts with:

- Closer coordination with AusAID's capacity building support to the KPA, so as to help operationalize lines of responsibility between the KPA and the KPAD's in USAID's intervention areas;
- Tailored support for capacity building to the individual KPADs in USAID's intervention areas, to ensure that there are fully functioning KPADs in all ten geographic sites; and
- Support for capacity building within MOH provincial offices within USAID's intervention areas, as appropriate and on a case-by-case basis.

(5) Sub-Intermediate Result 1.1

Increased leveraging of programmatic interventions and financial resources

Problem discussion

USAID/Indonesia remains committed to the leveraging of private and commercial sector participation in the prevention of STI/HIV/AIDS and the care and support of persons affected by STIs and HIV/AIDS. A cornerstone of the GOI-USAID SOAG health protection strategy is the empowerment and sharing of responsibility of all community-level stakeholders. As STIs and HIV/AIDS increasing impacts key economic sectors and industries across the archipelago, Indonesia is now beginning to see a new level of interest within the for-profit sector to learn how HIV affects business, employees, communities and customers.

Indonesia has a history of private sector commitment to corporate responsibility and community service from its long-standing tradition of *gotong-royong*⁴. However, given the current level of awareness and sensitivity to STIs and HIV seen outside the public health sector, a big challenge will be how to attract and maintain private sector interest in the issue.

Creating a role and responsibility for the private sector in HIV/AIDS is a timely issue. There has been a concerted effort to push private sector participation in HIV/AIDS in key Asian economies from Thailand to India, following the lead of efforts in Sub Saharan Africa. A *private sector partnership strategy* is one involving few risks with a high propensity for success. With a small initial investment, private sector responses are largely managed in-house with human resource development, health care and external relations/community development resources. Beyond the corporate family of

⁴ *Gotong-royong* is Indonesia's traditional spirit of mutual help among members of a community. This spirit is a reflection of mutual group interest, solidarity and responsibility. The underlying philosophy is that people cannot live a solitary existence; they need each other. This spirit is reflected in community-based conservation programs managed by local farmers and in community development programs such as a joint venture social development NGO initiated by Chevron and Texaco in 1993.

management and staff, the for-profit sector engages local communities on a daily basis. Good HIV/AIDS policy reaches out beyond the job site to the local community, to local government leaders, civil servants, subsidiary businesses, local schools, houses of prayer and into neighboring homes. PT Freeport of Timika, Papua demonstrates the value of being “Positive Towards HIV,” serving as a leader in the dissemination of disease prevention messages to its employees and to the greater community of Timika on the importance of safer sex, personal protection and family responsibility. Over the past several years, Yayasan Kusuma Buana (YKB), a long-experienced health sector NGO based in Jakarta, has developed a working relationship with the Thai Business Coalition for AIDS (the leader in Thailand’s corporate sector response to HIV/AIDS) to introduce the concept to Indonesia’s business sector.

The for-profit commercial sector presents its own challenges and opportunities some of which will need to be addressed as part of a *flexible implementation approach*. One of the bigger challenges is STI policy. The majority of health insurance companies operating in Indonesia sell policies which exclude STI care coverage for employees. If HIV prevention is the ultimate goal, for-profit companies will need to make STI prevention and care a standard benefit in their employee health care package. In addition, the USAID program will need to bring Indonesia’s insurance sector on board as a primary advocate for HIV/AIDS and STI workplace and private sector initiatives. A second challenge will be the ability to convince small-to-mid sized industries to join forces against HIV/AIDS. In order to gain a critical mass of private sector participants countrywide, the economic and financial cost of HIV/AIDS across industrial sectors needs to be explained. Given Indonesia’s current business climate it is imperative that government policy makers and business leaders at both the national and district levels are cognizant of the economic impact of HIV, the benefits of a healthy workplace, and how HIV/AIDS can affect business.

In 2002 USAID Administrator Andrew Natsios announced a new initiative, the *Global Development Alliance* (GDA), with the goal to enhance development impact through the mobilization of public sector efforts and resources with those of the private sector and NGOs. In mid-2002 a GDA partnership was developed between a number of USAID/Indonesia Strategic Objective (SO) teams and BP (BP Berau Limited) in support of regional development initiatives for the Bird’s Head region of Papua. The *Bird’s Head Alliance* marries BP and its development of the Tangguh Liquefied Natural Gas (LNG) Project with complementary local government and civil society organizational strengthening initiatives in a diversified development strategy that builds capacity and accountability in local management and utilization of resources. SO 8’s contribution to the Alliance is collaboration and cooperation with BP in appropriate HIV/AIDS interventions and local capacity development in the Bird’s Head region, including the urban centers of Sorong, Manokwari and Fak-Fak. As Sorong currently maintains the second highest HIV prevalence rates (FSW) in Papua, there is great concern that the BP project will only intensify HIV/AIDS in Papua with the in-migration of short-term construction workers, the expansion of local entertainment areas and the resultant in-migration of sex workers. Both USAID and BP are committed to tackle these new challenges with complementary technical assistance and support for NGOs, KPAD and other activities in the adjacent Bird’s Head communities. Also, in this new collaboration, BP is committed to the establishment of a workplace-based HIV prevention program at the jobsite. This too will serve as a new model of corporate responsibility and commitment to HIV/AIDS in Indonesia.

Expanded program response

USAID/Indonesia will support new and innovative approaches to solicit action and commitment in HIV/AIDS by for-profit sector, including:

- Implementation of a flexible implementation strategy that takes advantage of favorable market conditions, the state of the epidemic and local government or social conditions;
- The sharing of lessons-learned from neighboring countries such as Thailand and India, as part of the development of locally appropriate training packages and marketing approaches to attract Indonesian businesses;

- The capacity-building of selected NGO partners located in key districts motivated to serve as the lead training agency, technical assistance resource and local advocate for interested private sector companies;
- Private sector partnership training is delivered to individual companies and business leaders in an effort to gain private sector commitment to: develop in-house employee prevention and awareness programs, including the institution of corporate policy on HIV/AIDS and STIs;
- Establish corporate-sponsored community based HIV/AIDS activities for local communities and customers;
- Initiate corporate-sponsored prevention and treatment programs serving employees, family members and/or local communities; and/or
- Initiate corporate sponsorship and collaboration with the USAID HIV/AIDS mass media or similar public health campaigns;
- Attention will be given to target key industries that have the potential to serve as leaders within a particular industry or geographical area. This includes companies employing large numbers of male employees (i.e., a large extractive industry, or transport/shipping company), young adult workers, or those situated close to tourist or entertainment areas. Highly visible companies and luxury hotels located in industrial trade zones such as the Riau Islands offer real potential as they seek to be competitive in the expanding Indo-Singapore-Malaysia economic triangle;
- Educate businesses, local leaders and commercial networks on the economic impact of HIV, the benefits of a healthy workplace, and how HIV/AIDS will affect future markets and business profitability; and
- Active participation in the Bird's Head Alliance with BP and Mission SO teams with support for coordinated interventions with local governments and communities in Sorong, Manokwari and Fak-Fak, Papua.

VI. CROSSCUTTING ISSUES

a. Human Rights and Stigma

Key among the contextual factors that impact effective HIV prevention, and care activities is the human rights environment in the country and the stigma environment at the community level. Human rights principles are laid out clearly in several UN documents that Indonesia has signed and ratified. These principles, as part of the Indonesian governance structure, can help guide the Indonesian national response to HIV/AIDS, and should likewise help guide USAID/Indonesia's assistance in that response. At the same time, at the community level, stigma (devaluing another individual or group because of a characteristic that they possess and which makes them different from the majority) forces those most vulnerable to HIV infection underground and, therefore, strengthens the chain of transmission among those individuals and groups, and through them to the rest of the community.

When a government, from the national level to the local level, recognizes and respects the rights of those who are marginalized, including PLWHAs, programs for HIV prevention and care can be delivered more efficiently by service providers, and will be received more readily by otherwise vulnerable groups. That is, respect for rights translates into more effective prevention and care.

When a local community works to lessen stigma directed at those individuals and groups that are usually most vulnerable to HIV transmission (SW, MSM, IDU, others perceived by the community to be at-risk for HIV), those individuals will be less afraid to access services, and so will more likely receive and internalize prevention information and messages. In the same way, when a local community works to eliminate stigma directed at PLWHAs, such individuals will not only be more likely to access appropriate care services, but will more likely be empowered to participate in the community's HIV prevention response.

The above elements of an effective strategy, raising awareness of human rights and lessening stigma, underscore the need for a multi-sectoral HIV/AIDS response. The governmental, community, and individual attitudinal change, as well as the requisite policy change to promote it, require both health and non-health sector collaboration. USAID/Indonesia, through policy advocacy assistance to the national government response, capacity building and empowerment of the most vulnerable communities to respond (including capacity building of NGOs reaching the most vulnerable populations), and the promotion of the greater involvement of PLWHAs, can help achieve both.

b. Gender

Bringing a gender perspective to all HIV/AIDS activities is an essential element to make them most effective. Men and women have different needs, perspectives and experiences both in areas relating to HIV prevention and to those relating to care and support once affected by HIV. In Indonesia, migrants represent a significant risk group, with male migrants leaving women at home and possibly placing them at risk upon their return. Many women migrants in Indonesia are subject to a variety of conditions of work both domestically and internationally, that place them at risk. Being that Indonesia currently ranks as “Tier 3” status (does not comply with the minimum standards of the 2000 Trafficking Victims Protection Act of 2000) in the Department of State’s 2002 Trafficking in Persons Report (TIP) as a result of the intensity of domestic and international trafficking of women and children in the illegal sex trade, Indonesian women and girls from poverty-afflicted communities are particularly vulnerable to HIV/AIDS. For a group such as IDUs, the concerns of female IDUs are frequently different from those of males, for example, issues relating to pregnancy and drug addiction. When a family member is infected with HIV and become sick, women bear the greater burden of health care, income loss and increased workload. A common major concern is managing to keep their children in school. Men typically are concerned to maintain their health and continue working for their families. Specific programs to alleviate these burdens can be developed with local partners. Thus, adapting both prevention and care and support activities to meet the gender-specific needs of men and women will be given focused attention.

c. Youth

Young people, between the ages of 13 and 24, form a major proportion of those persons in vulnerable groups, including sex workers and IDUs.

Drug use and experimentation is rampant in Indonesia’s cities. Indonesian urban youth have easy access to inexpensive injecting drugs. Studies show that the age of drug users seems to be decreasing with most users aged 16-25 years (60-80%) many of whom still attend junior and senior high school. Other studies reveal that despite knowledge of HIV/AIDS, condom use remains low, multiple sex partners is common, needle sharing is frequent, and needle cleaning practices are poor.

The economic crisis combined with pressures for “clean” young women and girls for sex due to the HIV pandemic have led to an increase in the number of young women seeking employment in or trafficked into the commercial sex industry across Indonesia. The majority of girls trafficked into or working in brothel or tightly controlled sex industry work environments have little if any power to make choices regarding condom use or to receive HIV/AIDS education.

Finally, Papuan youth may have greater risk behaviors than other youth. Papua youth engage in opportunity sex. This is frequent and fast sex often accompanied by compensation. Group sex among urban youth is on the rise and is associated with mobility and the use of alcohol and glue sniffing. A study showed that 29% of Papuan respondents to a Standard Interview Questionnaire had sex before the age of 16 and not one respondent under the age of 25 who lived in a rural area of Papua had ever used a condom.

Indonesia's State Guidelines for Reproductive Health for Youth (PROPENAS 2000-2004, Chapter VIII) addresses for the first time, the importance of reproductive health programming for youth in Indonesia. The State Guidelines identifies five priorities for youth, including: (1) the need to decrease the number of under-age marriages; (2) awareness raising of the importance of youth reproductive health within communities, families and among youth themselves; (3) the importance of reducing young pregnancy; (4) the importance of reducing premarital pregnancy; and (5) the importance of raising awareness, positive behavior and knowledge of STIs and HIV/AIDS among youth. While the PROPENAS identifies specific activities to reach youth through national family planning, health and education activities, the current reality in Indonesia greatly limits the GOI's ability to achieve these objectives. Reaching youth and young adults with reproductive health and information services continues to be a major challenge in the new era of HIV/AIDS/STIs and drug use. In the Government's current political climate, the Ministry of Education has removed school-based reproductive health from the family life curricula in junior and senior high schools. At the same time, the 1992 Family Planning Law limits the Government's ability to reach young adults by providing reproductive health and family planning services to married young adults only. Consequently, young adult reproductive health services are only accessible through local NGO services and programming.

While USAID's Indonesia strategy focuses on prevention and surveillance related interventions for core-transmitter and bridge populations, it is important to understand that within the Indonesian context, a significant portion of the target groups most-at-risk include underage sex workers (under 18 years of age), young blue-collar clients, and active junior and senior high school-level drug users. Interventions developed for these specific groups must be carefully designed considering both local and national policies and regulations (commercial sex, narcotics, reproductive health education and reproductive health services), local culture and religious practices.

USAID's Papua strategy includes youth as a major most-at-risk population. In Papua interventions are now underway in priority urban areas with further expansion planned to work directly with both in-school and out-of-school youth utilizing a variety of prevention intervention interventions including new life-skills training approaches. In late 2002 a new Youth and Reproductive Health Survey (YARHS), conducted in tandem with the 2002 Indonesian Demographic Survey (IDHS), will survey youth in 16 provinces, including Papua (Jayapura City). Supported by USAID, the new YARHS will provide reproductive health and behavioral data previously unavailable, for unmarried female and male youth aged 15-24. This new data will not only help to guide interventions for Papuan youth, but will help in the development of all interventions working with young adults across all sites.

Aiming a variety of new prevention marketing strategies to the young (including *AB and C* messages), assuring that young people find VCT and STI services friendly and available, and most importantly, being certain that information regarding HIV/STI risk and protective behaviors is appropriate and delivered in a manner that reaches young people, are major aims of the Indonesia strategy.

d. Blood Safety

It is the policy in Indonesia for all blood donations to be screened for HIV, hepatitis B/C, and syphilis infections. In practice, there are variations in the extent to which this policy is implemented, although in most large cities and towns the vast majority of donations are certainly screened by the Indonesian Red Cross (PMI).

At the provincial level, there also seems to be some uncertainty about the relationship between the provincial laboratory and the PMI laboratory with regard to assuring test availability and quality control. It is also important for hospitals to be aware of the current status of blood screening technology and procedures.

Difficulties have nonetheless arisen in the supply of test kits for blood screening. Both, rapid test kits and ELISA kits have been hard to obtain in some provinces. The consequence of breaks in reagent and kit supply is not only a decrease in transfusion safety, but perhaps more importantly, an underlining of the competency of laboratory staff, and further reduction in the quality of screening.

Until 1998, only ten or 15 blood bags infected with HIV were typically found among the hundreds of thousands of blood donations, which are screened every year in Indonesia as part of the government's efforts to secure a safe blood supply. In the following three years, prevalence among blood donors increased more than ten fold, which represented the HIV prevalence trend among general population. In fact, more infections were found in the year ending December 2000 than in the period from 1992 to 1998.

USAID/Indonesia does not plan to directly support blood safety activities in Indonesia, but will:

- Encourage other donor agencies to assist GOI in assuring a regular supply of test kits and reagents, including ELISA;
- Encourage policy dialogue in the context of blood donation screening to improve the cooperation between the CDC&EH, PMI, and hospitals, especially at provincial and district levels on blood screening practices and protocols; and
- Support training for the PMI and laboratory staff at all levels on conducting appropriate HIV testing.

VII. MONITORING, EVALUATION AND REPORTING

A very important element of USAID/Indonesia's expanded HIV/AIDS strategy is the expansion of the Mission's established program monitoring and reporting system for HIV/AIDS to conform with the requirements of the Agency's *Expanded Response to HIV/AIDS*. Monitoring the effectiveness of USAID/Indonesia's program is essential to assure that future investments are sound and that activities and regional strategies are on the right track in addressing the AIDS epidemic in Indonesia. Rapid feedback to those who are implementing and managing the strategic interventions as well as to those who are affected is the key to improved outcomes.

The new performance monitoring plan (PMP) proposed in this expanded strategy document utilizes a majority of the indicators in the Mission's current PMP with the addition of national impact indicators appropriate for Indonesia's current status as a low-prevalence nation.

USAID/Indonesia's program has been developed in the context of key critical assumptions. The program's monitoring and reporting system is intimately tied to these critical assumptions which include:

- Government stability and increased commitment to STIs/HIV/AIDS.
- The success and effectiveness of local government decentralization.
- The possibility of averting future conflict (in Papua and the Malukus).
- Continued economic progress and political stabilization.
- Continued levels of donor commitment to HIV/AIDS in Indonesia.
- No existing generalized HIV/AIDS epidemic in Papua.

USAID/Indonesia will work toward the goal of maintaining prevalence below 1% among 15-49 year olds in its intervention areas and in collaboration with other donors, nationwide, by 2007. In accordance with Indonesia's upcoming, new national AIDS strategy, and in coordination with other donors as well as national and local HIV/AIDS agencies, the Mission will work to provide a comprehensive package of prevention activities to no less than 80% of the targeted population most-at-risk within the next 3-5 years.

USAID/Indonesia's expanded Performance Monitoring Plan proposes to collect and report on the following key indicators: (A detailed presentation of the Mission's PMP for HIV/AIDS follows in Table II.):

1.0 SO-Level Indicator

1.1 The percent of FSWs testing positive for HIV in DKI Jakarta, Tanjung Pinang, Riau and Surabaya, East Java.

2.0 HIV Seroprevalence Rates/National Level Impact Indicators

2.1 The percent of women aged 15-24 testing positive for HIV during routine sentinel surveillance at Jayapura, Papua antenatal clinics.

2.2 The percent of transvestites (*waria*) in DKI Jakarta testing positive for HIV.

3.0 National Level Changes in Sexual Risk Reduction Behavior

3.1 The percent of FSWs reporting condom use during most recent sex act with client.

3.2 The percent of target male groups reporting condom use during most recent sex act with commercial partner.

3.3 The percent of IDUs reporting condom use during most recent sex act with any partner.

3.4 The percent of Gays reporting condom use during most recent anal sex act with any partner.

3.5 The percent of transvestite (*waria*) sex workers using condom with last anal client.

3.6 The percent of male sex workers using condom with last anal client.

3.7 The median age at first (penetrative) sex among young men and women aged 15-24 surveyed.

4.0 USAID/Indonesia HIV/AIDS Progress and Coverage

4.1 Risk-reduction Behavior and Practices

4.1.1 The percent of FSWs reporting consistent condom use with clients during the past week.

4.1.2 The percent of target male groups reporting commercial sex in the last 12 months.

4.1.3 The percent of IDUs who report sharing injecting equipment at least once in the last week.

4.1.4 The percent of MSM target group reporting no unprotected anal sex in the past month.

4.1.5 The number of FSWs reached by peer educators in USAID-sponsored activities.

4.1.6 The number of USAID-supplied condoms distributed.

4.2 STI/HIV/AIDS Prevention, Care and Treatment Services

4.2.1 The percent of FSWs and other (male) clients diagnosed and treated for STIs in accordance with the GOI recommended STI treatment protocol in USAID-sponsored clinics.

4.2.2 The percent of USAID-sponsored clinics reporting no stock outages of > 5 days of essential drugs.

4.2.3 The percent of commercial sex establishments having condoms available on site for male clients at time of survey.

4.2.4 Number of clients provided services at USAID-sponsored STI clinics.

4.2.5 Number of STI clinics with USAID assistance.

4.2.6 Number of clients seen at USAID-sponsored VCT centers.

4.2.7 Number of persons reached by USAID-assisted community and home-based care programs.

4.2.8 Number of USAID-assisted community and home-based care programs.

4.3 HIV/STI Surveillance Systems and their Use in Decision-Making

- 4.3.1 The percent of provinces in which USAID is active that have collected HIV surveillance and behavioral surveillance data from appropriate risk groups (FSWs, male groups, IDU and MSM).
- 4.3.2 The percent of provinces in which USAID is active that have held a “Second Generation Surveillance” workshop in the past year and input is used to review and analyze available data and improve program planning.
- 4.3.3 Monthly press reports on HIV related issues supporting program objectives in sentinel newspapers.

4.4 Organizational Capacity-Building

- 4.4.1 The percent of districts in which USAID is active where the district budget for KPAD increased over the previous year relative to overall development spending.

4.5 Private Sector Leveraging

- 4.5.1 The percent of provinces in which USAID is active where the number of private sector organizations with workplace HIV prevention programs or substantial in-kind donations to prevention activities increased over the previous year.
- 4.5.2 The percent of provinces in which USAID is active where the total cost share from non-USAID sources increased over the previous year.

**Table II.
USAID/Indonesia's HIV/AIDS Performance Monitoring Plan (PMP)**

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target	2006 Target	2007 Target
<i>SO Level</i>							
1.0. % of FSWs testing positive for HIV.							
DKI Jakarta: Indirect sex workers	2001	1.75%	Below 3.0%	Below 3.0%	Below 3.0%	Below 3.0%	Below 3.0%
Tanjung Pinang, Riau: Direct sex workers	2001	8.00%	10.0%	10.0%	10.0%	10.0%	10.0%
Surabaya, East Java: Direct sex workers	2001	2.70%	Below 4.0%	Below 4.0%	Below 4.0%	Below 4.0%	Below 4.0%
Notes: Indicator 1.0 data source: GOI sentinel surveillance surveys. Direct sex workers are brothel-based and indirect sex workers are street-based/informal sex workers.							

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target
Impact					
1.0 % of women aged 15-24 testing positive for HIV during routine sentinel surveillance at Jayapura, Papua antenatal clinics.	2004	Available in 2004	Not Available	TBD	TBD
2.0 % of transvestites (<i>waria</i>) in DKI Jakarta testing positive for HIV.	2002	22.7%	25.0%	25.0%	25.0%
Notes: Indicator 1.0 data source: GOI sentinel surveillance surveys. Indicator 2.0 data source: The FHI/ASA MSM study for baseline data and GOI sentinel surveillance surveys for subsequent years.					

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target
<i>Sub-Intermediate Result 3.1</i> <i>Increased risk reduction behavior and practices among individuals most-at-risk for HIV and sexually transmitted infections</i>					
3.1.1 % of FSWs reporting condom use during most recent sex act with client.					
DKI Jakarta: Indirect sex workers	2002	50.1%	60.0%	70.0%	75.0%
Tanjung Pinang, Riau: Direct sex workers	2002	57.0%	65.0%	70.0%	80.0%
Surabaya, East Java: Direct sex workers	2000	45.0%	56.0%	65.0%	72.0%
3.1.2 % of FSWs reporting consistent condom use with clients during past week.					
DKI Jakarta: Indirect sex workers	2002	18.0%	30.0%	45.0%	55.0%
Tanjung Pinang, Riau: Direct sex workers	2002	17.0%	30.0%	45.0%	55.0%
Surabaya, East Java: Direct sex workers	2000	16.0%	30.0%	45.0%	55.0%
3.1.3 % of Target Male Groups reporting commercial sex in the last 12 months.					
DKI Jakarta: Seamen	2002	42.0%	35.0%	30.0%	30.0%
North Sumatra: Truckers	2002	56.0%	45.0%	35.0%	30.0%
Tanjung Pinang, Riau: Seamen	2002	75.0%	60.0%	50.0%	40.0%
Surabaya, East Java: Seamen	2000	42.0%	42.0%	35.0%	30.0%
Notes: Indicators 3.1.1 – 3.1.3 data source: GOI behavioral surveillance surveys.					

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target
3.1.4 % of Target Male Groups reporting condom use during most recent sex act with commercial partner.					
DKI Jakarta: Seamen	2002	15.0%	25.0%	35.0%	45.0%
North Sumatra: Truckers	2002	7.0%	20.0%	30.0%	40.0%
Tanjung Pinang, Riau: Seamen	2002	40.0%	50.0%	60.0%	65.0%
Surabaya, East Java: Seamen	2000	25.0%	40.0%	50.0%	65.0%
3.1.5 % of IDUs who report sharing injecting equipment at least once in the last week.					
DKI Jakarta	2002	92.0%	75.0%	60.0%	45.0%
3.1.6 % of IDUs reporting condom use during most recent sex act with any partner.					
DKI Jakarta	2002	25.0%	40.0%	52.0%	65.0%
Notes: Indicator 3.1.4 data source: GOI behavioral surveillance surveys. Indicators 3.1.5 and 3.1.6 data source: Jakarta Drug Rehabilitation Hospital (RSKO) reports.					

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target
3.1.7 % of MSM Target Group reporting no unprotected anal sex in the past one month. DKI Jakarta: Transvestites (<i>waria</i>) DKI Jakarta: Male sex workers DKI Jakarta: Gay	2002 2002 2002	49.0% 38.0% 47.0%	55.0% 45.0% 55.0%	65.0% 55.0% 65.0%	70.0% 60.0% 70.0%
3.1.8 % of Gays (MSM Target Group) reporting condom use during most recent anal sex act with any partner. DKI Jakarta	2002	31.0%	40.0%	50.0%	60.0%
3.1.9 % of transvestite (<i>waria</i>) sex workers using condom with last anal client. DKI Jakarta	2002	48.6%	60.0%	70.0%	80.0%
3.1.10 % of male sex workers using condom with last anal client. DKI Jakarta	2002	36.0%	45.0%	55.0%	65.0%
3.1.11 Median age at first (penetrative) sex among young men and women aged 15-24 surveyed.	2003	Available in 2003	TBD	TBD	TBD
3.1.12 The number of FSWs reached by outreach educators in USAID-sponsored activities.	2001	4,235	15,000	18,000	22,000
3.1.13 The number of USAID-supplied condoms distributed.	2003	Available in 2003	TBD	TBD	TBD
<p>Notes: Indicators 3.1.7 – 3.1.10 data source: The FHI/ASA MSM study for baseline data and GOI behavioral surveillance surveys for subsequent years. 3.1.7 <i>waria</i> data reports no unprotected anal sex in the past one week. Indicator 3.1.11 data source: The 2002/3 <i>Young Adult Reproductive Health Survey (YARHS)</i> conducted in 13 provinces (Riau, Lampung, South Sumatra, North Sulawesi, South Sulawesi, DKI Jakarta, West Java, Central Java, DI-Yogyakarta, East Java, Nusa Tenggara Barat, West Kalimantan, South Kalimantan and Papua (Jayapura City)). Indicator 3.1.12 data source: FHI/ASA fourth quarter performance reports. Indicator 3.1.13 data source: FHI/ASA fourth quarter performance reports. USAID-supplied condoms are provided through USAID's Commodity Promotion Fund.</p>					

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target
<u>Sub-Intermediate Result 2.1</u> <i>Strengthened quality, accessibility, and utilization of prevention, care and treatment services for individuals most-at-risk for STI/HIV/AIDS</i>					
2.1.1 % of FSWs and other clients diagnosed and treated for STIs in accordance with the GOI recommended STI treatment protocol in USAID-sponsored clinics.	2002	96%	100%	100%	100%
2.1.2 % of USAID-sponsored clinics reporting no stock outages of > 5 days of essential drugs.	2003	Available in 2003	TBD	TBD	TBD
2.1.3 % of commercial sex establishments having condoms available on site for male clients at time of survey.	2002	75%	85%	100%	100%
2.1.4 Number of clients provided services at USAID-sponsored STI clinics.					
Male clients	2002	216	8,000	8,500	9,000
Female clients	2002	2,713	10,000	11,000	12,000
Total clients	2002	2,929	18,000	19,500	21,000
2.1.5 Number of STI clinics with USAID assistance.	2002	10	22	22	22
Notes: Indicators 2.1.1 –2.1.5 data source: FHI/ASA fourth quarter performance reports					

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target
2.1.6 Number of clients seen at USAID-sponsored VCT centers. <div style="text-align: right;"> Male clients Female clients Total clients </div>	2003 2003 2003	Available in 2003	TBD	TBD	TBD
2.1.7 Number of persons reached by USAID-assisted community and home-based care programs. <div style="text-align: right;"> Males Females Total </div>	2003	Available in 2003	TBD	TBD	TBD
2.1.8 Number of USAID-assisted community and home-based care programs.	2003	Available in 2003	TBD	TBD	TBD
Notes: Indicators 2.1.6 –2.1.8 data source: FHI/ASA fourth quarter performance reports.					

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target
<i>Sub-Intermediate Result 2.2</i> <i>Enhanced capacity and quality of GOI HIV/STI surveillance systems and their use in decision-making</i>					
2.2.1 % of provinces in which USAID is active that have collected HIV surveillance and behavioral surveillance data from appropriate risk groups:					
FSWs	2002	100%	100%	100%	100%
Male Groups	2002	40%	100%	100%	100%
IDU	2002	20%	30%	30%	30%
MSM	2002	10%	30%	40%	50%
2.2.2 % of provinces in which USAID is active that have held a "Second Generation Surveillance" workshop in the past year and input is used to review and analyze available data and improve program planning.	2002	10%	100%	100%	100%
2.2.3 Monthly press reports on HIV related issues supporting program objectives in sentinel newspapers.	2000	13/month (156/year)	20/month (240/year)	20/month (240/year)	20/month (240/year)
Notes: Indicators 2.2.1 –2.2.3 data source: FHI/ASA fourth quarter performance reports.					

Performance Indicator	Baseline Year	Baseline Value	2003 Target	2004 Target	2005 Target
<u>Sub-Intermediate Result 2.3</u> <i>Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI responses</i>					
2.3.1 % of districts in which USAID is active where the district budget for KPAD increased over the previous year, relative to overall development spending.	2002	80%	80%	85%	90%
<u>Sub-Intermediate Result 1.1</u> <i>Increased leveraging of programmatic interventions and financial resources</i>					
1.1.1 % of provinces in which USAID is active where the number of private sector organizations with workplace HIV prevention programs or substantial in-kind donations to prevention activities increased over the previous year.	2002	0	30%	60%	80%
1.1.2 % of provinces in which USAID is active where the total cost share from non-USAID sources increased over the previous year.	2002	80%	100%	100%	100%
Notes: Indicators 2.3.1 data source: FHI/ASA fourth quarter performance reports. Indicators 1.1.1 – 1.1.2 data source: FHI/ASA fourth quarter performance reports.					

VIII. BUDGET AND MANAGEMENT SUPPORT

The pace of progress and accomplishments of the 2000-2002 USAID/Indonesia HIV/AIDS activity has been constrained by limited funds. The FY01 level of funding provided by USAID/W (\$ 4.0 m.) was inadequate to keep on schedule with planned program implementation. The FY02 level of \$ 7.3 m. (CSH) and \$ 1.0 m. (ESF) was an improvement. Annual levels of approximately \$ 9-10 million/year for FY03 and FY04 are certainly justifiable given the scope and urgency of the expanded Indonesia strategy. A critical factor needed to be considered by USAID/Washington is the hydraulic effect of increased HIV/AIDS funding on other child survival, health and other SO priorities for Indonesia.

With the availability of additional funding, the Mission and its cooperating agencies will need to carefully monitor supervisory and management capacities. At present two full time and one-quarter time professional staff members and the US Direct Hire HPN Team Leader manage the HIV/AIDS program with one-half time secretarial/ administrative support. Over the next 2-5 years, as the major HIV/AIDS donor in Indonesia, Mission staff will have significantly increased program supervisory responsibilities monitoring resource use, as well as in encouraging additional donor participation in HIV/AIDS, ensuring more effective donor coordination, and encouraging HIV/AIDS advocacy among Indonesian leadership. The Mission's direct hire ceiling for the Health, Population and Nutrition strategic objective is limited to two staff persons. Therefore, the Mission's staffing plan for the HIV/AIDS activity at present will be to continue to utilize one full-time Foreign Service National (FSN) and one full-time internationally-recruited Personal Services Contractor (to be converted to a full-time TAACS position in FY03). The Mission is fully aware of the expanding scope and importance of increased Mission staffing and management oversight of HIV/AIDS programming and issues, and plans increased participation and advocacy in HIV/AIDS issues by the Ambassador, USAID Mission Director, Deputy Director, and HPN Team Leader in networking opportunities with Government counterparts, other donors and private sector interests. Likewise, the management capacity of the Mission's principal activity cooperating agency also requires careful monitoring and review, and if deemed necessary, expansion. Given the expanded objectives at these sites, the current structure needs to be regularly reviewed as implementation progresses by the HPN, CA and GOI management team. Implementing expanded programs in ten sites across a 2000-mile archipelago is a daunting task for any organization and may well be the broadest scope of any USAID-funded implementing partner presently working in Indonesia.

The Mission will carefully review the management issues associated with an expanded HIV/AIDS program, assessing the demonstrated strengths and weaknesses of the existing implementing partner and capacity for expansion. As appropriate, the Mission may consider utilizing an additional cooperating agency (through a USAID/W add-on) to ensure expanded attention to specific program areas.

Key management actions and issues to be considered by the Mission include:

1. Extension of the current Cooperative Agreement thru FY05 (period allowed by the current HPN SOAG and Mission Country Strategy) by January 2003.
2. Plan for an Expanded Program and Management Review in early 2004.
3. Ensure cooperating agency operationalizes their new decentralized and stream-lined sub-contracting mechanism as planned in early FY03.
4. Work with cooperating agency to ensure adequate management capacity at second phase intervention sites.
5. Reinforce linkages with other USAID Mission programs, particularly with the Community and Civic Participation (CPT), Economic Growth (ECG), Decentralized Local Government (DLG), and Rural Environmental Management (REM) Strategic Objective (SO) teams.
6. Encourage partnerships with Mission anti-trafficking activities to pilot new linkages and interventions to protect the health of domestically trafficked women and children.

7. Solicit participation of the American Ambassador, USAID Mission Director and Deputy Director and other Embassy resources for HIV/AIDS advocacy in Indonesia.
8. Solicit participation of the American Chamber of Commerce and other civic groups (Rotary, etc.) to encourage innovative involvement by the private sector in HIV/AIDS in Indonesia.
9. Encourage the start-up of routine HIV/AIDS Donor Meetings to be managed by the National AIDS Commission or as part of an expanded UN Theme Group meeting structure.
10. Advocate and encourage additional donor and other resources to participate in the Indonesian response to HIV/AIDS, particularly the Japanese through its JICA collaboration with the Ministry of Health.
11. Mission support to assist The Global Fund's (GFATM) Country Coordinating Mechanism (CCM) in Indonesia to ensure effective planning and coordination of Global Fund HIV/AIDS resources in Indonesia.

Budget Planning for FY03 – FY05

Budget plans supporting the Mission's request for \$9.0 m. (CSH) for FY03, FY04 and FY05 respectively, are presented below by sub-intermediate result in Table III. This budget table presents the Mission's expected budget levels for the period FY03 –FY05 as outlined in Section V., detailing USAID/Indonesia's expanded response strategy for HIV/AIDS.

Table III.

Sub-Intermediate Results	FY03	FY04	FY05	Total
1. Increased Risk Reduction Behavior and Practices among individuals most-at-risk for HIV and sexually-transmitted infections	4.214	3.899	3.949	12.062
2. Strengthened quality, accessibility and utilization of prevention, care and treatment services for individuals most-at-risk for STI/HIV/AIDS	2.687	2.935	3.041	8.663
3. Enhanced capacity and quality of GOI HIV/STI surveillance systems and their use in decision making	.801	.915	.954	2.670
4. Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI responses	.800	.717	.538	2.055
5. Increased leveraging of programmatic interventions and financial resources	.498	.534	.518	1.550
Total	9.000	9.000	9.000	27.000

At the request of the Office of HIV/AIDS, a second table, Table IV., presents a reduced budget scenario of \$7.3 m. for FY03, with the planned levels of \$9.0 m. for FY04 and FY05. Along with this reduced budget scenario, is a description of the impact that a reduced budget of \$1.7 m. for FY03 will have on USAID/Indonesia's expanded strategy.

Table IV.

Sub-Intermediate Results	FY03	FY04	FY05	Total
1. Increased Risk Reduction Behavior and Practices among individuals most-at-risk for HIV and sexually-transmitted infections	3.631	3.899	3.949	11.479
2. Strengthened quality, accessibility and utilization of prevention, care and treatment services for individuals most-at-risk for STI/HIV/AIDS	2.137	2.935	3.041	8.113
3. Enhanced capacity and quality of GOI HIV/STI surveillance systems and their use in decision making	.799	.915	.954	2.668
4. Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI responses	.324	.717	.538	1.579
5. Increased leveraging of programmatic interventions and financial resources	.409	.534	.518	1.461
Total	7.300	9.000	9.000	25.300

A budget reduction of \$1.7 million for FY03 will have a significant impact on the quality and quantity of HIV/AIDS prevention and care interventions to be supported by USAID in Indonesia from October 1, 2003 through September 30, 2004. Key reductions in the FY03 approved ASA workplan will include:

- A reduction in the number of subagreements supporting NGO activities would be reduced by approximately 20% over the planned level. This would result in a large reduction in the scope of STI services available, and the volume of outreach activities, particularly for male clients of sex workers and injecting drug users. This would also force the cancellation of all activities in at least two of the ten target provinces, including Maluku and South Sumatra.
- The number of activities organized directly by the ASA program and/or in collaboration with the GOI at national and local levels will be reduced by almost 50%. All capacity building activities for the Local AIDS Commissions (KPAD) at the district and provincial levels would be cancelled; including efforts to increase the quality of data based decision-making and strategic planning at the local level. Trainings, seminars and workshops supporting national surveillance, and prevention activities with the uniformed services and prisons will also be greatly reduced.
- A reduction in international and local technical assistance by at least 75% of that planned for FY03. This will greatly impact the quality of interventions, especially in the areas of behavior change, risk minimalization for injecting drug users, STI services, care and support and surveillance.
- A reduction in field-based monitoring and oversight of activity implementation resulting from a 35% reduction in the travel budget.

- A significant reduction in technical assistance to NGO partners and implementing agencies with the elimination of three full-time positions in FHI/ASA's Technical Unit, including the loss of one expatriate and two local hire staff.

Annex 1: 2002 National HIV Infection Estimates

Indonesia

Total Population: 206,141,519

Total Population 15-49: 115,214,749

Populations	Estimated population size			Estimated HIV prevalence			People Living with HIV
	Low Estimate	High Estimate	Average	Low Prevalence	High Prevalence	Average	Average
IDU	123,849	195,597	159,723	19.18	34.35	26.76	42,749
Non-IDU partners of IDU	94,125	148,654	121,389	6.39	11.45	8.92	10,830
Sex workers	193,234	272,844	233,039	1.98	5.20	3.59	8,369
Clients of sex workers	6,859,402	9,585,103	8,222,253	0.20	0.61	0.40	32,922
Regular partners of clients	4,934,487	7,293,178	6,113,833	0.03	0.11	0.07	4,457
Gay	574,904	1,724,713	1,149,809	0.40	1.34	0.87	10,021
Male sex workers	2,100	2,900	2,500	2.74	5.29	4.02	100
Female partners of male sex workers	992	1,372	1,182	1.00	1.99	1.50	18
<i>Waria</i>	7,831	14,712	11,272	9.34	14.33	11.84	1,334
Clients of <i>waria</i> sex workers	173,050	339,927	256,488	1.88	2.87	2.37	6,085
Regular partners of <i>waria</i>	2,128	3,972	3,050	4.37	6.59	5.48	167
Prisoners	73,794	73,794	73,794	8.61	15.38	11.99	8,851
Street children	70,872	70,872	70,872	0.00	0.17	0.08	59
Total	12,791,783	19,235,233	16,013,508	0.42	0.97	0.69	110,800

Source: Report of the Ministry of Health's HIV/AIDS National Estimation Meeting, September 12-14, 2002 "National Estimates of Adult HIV Infection, Indonesia 2002: A Description of Methods", Family Health International/*Aksi Stop AIDS*, December 2002.

Annex 2: 2002 Provincial HIV Infection Estimates for USAID Intervention Areas

Central Java

Total Population: 31,677,056

Total Population 15-49: 17,704,653

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	28,352	3.00	489
Clients of FSW	1,066,239	.30	1,839
IDU	16,706	35.00	4,109
MSM	265,570	1.00	0
<i>Waria</i>	1,357	15.00	119

East Java

Total Population: 35,612,425

Total Population 15-49: 19,904,174

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	33,756	5.00	1,092
Clients of FSW	1,910,554	.50	6,180
IDU	14,968	35.00	4,052
MSM	298,563	2.00	2,488
<i>Waria</i>	2,431	12.00	164

Jakarta

Total Population: 8,550,305

Total Population 15-49: 4,778,859

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	37,619	5.00	892
Clients of FSW	1,489,721	.50	3,534
IDU	27,796	50.00	10,326
MSM	71,683	2.00	597
<i>Waria</i>	3,000	22.00	440

Maluku

Total Population: 1,149,899

Total Population 15-49: 658,338

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	2,208	1.00	12
Clients of FSW	83,294	.10	47
IDU	2,610	25.00	264
MSM	9,875	.50	23
<i>Waria</i>	135	5.00	3

North Sulawesi

Total Population: 2,021,486

Total Population 15-49: 1,129,831

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	1,111	3.00	19
Clients of FSW	23,070	.30	40
IDU	633	25.00	70
MSM	16,947	.50	40
Waria	29	5.00	1

North Sumatra

Total Population: 11,786,957

Total Population 15-49: 6,587,859

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	21,633	1.20	149
Clients of FSW	619,059	.10	427
IDU	23,222	25.00	3,748
MSM	98,818	.50	231
Waria	700	10.00	41

Papua

Total Population: 1,739,324

Total Population 15-49: 972,127

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	10,881	15.00	1,032
Clients of FSW	409,214	2.70	6,000
IDU	1,774	25.00	182
MSM	14,582	.50	34
Waria	250	15.00	25

Riau

Total Population: 4,870,947

Total Population 15-49: 2,722,426

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	24,930	8.00	1,269
Clients of FSW	450,352	.80	2,290
IDU	9,665	25.00	1,095
MSM	40,836	2.00	340
Waria	677	20.00	88

South Sumatra

Total Population: 7,024,328

Total Population 15-49: 3,925,974

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	18,820	3.00	325
Clients of FSW	538,553	.30	929
IDU	2,822	25.00	549
MSM	58,890	.50	137
<i>Waria</i>	1,222	5.00	33

West Java

Total Population: 36,593,211

Total Population 15-49: 20,452,346

Risk Population	Population Size High Estimate	HIV Prevalence Estimate High Prevalence (%)	Living with HIV/AIDS Average
FSW	22,428	8.00	1,001
Clients of FSW	843,457	.80	3,763
IDU	26,684	35.00	6,087
MSM	306,785	2.00	2,557
<i>Waria</i>	944	22.00	134

Source: Report of the Ministry of Health's HIV/AIDS National Estimation Meeting, September 12-14, 2002 "National Estimates of Adult HIV Infection, Indonesia 2002: A Description of Methods", Family Health International/*Aksi Stop AIDS*, December 2002.

ACTION MEMORANDUM FOR THE DEPUTY MISSION DIRECTOR

DATE: April 23, 2002

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

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

TO: Sharon Cromer, Deputy Mission Director

Action Requested:

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

Background:

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

The USAID grant funds were channeled through:

- A FHI/AIDSCAP buy-in delivery order (1995 -1997) and a FHI performance based contract with USAID/Indonesia (1997-2000) for technical assistance, training, commodities, operational costs and intervention activities;
- A Participating Agencies Service Agreement (PASA) with CDC/Atlanta to provide short- and long-term technical assistance in preventing and managing Sexually Transmitted Infections (STIs); and
- Direct funding to the Ministry of Health (MOH) through Project Implementation Letters (PILs) for the development of training modules, training for MOH staff, workshops and supervision activities.

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

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

Budget:

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

Budget Summary:

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

Highlights of *HAPP* Achievements:

1. *HAPP*'s IEC/ Behavior Change Communication (BCC) two-pronged strategy promoted health services for STI control and condom use promotion through NGO outreach activities. More than 23,000 units of IEC materials were produced and distributed through outreach activities. Knowledge of acceptable ways to prevent HIV transmission among female sex workers (FSWs) increased from 70% in 1996 to 86% in 2000, and among male respondents increased from 76% in 1996 to 88% in 2000. The percentage of FSWs reporting condom use slightly increased from 36% in 1997 to 41% in 2000, and among high-risk males increased from 14% in 1996 to 22% in 2000.
2. In collaboration with the Futures Group International (TFG), *HAPP* developed a strategy to utilize commercial resources for the social marketing of condoms (SMC). Condom distribution and use was expanded through collaborative activities with the private sector condom consortium (Durex, Simplex, and Artika) to strengthen their promotion of brand name condoms through a variety of mass and print media. Commercial distributors hired sales team to distribute condoms among target groups, and special events for targeted audiences were managed to expand the availability of condoms in the three demonstration areas. Distribution penetration for condoms in red light areas in the three demonstration areas increased from 37% in 1996 to 65% in 2000.

3. Key public hospitals, health centers and family planning clinics were upgraded to provide comprehensive STI services, including STI counseling, and improved STI diagnosis/treatment using syndromic guidelines and simple lab testing. As appropriate, the integration of STIs and family services was encouraged. Beneficiaries (sex workers, sailors, truck drivers) liked these clinics because they were affordable, accessible, and provided quality services. Private practitioners (doctors and midwives) were trained to use STI syndromic guidelines. Central and provincial laboratories were upgraded to support epidemiological and clinical research on STIs and HIV/AIDS. The percentage of patients (high risk) correctly diagnosed and increased for STIs at *HAPP* upgraded facilities increased from 8% in 1996 to 48% in 2000. Universal Precaution guidelines for health centers were strengthened and standardized through a process involving the East Java Department of Health.
4. In collaboration with other donors and partner organizations, HIV serological and behavioral surveillance surveys (BSS) were conducted annually. The results were used to measure behavioral trends overtime, and were utilized by the MOH and World Bank for the 2000 national HIV/AIDS programming review and planning. AusAID adopted the same BSS system to conduct surveys in Makasar and Denpasar. The expanded use of behavior surveillance facilitated the comparison of behavioral data across sites in Indonesia.
5. An important focus of *HAPP* was to encourage collaboration among national and provincial government offices on the issue of HIV/AIDS prevention and control, as well as to strengthen the capacity of local partners to manage HIV/AIDS interventions. *HAPP* supported and encouraged the Provincial AIDS Commissions (KPAD) in the three demonstration areas to promote a greater interagency and community involvement in HIV/AIDS prevention and advocacy activities. *HAPP* strengthened the role and functioning of the KPAD by assisting the establishment of a working secretariat, hiring full-time staff, and enabling coordination between the KPAD and the *HAPP* partners.
6. In April 2000, *HAPP* established a foundation for future prevention strategies by reporting the changing patterns of HIV transmission and supporting an assessment of HIV risk among injecting drug users (IDU) in collaboration with UNAIDS, WHO and AusAID, in eight cities in Indonesia.

Lessons Learned

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

2. Quality communication and counseling skills are essential to successful outreach interventions. Focused training and capacity building on the development and utilization of appropriate IEC materials is crucial for effective behavior change interventions. The continued use of mass and print media and peer education approaches with female and male sex workers and their clients, transvestites, men who have sex with men, injecting drug users, and other high-risk population groups is highly encouraged.
3. Effective campaigns must be sensitive to religious and cultural issues while also targeting the myths and stigma attached to AIDS and condoms. The concept of protection is the strongest reason given by clients for purchasing condoms.
4. Although the knowledge of acceptable ways to prevent HIV transmission among FSWs and their clients was quite high, condom use among these vulnerable groups remained low. This was probably a result of several factors, including insufficient emphasis on outreach to male clients, and the difficulties associated with trying to reach highly mobile population groups (both FSWs and mobile men) through outreach education and condom promotion activities.
5. STI syndromic management remains a useful approach for the diagnosis and treatment of STIs in men, however, it is less useful for the screening, diagnosis and treatment of women, due to the fact that women exhibit few STI symptoms. Improved STI management includes the syndromic approach accompanied by a simple testing, counseling and referral system for vulnerable groups.
6. Not only is it important that the GOI's surveillance data are comprehensive, but it is also important that the surveillance process is transparent so that the surveillance data are perceived to be reliable. Resolving these issues and making the necessary changes to the STI/HIV surveillance systems to ensure quality standards are critical areas for USAID support. Programs to improve the monitoring of HIV and STIs should include the integration of serological and behavioral surveillance, as well as the analysis and use of the data for both local and national policy development and decision-making.
7. Both the national and local-level AIDS commissions serve an important role in HIV/AIDS policy-making and programming across the country. These commissions serve as a "community" forum involving government, political, civil society and religious leaders in making political and budgetary commitments to HIV/AIDS prevention and control. Long-term technical assistance and support to the national and local AIDS commissions are needed from the donor community to ensure organizational development and strengthening.
8. In order to maximize the use of limited local and donor resources for HIV/AIDS, it is critical that local government and civil society organizations manage planning and coordination early on in the implementation process.

Constraints

1. A devastating economic and political crisis has affected Indonesia since July 1997 and has resulted in a health crisis for vulnerable populations across the country. It is believed that Indonesia's health crisis will accelerate the spread of STIs, including HIV. With an on-going economic crisis, the GOI's ability to provide adequate counterpart funds for

HIV/AIDS and STIs is threatened. This, combined with a changing political situation, has affected current and future donor support to the sector. The limited numbers of donors active in the sector have presented plans to cut contributions to the national HIV/AIDS program. This, compounded with the impact of the economic crisis on family income, employment, and purchasing power directly impacts Indonesia's ability to prevent and control STIs and HIV/AIDS.

2. Limited technical skills and human resource capacity may be the greatest barrier to managing HIV/AIDS program interventions working to reduce risk behaviors. Evidence suggests that time and resource-intensive interventions are required to achieve sustainable behavior change.
3. Simple, cost effective solutions to the diagnosis and treatment of STIs are still lacking for women. Many vulnerable women continue to be ineffectively treated, due to poor treatment-seeking behaviors combined with poor quality STI services and the lack of "user friendly" services, for sex workers and other vulnerable women.

Post Project Assistance Completion Actions

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

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

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

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

Approved: _____

Disapproved : _____

Sharon Cromer, Deputy Mission Director

Attachments:

1. Strategic Objective Grant Agreement, No. 497-0380, dated August 19, 1998, between the Republic of Indonesia and the United States of America for Health and Reduced Fertility
2. HAPP Completion Report, 1997-2000, dated September 29, 2000
3. USAID Performance Evaluation and Award Fee Determination Report for FHI, dated May 21, 2001
4. USAID Final Contract Performance Report for FHI, dated March 6, 2001
5. USAID Contract Close-out Completion Statement for FHI, dated September 27, 2001
6. PASA/CDC Close Out- Completion Statement, dated May 25, 2001
7. Project Implementation Letter No. 9 for de-commitment excess funds, dated April 11, 2001
8. Final Host Country Contribution Report, dated September 20, 2000
9. A FHI critique of the Performance Base Contract, dated February 26, 1999
10. USAID Financial Status Report, dated March 21, 2002
11. External Assessment of USAID/Indonesia's HIV/AIDS Program, dated February 1999

**USAID/INDONESIA
HIV/AIDS
PRIORITY GEOGRAPHIC AREAS
2002 - 2007**



Annex 5: Strategy Review Team Members

Clifton Cortez, Office of HIV/AIDS, Bureau for Global Health, USAID/W;
Ratna Kurniawati, STI/HIV/AIDS/ID Team, USAID/Indonesia;
Billy Pick, HIV/AIDS Technical Specialist, Bureau for Asia and Near East, USAID/W (Co-team leader);
John Pielemeier, Consultant provided through the Synergy Project (Co-team leader);
Joy Pollock, STI/HIV/AIDS/ID Team, USAID/Indonesia; and
Sigit Privohutomo, Communicable Disease Control, Ministry of Health, Jakarta, Indonesia.

Annex 6. The Economic Engines of HIV in Indonesia

Indonesia must heed the warnings and focus attention on *reducing risk* within priority sectors and among individuals most-at-risk. HIV/AIDS is no longer an invisible public health issue in Indonesia. HIV/AIDS is now a major concern affecting the nation's primary engines of economic progress and national development. HIV threatens the future of Indonesia's future economic and social prosperity. In order to better visualize the impact of HIV on the new Indonesia it is important to identify behavioral risks and enabling environments that shape the dynamics of HIV transmission in Indonesia. ***Indonesia's powerful economic sectors, profitable industries and local enterprises facilitate increased risk behavior patterns.***

Tourism:

As a country with some of the world's richest cultural diversity, Indonesia remains a very attractive destination for international visitors. Primary tourist destinations include Bali, the Riau islands, and greater Jakarta followed by historical and cultural sites on the islands of Java, Lombok and Sulawesi. The Riau islands of Batam and Bintan are favored weekend destinations for Singaporeans and Malaysians, whereas Bali is the preferred destination for visiting Australians, Japanese, Europeans and North Americans. The tourist market brings valuable foreign exchange, along with increased demands for male and female sex workers, contract-wives, non-traditional sexual exchanges, and new sexually transmitted infections and strains of HIV.

Food and Entertainment Industries:

Throughout the archipelago local entertainment enterprises exist in large cities, small towns and villages in the form of food stalls, restaurants, street markets, entertainment halls, karaoke bars, massage parlors, small hotels, informal brothels, and controlled brothel complexes. While the majority of sex workers in Indonesia are female, other categories include male sex workers who service women and men, and transvestites (*waria*) who service only men. Indonesia's second largest city, Surabaya (population of 2.7 million) currently supports an estimated population of 10,000 female sex workers. This compares with the provincial city of Batam (population 359,000) with an estimated sex worker population of 10,000. Evening entertainment on the street and outside the family home remains a very popular and lucrative business sector in urban areas and provincial towns. Community entertainment areas market cigarettes, alcohol and other traded stimulants, offer a variety of inexpensive sexual entertainment options, and provide opportunities for individuals to discretely maintain multiple sexual partnerships.

Domestic Transport Industries:

As a nation of islands, Indonesia's economic prosperity is dependent upon the mobility and transfer of resources, goods, and people across an area of more than 5,100 kilometers. Domestic transport in Indonesia involves a variety of overland and water transport options including taxis, minibuses, long-haul trucks and buses, trains, riverboats, inter-island ferries and air travel. The nature of mobile, long-distance transport lends itself to long working hours and extensive periods of time away from families by (primarily) male workers. Within this context are increased opportunities for both multiple and commercial sexual exchanges in crossroads and cross-border towns. It is a well-documented fact that transient workers face a greater risk from exposure to HIV/AIDS than stable populations.

Resource Extraction Industries:

Indonesia is rich in valuable natural resources. Significant natural resources include: oil, natural gas, coal, tin, bauxite, gold, and timber. Key agricultural resources include: rubber, tea, palm oil, cacao, coffee, rice and tobacco. It is estimated that over 50% of Indonesia's national export income is derived from its natural and agricultural resource base. With the exception of most plantations and agricultural enterprises, the majority of Indonesia's extractive industries are located in remote, rural locations employing large numbers of predominantly, male labor. Extractive industries are located east to west from Papua to North Sulawesi to South Sulawesi to Central Kalimantan to

Sumbawa to Aceh in the far north to Riau's offshore oil and natural gas fields. These work environments as well as the adjacent towns and villages attract dedicated service industries, particularly bars and brothels employing large numbers of young, mobile, female sex workers from resource-poor communities located on the islands of Java, Sumatra and Sulawesi.

Indonesia's Large, Mobile Military Complex:

As the primary defender of the nation, the Indonesian military remains powerful in size and strength. The military maintains battalions nationwide, with very large contingents of soldiers moving in and out of key hot spots, from Papua to the Maluku Islands to West Timor to Kalimantan to Aceh. Military commands include both land-based units that protect key national interests, as well as naval operations, which control ports and harbors. It is estimated that Indonesia currently supports a force of 70,000 central commands and 150,000 deployments nationwide as part of the government's current national security strategy. Similar to other predominantly male, transient occupational groups, Indonesian military bases and short-term camps attract a dedicated service sector, which includes a variety of sexual entertainment enterprises and female sex workers.

Industrial Estates and Export Processing Zones:

Over the past ten years the Indonesian government has invested enormous capital resources into the development of specialized industrial production zones to attract increased foreign and domestic industrial investment to Indonesia. The location of the Riau islands close to Singapore and the Straits of Malacca provides Indonesia with a number of critical, regional economic comparative advantages. Today, Batam Island, located 20 kilometers south of Singapore, remains Indonesia's largest economic development zone with more than 8,400 industries located in specialized industrial estates. Employing approximately 150,000 workers, of which the majority is female, Batam-based industries hire tens of thousands of unskilled and semi-skilled labor for production-line contracts. The majority of these laborers are housed in basic industrial living quarters on the industrial estates. On weekends large numbers of young laborers frequent Batam's extensive commercial and entertainment districts for relaxation and entertainment.

As a result of Batam's growing economic success, plans are now underway to expand the Batam industrial zone to the adjacent Rempang and Galeng islands. Recently Sabang (in Aceh) was declared a free trade zone and proposals are now under consideration by the national assembly to further expand free trade status to other key port city economies. Proposed ports include Bitung in North Sulawesi, Morotai in Maluku, and Biak in Papua.

While Batam is regarded as one of Indonesia's best economic success stories, its social culture facilitates risky sexual behaviors. Regarded as a top site for the sex trade and sex tourism in the region, Batam is well known in the Malaysia-Singapore-Indonesia region for its flourishing nightlife of 10,000 brothel-based and street-based female and male sex workers. Unlike Indonesia's village social culture found in most community settings, Batam is devoid of Indonesia's traditional social networks. Batam is a community focused on business, exports, tourism, sex and money. Batam is unwittingly contributing to a growing Indonesian business venture -- the import-export of HIV/AIDS.

Indonesia's Marine Sector:

As an archipelago nation, the importance of sea-based commercial enterprises to national life, including the shipping and fishing industries, cannot be overstated.

Seafarers:

The commercial shipping industry is divided into three primary categories -- international, domestic and community. In general, domestic and community ships are owned and managed by the same company. These ships include small to mid-sized vessels as well as the traditional *Bugis Perahu* wooden schooners commonly used in community shipping. In the international category, the majority of the ships are foreign-owned and chartered for use by large Indonesian companies. The ocean-going ships serving Indonesian waters employ a diversity of nationalities. In 1992 ocean

going ships entering Jakarta ports showed a sailor profile of 12% Indonesian, 28% Asian and 60% from the rest of the world.

In addition to Indonesia's strategic geographic location surrounding Asia's primary shipping lanes between the Indian and Pacific oceans, key factors influencing visits to Indonesian ports include Surabaya's specialized ship maintenance facilities and the GOI's subsidy on marine fuel. Despite the fact that the GOI is proposing to reduce the fuel subsidy and the recent scathing reports on the conditions of merchant ships operating in Southeast Asian waters, worldwide, the sector continues to grow in an unprecedented economic boom. While all ships prefer to keep time in port to a minimum, on average ships of all types are found to remain in larger Indonesian ports for a period of four days. This provides sailors with sufficient opportunities to engage in risky "rest and relaxation" behavior in the large brothel and entertainment zones adjacent to most port areas.

Seamen:

Indonesia's rich marine resources continues to attract significant numbers of foreign as well as domestic commercial fishing and seafood processing ships to its waters. Key fishing areas are located in the eastern seas near Papua, the seas adjacent to the Maluku, the Java Sea straddling Indonesia and the Celebes Sea bordering the Philippines. Indonesia's sea resources attract small local fishing vessels, large vessels from major provincial ports, as well as large numbers of Asian factory ships with native crews from Thailand, Cambodia, Burma, Philippines, Vietnam and Taiwan. The rise of the commercial fishing industry in Indonesian waters has brought with it related service industries in the form of large canning factories, associated port services, and growing entertainment and commercial sex enterprises. Large factory ships employing hundreds to thousands of Thai and other Asian nationals are found across the archipelago, from North Sumatra ports, adjacent to the Thai border, to Papuan ports. While there is no government data on the absolute numbers of foreign fisherman in Indonesian waters at a given time, there are reports that Thai companies are in the process of expanding operations in Indonesian waters. Limited HIV prevention activities conducted by NGOs in ports frequented by Thai fishermen all report similar behavioral findings: multiple sexual contacts, low condom use and very low perception of risk of HIV outside Thailand.

Recent reports of high rates of HIV infection (over 30%) among Thai fishermen tested in Central Kalimantan ports indicates that the GOI's special deployment of public health officials to port city "border towns", as part of its HIV control strategy, is not effective. As the rapid rise in HIV prevalence in 2000 in Indonesian port cities directly correlates with those cities known to be frequented by foreign seamen (and seafarers) it is clear that Indonesia's ports serve as primary HIV transmission sites, and must become priority sites for immediate, intensive and coordinated disease prevention interventions.

Indonesia's Legal and Illegal Labor Industries:

Increased urban and rural poverty in Indonesia in an era of increased global demand for cheap labor places a variety of opportunities and constraints on Indonesia's vast labor supply.

Legal export labor:

The export of labor outside of Indonesia's borders is a government sanctioned and regulated industry. Each year thousands of young men and women are legally contracted for employment in overseas locations, primarily to neighboring Singapore, Malaysia, the Middle East, as well as to Hong Kong, Taiwan and Korea. An estimated 150,000 laborers are contracted annually as legal *Tenaga Kerja Indonesia (TKI)* export workers. While Indonesia does not compare with neighboring Philippines in the relative size of its overseas, export labor force, demand for Indonesia's export labor is increasing. At the same time, improved freedom of the press and transparency has begun to open the door on an industry fraught with corruption and violations of human rights and sexual abuse. Stories of physical abuse of women throughout the export process are commonplace. There are increasing reports of women returning from Malaysia and the Middle East infected with STIs and HIV.

Illegal export labor:

Labor is also being exported illegally through Indonesia's porous port cities and coastal villages. Controlled by regional mafia and local agents, the largest destination country for illegal migrants is Malaysia, followed by Singapore and other Asian countries. While many illegal laborers end up working in difficult work environments in private homes in Malaysia, more cases are appearing in the sexual entertainment areas in Asian cities, where the situations look more like trafficking cases. Similar to legal export workers, the illegal migrants have little to no access to legal aid support systems in Indonesia or destination countries.

Domestic migrant labor:

Transient workers and daily labor are commonplace throughout Indonesia. Unskilled transient labor arrives in urban areas and provincial cities on a seasonal basis and in response to local economic conditions. Since 1998, the numbers of jobless adults (as well as children and youth) appearing on urban streets has skyrocketed. These workers hope to end up in urban construction jobs, as seasonal agricultural workers, or in contracts with expanding industries. Since the economic crisis, more of these workers have had to accept the only positions available -- as illegal migrants, trafficking victims or as new sex workers. Many female school dropouts start a life on an urban street as an innocent street kid and end up serving an urban pimp as a "streetwalker".

It is also important to recognize the critical role this particular population group serves as clients to the sex industry. Transient laborers are among the largest consumers of commercial sex in urban slum areas, seeking services in informal brothel zones, *warungs* and bars close to railway stations, bus depots and port areas. The sex is cheap and very accessible. Use of condoms and other health-seeking behavior among transient laborers is very low as a result of low levels of education and a general lack of knowledge and neglect of personal health.

Women and Child Trafficking:

The trafficking of humans, particularly young women and girl children, is an increasing reality throughout Indonesia. Global pressures for "clean" young women and girls for sex (and marriage) as a result of the global HIV pandemic have created a very powerful and prosperous human trafficking industry in Indonesia.

The increased value of Indonesian women, added to the local traditions of employment or the early marriage of daughters in an era of increased poverty remain significant "push factors" for the trade of girl children in particular geographical areas, including West Java, East Java, Sumatra, Kalimantan, Bali and Sulawesi. As in other Asian nations, trafficking in the Indonesia context is both a domestic and international issue. In numerical terms, international trafficking appears to be a smaller problem than domestic trafficking. Key destination countries for trafficked women include Malaysia, Singapore, Hong Kong, Taiwan, Japan, and Australia. Most of these women are duped or sold by family members through local syndicates and then transported internationally through coastal communities and port cities (such as Batam) to work in sexual slavery or in bonded labor. While official data on internationally trafficked Indonesians is not available the actual supply appears to be lower than that documented by some neighboring nations.

In contrast, the situation and extent of domestic (cross-island) trafficking of young Indonesian women, girls and boys is an issue of extraordinary magnitude in Indonesia today. Estimates of domestically trafficked women and children range from several hundred thousand to more than half a million annually. While the numbers of trafficked persons living in brothel communities is not documented due to the routine falsification of identification, NGOs working with these communities estimate that in some localities 30-50% of brothel-based sex workers are in fact, trafficked girls, under age 18. Public discussion of this issue has only been permitted since the fall of the New Order regime. In the last three years NGOs, donors, and concerned citizens and government officials began to address this most sensitive problem.

Young women and girls are trafficked throughout the archipelago. Traffic patterns are seen from West Java and East Java communities, as well as districts in Sumatra, Kalimantan and Sulawesi, to transit sites and final destinations where the women and girls work in prostitution or servitude in port cities, urban areas, tourist enclaves, or industrial towns. Communities of trafficked women and girls are commonplace: (1) in cities including Jakarta, Surabaya, Palembang, Medan, Jayapura, and Manado; (2) in tourist areas such as Bali, Batam, and Bintan, and (3) in bustling port cities such as Tanjung Pinang (Bintan Island/Riau), Tanjung Batu (Kundur Island/Riau), Bitung (North Sulawesi) and Sorong (Papua). While the trafficking of boys is believed to be only a small number in relation to girls, it does exist in Indonesia in the form of pornography, sex tourism, and forced labor in dangerous industrial/agricultural settings.

The trafficking of persons within Indonesian borders continues without interference of police, military, community or religious leaders. In many situations it appears that community leaders are directly involved in the management of these exploitative acts. This is certainly the case in most controlled brothel settings. As sub-epidemics of HIV continue to grow in Indonesia in the near future, the issue of human trafficking will be increasingly recognized. It is already a major public health concern among government health officials located in key cross-border communities. These officials worry about the impact of the increasingly popular “pleasure” industries in their communities.

Source: Annex to the 2000 USAID/Indonesia Annual Report, entitled “HIV/AIDS: Another Threatening Crisis”, pp. 11-17.
